United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: November 15-19, 2010

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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 Facility for Persons with Mental Retardation (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 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 or her every six months, and detailing his or 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 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of the State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Health Care Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry, 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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this review, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, at-risk procedures, and consent; Natalie Russo

reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Daphne Glindmeyer reviewed psychiatry services; Gary Pace reviewed psychological care and services, restraint, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, recordkeeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 might 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, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. 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 review. The Monitoring Team made additional requests for documents while onsite.

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), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living discharge plans (CLDPs), 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 onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

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.

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, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment:** No later than 14 calendar days prior to each visit, the facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** 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 noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. 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. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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

IV. Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SGSSLC for their openness and responsiveness to the many activities, requests, and schedule

disruptions caused by the onsite monitoring review. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The facility director, Dr. Philip Baugh, set the tone for the week of the onsite review. He was readily available, ensured that all requested information was obtained, and directed all of the staff to work cooperatively and openly with the monitoring team. The monitoring team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Penny Bivens. She worked tirelessly during the week of the onsite review (as well as during the weeks immediately proceeding and following the onsite review) to ensure that the monitoring team members were able to obtain the information they needed to conduct this review.

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

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

Third, this was the first post-baseline review of SGSSLC. These reviews are called compliance reviews and this is a report of the compliance review, that is, of the facility's status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement requires the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. In the monitoring report, the Monitor is to describe and comment upon the self-assessment steps the facility undertook to assess compliance and the results of this self-assessment. At SGSSLC, the self-assessment consisted of two documents called the Plan of Improvement (POI) and Supplemental Plan of Improvement (SPOI). These were submitted to the Monitor within the required timeframes. The POI described the many actions the facility had taken, or planned to take regarding each provision of the Settlement Agreement. The SPOI described the facility's response to each of the recommendations in the baseline report. The Monitoring Panel and the

parties have had a number of discussions regarding the POI and SPOI. As a result, a number of revisions and additions are going to be put in place for future POIs and SPOIs because in its current version, the documents did not provide the Monitor with sufficient detail regarding the facility's actions (e.g., number of cases reviewed, criterion used). A draft version of a new POI was circulated and it appeared that the revised format would allow the facility to describe its progress specific to each provision and provision item, detail the actions it planned to take, and respond to recommendations and suggestions from the monitoring team.

The monitoring review at SGSSLC is the last facility reviewed during each round of the monitoring teams' 13 compliance reviews. The monitoring team at SGSSLC was pleased to see examples of initiatives taken based upon reviews that were conducted earlier in this round of reviews over the past few months. One example was the initiation of psychiatry staff's handling a greater responsibility for the consenting process for psychotropic medications.

Fourth, many changes were in process during the time of this compliance review. Some were a function of statewide changes based upon requirements of the Settlement Agreement, including specific responses to comments in baseline reports and compliance reports conducted over the past few months at other facilities. The monitoring team looks forward to seeing the results of these new processes during the next onsite review. Some examples of processes that had recently been initiated, revised, or were pending revision included:

- Personal Support Plan meetings
- Personal Support Plan documents
- Community Living Discharge Plan activities
- Community Living Discharge documents
- Psychology department activities and a new director of psychology
- Psychiatry department and a new lead psychiatrist
- Pharmacy activities and a new clinical pharmacist
- Quality Assurance activities
- Assessment and management of individual risk
- Physical and Nutritional Management Team
- Self-advocacy group activities

Fifth, a brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraints

- The facility gathered and analyzed data on restraints monthly and produced both a monthly and an annual report that looked at the implementation of restraint along a variety of variables (e.g., types, individuals involved, location on campus). The facility's data indicated that there had been a total of 964 emergency and programmatic restraints utilized in FY10. There had been 390 total restraint incidents at the facility during the quarter prior to the monitoring visit (FY10 4th quarter). This was an increase of 46% when compared to the previous quarter and a 33% increase when compared to the FY09 4th quarter. There had been 880 restraints used between 1/1/10 and 9/30/10. Of those restraints, 357(41%) were programmatic restraints and 523 (59%) were emergency restraints involving 89 individuals. Trending of data indicated that there had been an overall increase in the use of all restraints at the facility since last year.
- The use of a six-point posey net as a form of mechanical restraint had been discontinued by the facility in August 2010. In the three months prior to the monitoring visit, there was a decreasing trend in the use of chemical restraints and an increasing trend in the percentage of mechanical restraints implemented. In July 2010, 23% of behavioral intervention restraints were chemical restraints and less than 2% were mechanical restraints. In August 2010, 20% were chemical restraints and 5% were mechanical restraints. In September 2010, 14% were chemical restraints and 7% were mechanical restraints, the remaining 79% were physical restraints.
- Four restraints were examined by the facility's QA department. None met the mandates of the Settlement Agreement in two or more major compliance areas. The facility had rated the restraints as being 100% compliant in any area that did not apply to the restraint incident, and this also resulted in ratings that did not accurately reflect data collected. The facility needs to review the monitoring process to determine how data will be collected and used to develop a plan to correct any deficiencies identified.
- The facility now had data regarding the use of both medical and dental restraints since 1/1/10 and was just beginning to look at implementing desensitization plans for individuals who required restraint for routine medical and/or dental procedures. The dental hygienist at the facility had developed some informal desensitization procedures, but strategies were not typically included in individual plans. Although the facility had an interdisciplinary Restraint Reduction Committee in place that met quarterly, efforts had not had an impact on restraint reduction. The committee had redefined its purpose and mission to match recommendations made by the monitoring team during the baseline review. The committee was struggling with how to most effectively address restraint reduction. In addition, the facility had recently developed a work group focused on programming at the facility. The lack of meaningful engaging activities and programming at the facility seemed to be an overriding factor in behavioral issues leading to restraints. The work group had partnered with the facility's self-advocacy group to address this issue and seemed to be sincerely attentive to programming issues identified by individuals living at SGSLLC. Some of the planned changes included a new recreation center, an adult oriented art center, work readiness programs, and peer-to-peer counseling.

Abuse, Neglect, and Incident Management

- Investigation of 844 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/09 through 8/31/10. These 844 cases included 1597 allegations involving 405 individuals identified as potential victims, and 335 staff at SGSSLC identified as possible perpetrators. Of these 844 cases, 51 (6%) were confirmed by DFPS. These 51 confirmed cases involved 92 allegations of abuse or neglect. Fifty-seven additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The remainder of the cases included 465 unconfirmed cases, 204 cases referred back to the facility, and 44 unfounded cases. There was an increase of 6% in the total number of cases reported to DFPS from FY09. Trends reports showed a steady increase in the number of cases reported to DFPS for each quarter of FY10, with the fourth quarter total being the highest in the past two years (263 cases). There were a total of 3597 injuries reported at the facility in FY10. A total of 1030 of these injuries occurred in the 4th quarter of FY10. This was an increase of 19% from the 4th quarter in FY09 and an increase of 11% from the 3rd quarter of FY10. Of the 3597 injuries reported during FY10, 42 were considered serious injuries (less than 2%), 2701 were non-serious injuries requiring first aid, and 852 required no treatment. There had been four serious injuries documented in September 2010 alone, with two fractures and two requiring sutures or staples.
- Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. Evidence from the surveillance cameras was being used in investigations. This evidence was beneficial for confirming abuse and neglect in cases where evidence might not otherwise have been available to support the allegations. The facility only employed two full time investigators. Facility management should review the workload of the two investigators and determine if thorough investigation of all incidents is a reasonable expectation for two facility investigators. Unfortunately, the number of spurious allegations at the facility drained facility resources and created an environment where abuse and neglect could go unnoticed.
- It was evident throughout the monitoring review that SGSSLC, DFPS, and OIG worked cooperatively together to address issues identified in the incident management process. The continuing of this cooperative relationship will be essential in meeting the requirements of section D given the significant number of incidents reported at the facility, and the resulting strain placed on the staff of all three entities. Some provisions in section D were not rated as being in noncompliance based on current DFPS policies and procedures. These issues were discussed in a meeting with DFPS, DADS, and the monitoring teams on 12/2/10. DFPS had already addressed a number of concerns raised by the monitoring team. The monitoring team anticipates that DFPS will continue to work cooperatively with DADS to address issues as they are presented in subsequent monitoring reports.

Quality Assurance

- Further work on the collection of data, review of data by the new QIC, the management of corrective actions, and the creation of a QA plan and a QA report are some of the activities that will be required in order for SGSSLC to be in substantial compliance with this provision. A lot of QA-related activity, however, had occurred since the baseline monitoring review. First, the PIC had been changed to the QIC. The plans were for the QIC to have responsibility for looking at a variety of data sets from across all operations at the facility (e.g., Settlement Agreement compliance, ICFMR regulations, Life Safety Code activities, and data from all of the operational and service departments of the facility), to determine when corrective actions were needed, and to manage and oversee implementation of those corrective actions. Second, the QA department had recently begun the task of creating a comprehensive list of all data that were collected at the facility. The intention was for this list to then be reviewed by QIC so that the QIC could determine what data it wanted to regularly review. Third, observation and monitoring of various areas by QA department staff across the facility had continued since the baseline review.
- Data collected at SGSSLC, however, were not organized under a QA plan as to what data should be collected by QA staff, what data should be submitted by facility departments to the QA department, and how those data should be handled once submitted. Regular reports were not completed by the QA department for use by senior management. Initial attempts at CAPs were seen at the facility.
- Self-advocacy activities remained active. The group met each month. According to the minutes of the meetings, little had changed since the baseline review. That is, the meetings remained, primarily, a forum for individuals to bring up problems (e.g., need for cigarette lighter access) that facility staff solved or followed up on. The most recent meeting, however, was encouraging because it presented the self-advocacy group with a problem (safety in the evenings at the facility's on campus park area) and asked them to help solve it by generating possible solutions and volunteering to be on a committee.

Integrated Protections, Services, Treatment, and Support

- The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings. PST meetings observed the week of the monitoring visit were in the new-style format. For all QMRPs facilitating the meetings, this was a new process for them, as well as for other team members participating in the meetings. As expected, the meeting format was not completely comfortable for the QMRPs and the other team members.
- Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective.

Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST.

- Administrative staff at SGSSLC had taken some positive steps towards evaluating and revamping the service delivery system in regards to active treatment at the facility including:
    - Beginning implementation of the new statewide person centered planning process.
    - Developing a focus group to look at person centered programming at the facility in terms of needs specific to the population served at SGSSLC.
    - Identifying gaps in present programming and service delivery with input from individuals served by the facility.
    - Developing plans to address some of the gaps in services identified through this process.
- Quality Enhancement activities with regards to PSPs were in the initial stages of development. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual.

<u>Integrated Clinical Services and Minimum Common Elements of Clinical Care</u>

- State policies were not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. Even so, some activities were occurring at SGSSLC. Medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. The facility had identified the medical director and the chief nurse executive as the lead managers for these provisions of the Settlement Agreement, and a number of activities had occurred regarding this provision item since the baseline review. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which SGSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below in sections G and H. It is likely that a specific focus to ensure that all areas of clinical service provision as specified in both provisions are included in the facility's provision of integrated clinical services. It is recommended that the facility's QA play a role in addressing this provision.

<u>At-Risk Individuals</u>

- The state had recently revised the policy regarding risk identification. It was now in draft form and was being piloted at two other SSLCs. The hope is that this will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place. DADS Policy #006: At Risk Individuals was the policy being implemented at SGSSLC. The state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy that went along with this policy. The

rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place. The facility had a system in place to address risk in 18 specific areas. A Health Status Team was actively reviewing individuals for risk in all of these areas. It was noted, however, that not all medical concerns were addressed for each individual. A risk area of concern that was identified in the review of unusual incidents at the facility was the potential spread of sexually transmitted disease due to the high number of sexual incidents reported at the facility. There was no indication that this had been identified for a number of individuals involved in multiple sexual incidents other than to try to reinforce the facility's "no sex" policy. Safe sex practices had not been supported or encouraged at the facility for individuals whose rights to engage in consensual relationship had not been formally restricted.

<u>Psychiatric Care and Services</u>

- SGSSLC had a physician and a physician extender (advance practice nurse) providing psychiatric care, however, they were overwhelmed with the current clinical and administrative responsibilities. A recently recruited lead psychiatrist was reportedly joining the psychiatric team in December 2010, much to the relief of the current practitioners. The current psychiatric practitioners had integrated themselves well with the primary care physicians. The physicians reported frequent informal reviews of the cases of individuals who were experiencing behavioral challenges or medication side effects that did not rise to the level of requiring inpatient or infirmary care. This was the area where integration was most developed. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation).
- What was most striking during the review, was that staff overall were caring and invested in the treatment of the individuals and had the desire to see the individuals benefit from treatment. It was, however, impossible to determine this investment via document review because, in many records, there were no psychiatric records to review. There was a great deal of delinquent dictation and documentation. The monitoring team suggested that, as providers would likely not be able to accurately recall the details of so many past clinical encounters, that the providers dictate one note covering care over a period of time and "start fresh." This, while not optimal, is better than the current lack of documentation. It is hoped that the new lead psychiatrist can infuse the department with the vigor and tenacity they will need to complete their documentation requirements, integrate themselves with the other team members, and collaborate fully with psychology in the treatment of the individuals assigned

to their caseload. Even with the noted deficits, there were some "bright spots" that were specific to individual employees. The current psychiatric assistant was doing an excellent job with regard to organizing and tabulating data.

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was however, progress in several items. The monitoring team noted several positive developments at SGSSLC since the baseline review. These included the commitment of the department to become competent in Applied Behavior Analysis (ABA) as measured by the completion of one psychologist's coursework for board certified behavior analyst (BCBA) certification, enrollment of eight psychologists in BCBA coursework, and the obvious enthusiasm of the psychology department to learn more about the field of ABA; the addition of a qualified director of psychology; the establishment of the foundation of internal peer review; and improvements to the data collection system.
- There were also areas that the monitoring team believes require immediate attention. Those areas include enhance the accountability of the data collection system by requiring direct care professionals (DCPs) to mark every interval of the data card; simplify the data system by reserving the collection of ABC data for assessment purposes only; expand the data system by adding duration and time sampling measures; and incorporate the use of potent contingencies (e.g., positive reinforcement, differential reinforcement, response cost) into PBSPs to both increase desirable behaviors and decrease dangerous and undesirable behaviors.

Medical Care

- Progress from the baseline visit was seen in several areas. Efforts in developing a quality improvement process were evident based on the various tools that had been piloted. In other areas, such as the mortality review process, no substantial improvement was noted. The facility had been unable to secure the services of an external physician reviewer to participate in the process. Observations in several homes indicated a lack of physician presence in these areas. The monitoring team observed the primary care physicians spending significant time in the medical complex office areas engaged in casual and informal meetings. There were significant problems related to the failure to complete annual medical summaries in a timely manner. This resulted in annual PSP meetings sometimes using old information during the planning process. Requirements for completion of quarterly medical summaries were also not met.
- The most concerning issue was inadequate follow-up of problems as evidenced by a lack of physician documentation. Individuals who returned from the hospital frequently did not have any documentation by the SGSSLC physician of the hospital event. Labs, consults, and other abnormal findings were rarely documented in the progress notes. A lack of summary notes, annual medical assessments, and quarterly summaries resulted in the user of the integrated record being unable to obtain a quick snapshot of the status of the individual.

Individuals with complex medical problems and frequent hospitalizations did not appear to receive additional follow-up or planning.

- Overall, there appeared to be a lack of integration of medical into the team process. There were no daily meetings with other disciplines and the medical staff did not usually participate in the personal support planning meetings or addendums.

Nursing Care

- All homes were visited, 20 nurses were interviewed, and 25 individuals' records were reviewed. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in recordkeeping practices. Also progress was made toward substantial compliance with other provisions of the Settlement Agreement and Health Care Guidelines. For example, monitoring tools had been selected, reviews had occurred, and the establishment of inter-rater reliability was underway. Various other performance improvement activities were developed in response to the facility's identification of problems and areas of deficiencies in performance. The monitoring team met nurses who were proud to show the results of their efforts to improve the timeliness, content, and quality of individuals' nursing assessments and plans of care. The conduct and competence of the Hospital Liaison was a good example of the facility's progress toward achieving compliance with nursing assessment and reporting protocols.
- Notwithstanding these positive findings, as noted in the baseline review, SGSSLC continued to operate under the situation of a nursing shortage. Indeed, the nursing shortage had intensified since the baseline review and, despite the hard work of many nurses, it had taken its toll on the delivery of nursing supports and services to individuals. For example, there were frequent and regular absences of complete nursing assessment and follow-up to individuals' emergent health care problems and needs and a pattern of failure to develop adequate, appropriate, individualized plans to address/resolve individuals' health problems, needs, and risks through the implementation of planned, individualized interventions.
- In 21 of the 25 records reviewed (84%), nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including, but not limited to medications and treatment, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments.
- The administration of medication and the management of the medication administration system at SGSSLC had also not improved since the baseline monitoring review. As indicated in more detail below, much work still needed to be done to ensure that medications were administered and accounted for in accordance with standards of practice and the Health Care Guidelines.

Pharmacy Services and Safe Medication Practices

- The pharmacy was staffed with a pharmacy director, pharmacist, and three pharmacy technicians. The facility was negotiating with a clinical pharmacist at the time of the onsite review and the pharmacy director believed that one would be hired by the end of November 2010. Little progress had been made since the baseline visit. The pharmacy director expressed that he was overwhelmed by his duties and felt that many of the requirements related to the Settlement Agreement were beyond the scope of his practice. He reported that he had little guidance in carrying out these duties and was functioning as best possible. Statewide conference calls involving all pharmacy directors had proven beneficial, but had not occurred in recent months.
- Significant issues were noted in every section of this provision, including that there was no documentary evidence that all medication orders received the appropriate reviews; drug regimen reviews were not being completed in a timely manner and many were appearing in the records four to eight months after the due dates; primary care providers did not comply with the requirement to agree or disagree with the recommendations of the pharmacists; the facility had not established a system for detecting, monitoring, and reporting adverse drug reactions; and the drug utilization evaluations completed were rudimentary and the system did not meet the requirements of the Health Care Guidelines. Two serious medication errors resulting in hospitalization had occurred in the month prior to the onsite review.

Physical and Nutritional Management

- The process used to establish health risks continued to be inconsistent across the HST and NMT. A new system for risk assessment had been developed, but was not yet in place statewide. There was also a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT). SGSSLC had identified the team members and a meeting was scheduled for 12/15/10. The existing NMC functions were to be integrated into the PSP process. In addition, the health risk assessment system was also being revised and a trial was being conducted at the time of this onsite review. Review of this process as implemented at SGSSLC will be necessary as the new systems for Health Risk Assessment and PNMT review are established during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team expects that these issues will be resolved as the new systems are implemented in the near future.
- There were observable improvements at mealtimes and more so related to positioning. There continued to be some inconsistencies as information did not also match across each of the plans. There continued to be room for improvement and a clear need for competency-based staff training and monitoring of compliance. The PNMPCs were not consistently identifying errors noted by the monitoring team that should have been recognized and remedied. Staff training continued to be more focused on information rather than skills necessary to appropriately implement PNMPs. PNMPC training will be a critical element to the overall success relative to PNM supports and services.

Physical and Occupational Therapy

- The focus for OT/PT had been related to improving the assessment process and the provision of staff training. The assessment format was revised to include medications, medical history, comparing changes across time, and other modifications to the content of the reports. In addition, a Living Options section was added and currently, the risk levels identified through the HST process were also addressed. Increased evidence of comparative analysis relative progress or regression was noted in a number of recently completed assessments. There was no data system used to track completion of assessments submitted. There was great inconsistency in the types of assessments used across individual, however, the facility later indicated that recent changes were being put in place. For example, updates were used for annual assessments as well as a progress note-type of documentation related to a problem or for documentation of interventions provided. In other cases, a consult report was used. There was less frequent documentation by therapists in the integrated progress notes and as a result the information was not well integrated into the process of service delivery as a member of the PST.
- The process observed during the PNMP Clinic was interactive, interdisciplinary, and generally thorough. There was evidence that the clinicians were very active in the provision of indirect supports to address identified issues as they came up, however, the documentation did not accurately reflect this activity. In general, however, it appeared that staff were attending better to the details of proper positioning and compliance with the PNMPs and implementation was improved since the previous onsite review by the monitoring team.
- In general, the clinical staff worked well together and presented with a strong knowledge base relative to therapy clinical information. There was a need to tighten up their systems and documentation. Staffing levels remained unchanged since the previous review and continued to pose a challenge to effective implementation of the elements of the Settlement Agreement. There were eight PNMPCs who provided monitoring and staff training. The training programs for these staff were ongoing to identify specific competencies for PNM-related areas such as mealtime, alignment and positioning.

Dental Services

- The Dental Department staff was comprised of the dental director, full-time dental hygienist, part time dental hygienist, dental assistant, and a contract dentist/anesthesiologist. The part time hygienist worked eight hours on Tuesday and Thursday. The full time hygienist did not provide any direct clinical care. There were three operatories, two of which were fully equipped.
- The facility had made significant progress since the baseline visit by addressing every recommendation contained in the baseline report. Initiatives in data management, quality improvement, documentation, and restraint management were visible. The clinic benefitted from the leadership of a full-time RDH who was responsible for ensuring that the clinic staff was knowledgeable about the provisions of the Settlement Agreement, dental policies, the Health Care Guidelines, and the agency's POI.

- Record reviews, interviews and observations indicated that individuals were receiving a variety of services in the dental clinic. Problems were identified in the areas of restraint use, oral hygiene in the homes, and missed appointments. It was evident that a great deal of thought and effort had been utilized by the clinic staff in identification and analysis of the problems. Corrective actions were implemented in the problematic areas. In spite of this diligence, the monitoring team was not able to find adequate evidence to support compliance. The dental clinic will need support from disciplines such as psychology, nursing, and residential services in order to meet the requirements set forth in the Settlement Agreement.

Communication

- Positive progress was evident since the baseline review. Staffing had changed somewhat with the addition of two additional part-time contract staff, however, the fulltime clinician available during the baseline review had since resigned. SGSSLC had not been able to successfully recruit additional SLPs. As reported in the baseline review, clinician caseloads were still very high and it would likely be difficult to meet all this provision of the Settlement Agreement with the current numbers of staff.
- Revising the communication assessment format, revising the Master Plan to determine priorities for completion of new assessments, and increasing communication opportunities for individuals at SGSSLC was a focus since the previous review. Each of the individuals had been prioritized for re-assessment because the previous assessments were inadequate. There were approximately 30 individuals who had received a more current assessment since the previous onsite review by the monitoring team. The current assessments were much improved, though clinicians should take care so that there is sufficient exploration of AAC supports for those with serious communication deficits and for those who were non-verbal with communication-based behavior concerns. Recommendations appeared to be based primarily on existing abilities only, rather than also on potential for benefit from structured exposure to and training opportunities related to AAC use.
- In some cases, the assessment addressed expansion of current abilities via very limited recommendations for communication strategies, such as reinforcing the individual's communicative efforts or advising staff to refer to the individual's communication dictionary. There was no evidence that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. In some cases, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine.

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility.
- Although no items of this provision were found to be in substantial compliance, since the baseline review the facility had begun several new initiatives. These included recent trainings to improve the incorporation of individual's needs and preferences into specific program objectives (SPOs); development of new assessments of individual skills (including new vocational assessments); development of a new SPO monitoring form; establishment of a multidisciplinary team to improve individual engagement; development of a tool to measure engagement; and addition of six activity specialists that are responsible for planning community outings and improving community integration.
- Facility management should consider other areas of training and education for individuals at SGSSLC. Two areas of need noted by the monitoring team were related to healthy living: cigarette smoking and safe sex practices.
- Some progress was observed in the provision of educational services to individuals at SGSSLC who were under age 22 and still qualified for educational services. There was a positive working relationship between SGSSLC and the local school district, Water Valley Independent School District (WISD).

Most Integrated Setting Practices

- Overall, SGSSLC had made progress in some areas since the baseline report. For example, the new PSP process was in place, referrals and placements were maintained at the same rate, and all three post move monitoring visits were occurring at the community residence. On the other hand, not a lot had changed since the baseline review, especially regarding the addressing of obstacles to placement, the determination and defining of essential and nonessential supports, and the reporting of post move monitoring.
- The number of individuals placed in the community represented a relatively small percentage of the SGSSLC population, that is 9% of the individuals over the past 12 months (23 placements since December 2009). The facility created listings of individuals for whom LAR preference was the only reason for he or she not being referred for placement. The lists did not include all of the individuals to whom this applied and it is recommended that the lists be corrected so that this important information can be regularly shared with SGSSLC management.
- The new PSP was recently initiated at SGSSLC. Three annual PSP meetings were observed by the monitoring team. The new process appeared to have the potential to improve the depth and breadth of discussion regarding optimistic optimal living characteristics for each individual. At the time of this onsite review, however, the new style PSP meetings were not accomplishing this goal. This was not surprising given that it was

only the second or third time that each QMRP had implemented the new process. It seemed apparent, however, that the QMRPs needed to become more fluent with this new process. In addition, the QMRPs would benefit from, and should be given, training in how to facilitate and lead these types of meetings. Twenty-two new-style PSPs were reviewed. There was consistency in format, but more information was needed regarding the supports and services needed by the individual, obstacles to placement, and comprehensiveness of training objectives chosen. Specific questions were raised for four of the PSPs.

- SGSSLC continued to engage in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. SGSSLC, however, should consider ways of assessing the effects of these activities and making improvements. For example, regarding the provider fair, the facility could determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. Similarly, the CLOIP process had been in place for a number of years. Outcomes of the CLOIP should be determined and the effectiveness of the CLOIP assessed. Further, as noted below, more work should be done on the system of community tours, and the self-advocacy group could be used as an opportunity to educate individuals about community placement.
- The CLDP process was also being revised. Comments are provided regarding the proposed new CLDP and post-move monitoring forms and procedures. A continuing problem was the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. The ability of PSTs to play a more active role was needed; examples are provided.
- Post move monitoring was occurring, however, 25% of the visits occurred later than required by the timeframes of the Settlement Agreement. Further, there continued to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home for a 90-day post-move monitoring visit occurred. Important information was obtained and the post move monitor conducted the visit in a professional and organized manner. Improvements, however, were needed to ensure that adequate evidence was observed to indicate the presence of each support. Further, the home was in poor condition indicating that further action was required of the post move monitor.
- Specific quality assurance procedures were not in place (see section E above), however, admissions and placement staff, as well as one QA staff member, had recently begun to complete monitoring tools regarding some of their work.

<u>Consent</u>

- SGSSLC was waiting on the final statewide policy before taking most actions related to this provision. While the facility maintained a list of individuals needing an LAR, not all individuals had been assessed and not all PSTs were adequately addressing the need for a LAR or advocate. The facility reported little activity or planning to

solicit guardians for those determined to be in need. Substantial compliance with this provision item U2 will necessarily be contingent to a certain degree on achieving substantial compliance with provision item U1 as a prerequisite. The facility did have an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were holding good discussions around the need for guardians while other teams were only minimally discussing the capacity for individuals to make decisions and give consent.

Recordkeeping and General Plan Implementation

- SGSSLC made progress towards meeting this provision of the Settlement Agreement. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. The facility had edited the state's table of contents making it a lengthier, but thorough list. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record.
- Two practices required attention from the facility. First, all volumes of the active record were transported whenever any portion of the active record was taken from the residence for any activity, even if much of the record was not going to be used, such as for a medical appointment. Second, the individual notebooks did not stay with most individuals at the facility, but instead remained in the residence office. Other recommendations for modifications to the records are made below and include addressing inconsistencies in where breaks occur across volumes, and whether any unnecessary documents are in the individual notebooks.
- The Unified Record Coordinator was committed to having an organized, user-friendly recordkeeping system. She was knowledgeable about the records and was interested in improving the records as implementation of this new system moved forward. Comments from staff at all levels indicated an overall satisfaction with the new recordkeeping practices. Audits as per provision item V3 had only begun a few weeks prior to the onsite review and, as a result, only two had been completed. Even so, useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. It will be important for SGSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the recordkeeping system.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of SGSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team continues to look forward to continuing to work with DADS, DOJ, and SGSSLC.
Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Use of Restraint Policy #001, dated 8/31/09 o DADS Administration of Chemical Restraint Consult Form o DADS Restraint Checklist Form, numbered 06032010R o DADS Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint o SGSSLC Response to Behavioral Emergencies Procedure dated 9/3/10 o SGSSLC Restraint Checklist, dated 7/27/10 o Training Curriculum: Restraint Prevention and Rules for Use at MR Facilities (2007) o Memo from SGSSLC Residential Services Department, dated 10/5/10 regarding requirements for Crisis Intervention Team involvement o SGSSLC Body Wrap Guidelines dated 9/30/10 o SGSSLC Crisis Intervention Guidelines off Campus o SGSSLC Crisis Intervention Team Agreement of Performance Form o SGSSLC Restraint Monitoring Tool o SGSSLC FY10 Restraint Trend Analysis Report o Training transcripts for 24 staff at SGSSLC o Restraint Reduction Committee meeting minutes since 1/1/10 o List of all individuals receiving emergency psychotropic medication since 4/1/10 o List of all medical and dental restraints since 1/1/10 o List of all restraint related injuries since 1/1/10 o List of all chemical restraints used since 4/1/10 o Incident Management Team meeting minutes 7/1/10-9/30/10 o List of individuals with medical and/or dental desensitization plans o Positive Behavior Support Plans in regards to provision item C7 for: • Individual #96, Individual #316, Individual #165, Individual #9, Individual #48, Individual #391, Individual #243, Individual #215, Individual #385 o Personal Support Plan addendums in regards to provision item C7 for: • Individual #48, Individual #391, Individual #249, Individual #351, Individual #243, Individual #9, Individual #316

- The following individual documentation for 45 restraint incidents:

Individual	Date/Type	Restraint Checklist and Face to Face Assessment	PSP Addendum(A)	PBSP	Safety Plan
#215	9/1/10 Physical	X	8/3/10	9/17/10	7/9/10
	9/1/10 Physical	X			
	9/1/10 Physical	X			
	9/7/10 Physical	X			
	9/7/10 Physical	X			
	9/7/10 Physical	X			
	9/7/10 Physical	X			
	9/16/10 Physical	X			
	10/2/10 Physical	X			
	10/3/10 Physical	X			
#346	10/4/10 Physical	X	1/14/10	6/18/09	8/6/10
	10/4/10 Physical	X			
#96	10/4/10 Physical	X	5/26/10	1/28/10	1/28/10
#178	9/28/10 Chemical	X	8/3/10	5/9/08	
	9/29/10 Chemical	X	8/20/10(A)		
#249	9/2/10 Physical	X			10/1/10
	9/20/10 Physical	X			
	10/7/10 Physical	X			
	10/7/10 Physical	X			
#271	10/3/10 Physical	X	9/21/10		
#316	9/4/10 Physical	X			
	9/4/10 Physical	X			
	9/4/10 Physical	X			
	9/4/10 Physical	X			
	9/19/10 Physical	X			
	9/23/10 Physical	X			
	9/23/10 Physical	X			
	9/23/10 Chemical	X			
	10/10/10 Chemical	X			
#239	10/1/10 Chemical	X	9/22/10	10/1/10	
#331	9/1/10 Physical	X	3/23/10	9/25/09	8/27/10
	9/10/10 Physical	X	4/13/10 (A)		

	9/10/10 Physical	X			
	9/10/10 Physical	X			
	10/5/10 Physical	X			
	10/7/10 Physical	X			
#488	9/1/10 Chemical	X			
	9/1/10 Physical	X			
	9/1/10 Physical	X			
	9/7/10 Physical	X			
	9/7/10 Chemical	X			
#9	10/4/10 Physical	X			
#170	10/2/10 Physical	X			
#292	10/4/10 Physical	X	10/6/10		3/5/10
	10/4/10 Physical	X	6/23/10(A)		

Interviews and Meetings Held:

- Interviews with various direct support professionals in homes and day programs
- Dr. Philip Baugh, Facility Director
- Jalown McCleery, Program and Management Support
- Natalie Montalvo, Director of Residential Services

Observations Conducted:

- Observations at residences
- Observations at the onsite workshop
- Morning Unit Meeting for Unit #3 11/16/10
- Daily Incident Management Review Team Meeting 11/17/10
- Daily Incident Management Review Team Meeting 11/19/10
- Human Rights Committee Meeting 11/18/10
- Restraint Reduction Committee Meeting 11/18/10
- PSPA meeting for Individual #346

Facility Self-Assessment:

The facility's self-assessment, its POI, for section C indicated that all items were in noncompliance other than C1. Section C1 was self-rated as being in compliance based on the state policy having had all necessary components to meet the requirements of this provision. Since it was not evident that SGSSLC was following mandates of the state policy, the monitoring team did not concur with the facility's rating of compliance to this provision. The POI noted, that for most sections of this provision, the facility would continue to review restraints trends and develop plans of correction as necessary. The monitoring team agrees with the facility's determination of noncompliance for section C. This section was rated based on review of restraint incidents, interviews, and observations. The monitoring team found that, while most staff had received training in the use of restraint and documenting restraint, the staff was not implementing procedures

	included in the training. There were systems in place of the monitoring and the review of restraint incidents, but these did not appear to be effective as evidenced by findings throughout section C. The facility also needed to take a look at the restraint review process for determining compliance with this provision. In order to gain substantial compliance with this provision, it is essential for all staff at the facility to adopt the philosophy that restraints will be used as a last resort measure, and the staff must be provided with the tools and knowledge necessary to make this a realistic outcome.
	Summary of Monitor's Assessment: The facility gathered and analyzed data on restraints monthly and produced both a monthly and an annual report that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred. The facility's restraint trend analysis indicated that there had been a total of 964 emergency and programmatic restraints utilized at the facility in FY10. There had been 390 total restraint incidents at the facility during the quarter prior to the monitoring visit (FY10 4th quarter). This was an increase of 46% when compared to the previous quarter and a 33% increase when compared to the FY09 4th quarter. There had been 880 restraints used between 1/1/10 and 9/30/10. Of those restraints, 357(41%) were programmatic restraints and 523 (59%) were emergency restraints involving 89 individuals. There had been 149 restraints implemented in September 2010. This was the greatest number of restraints used in any month over the past two years. The facility attributed this increase to a particularly high number of restraints used with one individual. Data indicated that even if the 22 restraints for this individual were not included in the trending data, the remaining 127 restraints implemented in September 2010 still constituted a 41% increase in the number of restraints implemented in September 2009. Trending of data indicated that there had been an overall increase in the use of all restraints at the facility since last year. The use of a six-point posey net as a form of restraint had been discontinued by the facility in August 2010. In the three months prior to the monitoring visit, there had been a decreasing trend in the use of chemical restraints at the facility and an increasing trend in the percentage of mechanical restraints implemented. In July 2010, 23% of behavioral intervention restraints were chemical restraints and less than 2% were mechanical restraints. In August 2010, 20% were chemical restraints and 5% were mechanical restraints. In September 2010, 14% were chemical restraints and 7% were mechanical restraints, the remaining 79% were physical restraints. SGSSLC had developed a tool to review a sample of restraint incidents for compliance with provisions of the Settlement Agreement. From a sample of four restraint incidents reviewed in October 2010, the facility had determined that it was in 95% compliance with items in the Settlement Agreement addressing restraint. The overall compliance rating was calculated by averaging the total compliance percentage across all categories. This did not present a true picture of whether or not restraints incidents were implemented following mandates of the state policy or Settlement Agreement. Data reviewed in each of the restraint incidents indicated that all four restraints did not meet the mandates of the Settlement Agreement in two or more major compliance areas, indicating that 0% of the restraints were in compliance with restraint mandates. The facility had rated the restraints as being 100% compliant in any area that did not apply to

	the restraint incident, and this also resulted in ratings that did not accurately reflect data collected. The facility needs to review their monitoring process to determine how data will be collected and used to develop a plan to correct any deficiencies identified. It was noted during the baseline review that SGSSLC was not gathering data on medical and dental restraints. The facility had data regarding the use of both medical and dental restraints since 1/1/10 and was just beginning to look at implementing desensitization plans for individuals who required restraint for routine medical and/or dental procedures. The dental hygienist at the facility had developed some informal desensitization procedures, but strategies were not typically included in individual plans. Although the facility had an interdisciplinary Restraint Reduction Committee in place that met quarterly, efforts had not had an impact on restraint reduction. The committee had redefined its purpose and mission to match recommendations made by the monitoring team during the baseline review. The committee was struggling with how to most effectively address restraint reduction. The facility had recently developed a work group focused on programming at the facility. The lack of meaningful engaging activities and programming at the facility seemed to be an overriding factor in behavioral issues leading to restraints. The work group had partnered with the facility's self-advocacy group to address this issue and seemed to be sincerely attentive to programming issues identified by individuals living at SGSLLC. In interviews with both individuals and staff during the monitoring visit, it was clear that everyone was on board and looked forward to seeing changes at the facility. Some of the planned changes included a new recreation center, an adult oriented art center, work readiness programs, and peer-to-peer counseling. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, daily incident management meetings, morning unit meetings, and Human Rights Committee (HRC) meetings. It was observed by the monitoring team that most of these meetings were attended by an appropriate interdisciplinary team and discussion took place among meeting participants regarding specific restraint incidents.

#	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	The state policy prohibited the use of prone restraints and mandated that restraints only be used if the individual posed a serious risk of harm to himself, herself, or others; after a graduated range of less restrictive measure had been exhausted; and be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others. The policy further specified what types of restraints were allowable at the facility. These policies were in line with the requirements of this provision. There was no evidence that prone restraint had been used by the facility. During the baseline visit, it was noted that the facility was using a 6-point posey net mechanical restraint that violated the state's policy prohibiting supine restraint. The facility had discontinued the use of this restraint system in August 2010. The Restraint Reduction	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Committee minutes from 11/18/10 further indicated that mechanical body wraps would only be used in an extreme emergency and the facility planned to develop a procedure outlining when body wraps may be necessary and who would be authorized to apply the body wraps. Data for the month of September 2010 indicated that mechanical restraints had been utilized as emergency intervention with eight individuals in a total of 11 separate incidents. A memo to all residential staff from the facility's Residential Services Department, dated 10/5/10, outlined procedures for the use of the facility Crisis Intervention Team (CIT). The memo stated, "After staff has attempted prevention/de-escalation skills and the (rule of thumb) ten minute horizontal restraint and the individual is still a danger to themselves or others, staff may call and request the services of the CIT." The memo further directed that the CIT would then assess the situation and determine if body wraps were warranted (for transport purposes only). Body wrap guidelines indicated the Officer on Duty must be called to gain approval for body wrap use on the 10:00pm – 6:00am shift if a CIT Leader was not available. It was not evident from the restraint checklist reviewed that this procedure was being followed. Restraint checklist showed body wraps were being used, but it was not clear if they were only used for transport purposes or if the CIT was involved in implementation. An allegation of neglect was confirmed in DFPS case #37895620 regarding a restraint incident utilizing mechanical restraint for Individual #331. The investigation found that the individual was kept in body wraps for almost two hours. The body wrap was applied by residential support staff without the CIT present. Documentation should reflect if the CIT was called and how they responded during the restraint incident in the narrative section of the form. Forty-five restraint reports across 13 individuals were reviewed. Restraint reports included a checklist of common interventions attempted to avoid restraints. This checklist had been completed on each of the 45 restraint incidents reviewed, but staff comments were not sufficient in all of the checklists (100%) to indicate that individualized approaches outlined in Behavior Support plans had been implemented prior to restraint. Three of the 45 restraint checklists reviewed (7%) did not indicate that the individual posed an immediate and serious risk of harm to him/herself or others. Restraint should only be implemented when there is a clear danger of serious risk for harm and only after other least restrictive interventions have been unsuccessful. • A restraint checklist for Individual #331 dated 10/5/10 indicated that the individual was first placed in a basket hold, next the horizontal side-lying restraint, and then was placed in the mechanical body wrap after she went outside and refused to come back to the home. There was no indication that she posed an immediate and serious risk of harm to herself or others. The form	

#	Provision	Assessment of Status	Compliance
		further indicated that restraints were used following unsuccessful attempts at verbal prompts. Other attempts at less restrictive interventions were not documented. • Another restraint checklist for Individual #331 dated 9/19/10 indicated that a basket hold was implemented when the individual and a peer "were being verbally aggressive towards each other and making threats to fight." Staff statements did not indicate that the individual posed an immediate or serious risk of harm to herself or others. • A restraint checklist completed on 10/3/10 for Individual #271 stated that "he climbed the staircase on east side of building 543, was prompted several times to walk down stairs by home staff and night home manager." He was placed in a basket hold, followed by a horizontal hold. His PSP identified preferences for being independent and having free time to walk around campus whenever he chose to do so. It further stated that when he was on routine supervision, he could do this whenever he chose and, when on enhanced supervision, he had to have staff with him. There was no indication in the restraint documentation that his actions posed an immediate danger to himself or others. It was not evident that restraint had not been used in the absence of, or as an alternative to, treatment. That is, as noted throughout sections F, J, K, and S, the monitoring team found deficits in behavior and other programming at SGSSLC; these problems in engagement, activities, and programming may set the occasion for the occurrence of problem behaviors, some of which may result in the application of restraint. The facility had established a work group to look at developing more meaningful programming with input from the individuals at the facility. At the Restraint Reduction Committee (RRC) meeting held the week of the monitoring visit, the committee discussed the impact that they hoped this might have on reducing the number of restraint incidents at SGSSLC. The monitoring team agrees that this is a step in the right direction for addressing the numerous behavioral incidents at the facility. We look forward to seeing the impact of proposed changes in programming. As noted in the following sections, restraints were not always monitored as required, and desensitization plans had not been developed for all individuals receiving sedation prior to routine medical and dental appointments. The facility was not in compliance with this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to	The facility policy mandated that restraints be terminated as soon as the individual was calm and no longer a danger to self or others. Based on the restraints reviewed: • Twenty-seven of 34 restraint checklists (79%) reviewed used the release code	Noncompliance

#	Provision	Assessment of Status	Compliance
	him/herself or others.	"P" at the time of release indicating that the individual was released from restraint when no longer an immediate and serious risk of harm to self/others. • Six (18%) restraint checklists indicated that the individual was released from the restraint due to incorrect holds/unable to maintain correct hold. • One (3%) restraint checklist indicated that the individual was released due to injury. About one half of the restraints reviewed were relatively short, with: • 53% under three minutes • 32% under 10 minutes • the remaining five lasted 16 minutes, 18 minutes, 29 minutes, 12 minutes, and 130 minutes, respectively. The 130-minute restraint requires some additional comment. According to the state policy, the maximum time in restraint for crisis intervention prior to attempting release is 30 minutes. Individual #330 was restrained for 130 minutes on 9/10/10. The restraint documentation indicated that she was agitated, yelling, and struggling against restraints for 60 minutes before staff attempted to release her. After 60 minutes, the form indicated that an attempt was made at release, but was unsuccessful every 15 minutes until she was released 70 minutes later. The documentation for this incident indicated that a bear hug, horizontal restraint, and body wrap were all used, but the restraint checklist did not indicate how long each type of restraint was used and what action precipitated the change in method of restraint. A corresponding investigation indicated that the individual remained in body wraps for almost two hours. Psychology staff was not notified during the restraint. It is recommended that staff is instructed to notify psychology staff to intervene and offer suggestions when restraints are prolonged. As noted in section C1, a review of documentation did not support that individuals were always a danger to him/herself at the time of restraint, so the monitoring team could not make a determination that individuals were released when no longer a danger to him/herself. The monitoring team found the facility out of compliance with this provision item.	
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	The facility had policies governing the use of restraints. The policies were in compliance with the requirements of this provision. The policy on restraints required that all staff who assumed work responsibilities that might require the staff to participate in restraint will receive competency-based training, initially with subsequent annual refresher training in Restraint Use and PMAB. Training transcripts for 24 staff at SGSSLC were reviewed and all had completed PMAB training	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	and training on applying restraints annually. In many cases, restraints were not monitored according to methods included in required training. See section C5 for specific details regarding the monitoring of restraints. The facility was rated as being in noncompliance with this provision item.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	One individual (Individual #346) at the facility was wearing mitts on both hands to reportedly prevent further damage to an open skin wound on one hand and to prevent additional injury due to self-injurious behaviors on the other hand. There was an informal plan for the nurse to remove the mitt on the one hand with an open wound each shift to check the wound, but it was not clear how often staff removed the mitt on his other hand to check skin integrity. There was no written plan in place to instruct staff when to remove the mitts to ensure that skin integrity of his hands was not compromised by wearing the mitts. There was some confusion with his PST over whether this was to be classified as medical restraint or restraint for behavioral intervention. Regardless of the classification, the facility should insure that a determination is made by the team for when these restraints should be removed to monitor for circulation, injuries, and skin integrity. A plan should also be put into place to try to reduce the use of the restraint. A plan should also be put into place to try to reduce the use of these restraints. One individual at the facility was wearing mitts on both hands to reportedly prevent further damage to an open skin wound on one hand and to prevent additional injury due to self-injurious behaviors on the other hand. There was an informal plan for the nurse to remove the mitt on the one hand with an open wound each shift to check the wound, but it was not clear how often staff removed the mitt on his other hand to check skin integrity. There was no written plan in place to instruct staff when to remove the mitts to ensure that skin integrity of his hands was not compromised by wearing the mitts. In regards to medical/dental restraints, the state policy mandated, "If sedation or restraint is to be used (during or prior to treatment) for routine medical or dental care	Noncompliance

#	Provision	Assessment of Status	Compliance
		for an individual, the PSP for that individual shall include treatments or strategies to minimize or eliminate the need for sedation and restraint." The monitoring team found that not all PSTs routinely discussed the need for restraint or developed desensitization strategies when restraints were used for medical or dental treatment. A list of all medical and dental restraints since 1/1/10 included 131 restraints involving 52 individuals. Only five of the 52 individuals (10%) had a desensitization plan in place. Some examples of individuals who did not have a desensitization plan in place included: • Individual #344 did not have a medical desensitization plan in place nor had his PST discussed the need for a plan. He had medical pretreatment sedation for appointments on 1/22/10, 3/5/10, 6/30/10, 8/12/10, and 9/26/10. • Individual #294 did not have a medical desensitization plan in place and his PSP did not address the need for one. He had pretreatment sedation for medical appointments on 1/22/10, 3/3/10, 4/9/10, 5/26/10, 6/15/10, 6/25/10, 9/20/10 and 9/27/10. • Individual #217 did not have a medical or dental desensitization plan in place. She was given IM pretreatment sedation for a dental procedure on 5/28/10 and prior to an eye appointment on 6/18/10 and mammogram on 5/6/10. • Individual #328 did not have a medical or dental desensitization plan in place though documents indicated that he was sedated pretreatment for a dental appointment on 9/16/10 and for eye exams on 1/22/10 and 8/13/10. The facility needs to ensure that individuals receiving restraint for medical or dental appointments have a desensitization plan in place that includes concrete strategies, strategies are implemented, progress is documented, and plans are revised as necessary.	
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	It was not evident that restraints were always monitored as required by state policy. The state policy required that at least one Restraint Monitor must be on duty at all times to respond to restraints for crisis interventions and a restraint monitor must conduct and document an onsite 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. Of the 45 restraints reviewed, 26 (58%) indicated that the restraint monitor did <u>not</u> conduct a face-to-face assessment within 15 minutes. The following table illustrates this finding.	Noncompliance

#	Provision	Assessment of Status	Compliance
	document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.		

Individual	Date	Initiation of Restraint Time	Restraint Monitor Notified	Time Elapsed
#215	9/1/10	4:05pm	4:45 pm	40 minutes
#215	9/1/10	4:10pm	4:45pm	35 minutes
#215	9/1/10	4:20pm	4:45pm	25 minutes
#215	9/7/10	8:15am	8:40am	25 minutes
#215	9/16/10	3:30pm	4:15pm	45 minutes
#215	10/2/10	6:05pm	7:00pm	55 minutes
#331	9/19/10	1:25pm	1:45pm	20 minutes
#331	10/7/10	12:10pm	3:30pm	3 hrs 20 min
#316	9/4/10	11:10am	12:01pm	51 minutes
#316	9/23/10	10:02pm	12:48am	2 hrs 46 min
#316	9/23/10	10:15pm	12:48am	2 hrs 33 min
#316	9/4/10	11:28pm	12:16am	48 minutes
#316	9/4/10	11:55pm	10:05am (9/5)	10 hrs 10min
#316	9/19/10	1:25pm	1:45pm	20 minutes
#316	9/23/10	10:22pm	12:45am	2 hrs 23 min
#178	9/29/10	8:10am	8:30am	20 minutes
#96	10/4/10	4:10pm	4:30pm	20 minutes
#249	9/20/10	11:24pm	11:55pm	31 minutes
#249	9/2/10	9:50pm	10:00am (9/3)	11 hrs 50 min
#249	10/7/10	9:18pm	9:47pm	29 minutes
#292	10/4/10	12:49pm	1:30 pm	39 minutes
#292	10/4/10	2:15pm	2:45pm	30 minutes
#170	10/2/10	9:40am	10:05am	25 minutes
#196	9/7/10	10:30pm	11:00pm	30 minutes
#196	9/1/10	8:53pm	9:30am (9/2)	12 hrs 37 min
#196	9/7/10	11:03pm	9:30am (9/8)	10 hrs 27 min

Restraint Reduction Committee meeting minutes dated 9/23/10 indicated that the facility was aware of noncompliance with the mandate for a restraint monitor to complete a face-to-face assessment within 15 minutes. David Ponce, facility Applying Mechanical Restraint Instructor, was assigned responsibility for developing a plan of correction by 10/28/10. Minutes from the RRC meeting on 11/18/10 indicated that a plan had been completed. The monitoring team will look at the effectiveness of the plan

#	Provision	Assessment of Status	Compliance
		during next visit onsite review. The monitoring team also found that a licensed health care professional had not monitored and documented vital signs and mental status of each individual restrained, as required. A sample of 20 restraint checklists was reviewed for compliance with the requirement for nursing assessments. The monitoring team found that 25% of the sample did not comply with this requirement. • A restraint checklist for Individual #331 on 9/10/10 indicated that the nurse did not check vital signs and mental status until 6:30 am. The restraint was initiated at 4:05 am and lasted 130 minutes. This was particularly concerning, given the prolonged duration of this restraint and the increased risk for injury to the individual. The physician's order for the restraint indicated that the physician refused to sign the order following the restraint. • A restraint checklist for Individual #196, dated 9/7/10, indicated that the restraint occurred at 10:30 pm and a nurse did not complete an evaluation until 12:50 am. • Another restraint checklist for Individual #196, dated 9/1/10, indicated that the restraint occurred at 8:53 pm and a nursing assessment was not attempted until 8:30 am the following morning. The individual refused assessment at that time and no further attempt was documented. • A restraint checklist for Individual #9, dated 10/4/10, indicated that the restraint occurred at 7:42 pm and a nursing assessment was not attempted until 9:50 pm. The individual's vital signs and mental status were not documented by the nurse. • A restraint checklist for Individual #316, dated 10/10/10, indicated that the individual received Geodon IM at 11:50 pm. The nurse assessed the individual's vital signs and mental status 20 minutes after the injection and again at 45 minutes after the injection. The only other nursing note stated, "nurse busy, unable to assess." The policy required nursing staff to monitor individual's receiving chemical restraints for a minimum of two hours. The facility needs to develop a plan to ensure that monitoring and post restraint reviews are conducted as required and documented consistently. The facility was rated as being in noncompliance with this provision item.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to	Restraint documentation reviewed indicated restraints were generally brief and did not indicate that mealtimes were disrupted or that individuals needed the opportunity to exercise restrained limbs or use the toilet. • All restraint checklists (100%) indicated that individuals were checked for	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	restraint-related injuries. • There had been 50 restraint related injuries documented since 1/1/10. All of the documented injuries (100%) were non-serious injuries. Safety Plans indicated that restraints should be applied with one-to-one supervision and a restraint monitor in the room. As indicated in section C5, restraint monitors were often not present during restraints. Restraints were not monitored as mandated by policy. Restraint checklists reviewed did not indicate what level of supervision was assigned during restraint incidents. Staff completing documentation should be reminded to complete all sections of the restraint checklist and retraining should occur when audits of restraint incidents indicate a pervasive deficiency in documentation or process. The facility was rated as being in noncompliance with this provision item.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to documentation provided by the facility, there were 36 individuals (listed below) at SGSSLC who required the use of restraints more than three times in a rolling thirty-day period from 4/1/2010 to 10/7/2010. • Individual #96, Individual #316, Individual #194, Individual #165, Individual #196, Individual #9, Individual #48, Individual #29, Individual #391, Individual #243, Individual #351, Individual #346, Individual #215, Individual #385, Individual #155, Individual #331, Individual #249, Individual #34, Individual #129, Individual #170, Individual #154, Individual #69, Individual #116, Individual #153, Individual #247, Individual #252, individual #168, Individual #277, Individual #233, Individual #197, Individual #178, Individual #234, Individual #301, Individual #68, Individual #266, and Individual #81. The facility conducted personal support plan addendum (PSPA) meetings within six months of achieving the above restraint criterion, and had a PBSP in place for each individual reviewed. To evaluate compliance with this provision item, the monitoring team reviewed minutes from seven PSPA (Personal Support Plan Addendum) meeting, and reviewed nine of these individual's PBSPs. This item was rated as being in noncompliance because none of the PSPAs reviewed reflected an adequate review of the environmental, antecedent, and consequent variables	Noncompliance

#	Provision	Assessment of Status	Compliance
		that affected the behaviors that provoked restraint. It is recommended that the facility organize these PSPA meetings, and minutes, so as to ensure that each of the issues below are discussed and documented. Additionally in order to achieve compliance with this item, SGSSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors have been developed, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	None of the PSPAs minutes reviewed reflected a discussion of the individual's adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. For example, Individual #9's PSPA minutes stated "Due to her psychosis no attempts to calm her worked…" Her psychological condition may be an important precursor of the behavioral provoking her restraint, however, a more thorough discussion of the variables or conditions that are hypothesized to affect her psychiatric behaviors, and/or a discussion of how to address her psychiatric behaviors to decrease the future probability of restraint is needed to be reflected in the PSPA minutes. Another example of an issue that might be discussed here is medical conditions that are hypothesized to be contributing to a dangerous target behavior, and a recommendation to refer the individual to a physician for evaluation and treatment of the medical condition to prevent the probability of restraint in the future.	Noncompliance
	(b) review possibly contributing environmental conditions;	None of the PSPAs reviewed reflected a discussion of possible contributing environmental factors. Examples could include such things as noisy environments and suggestions for reducing noise to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of antecedents that may affect the behavior provoking restraints. Three of the PSPAs reviewed (i.e., Individual #9, Individual #249, Individual #391) briefly mentioned antecedents of the behavior that provoked restraint. For example, Individual #391's PSPA meeting minutes stated, "…was upset that she was on home restriction…" The minutes did not, however, reflect a discussion of this antecedent condition to determine if the team believed that home restriction was a predicable antecedent of dangerous behavior or just the antecedent of the most incident of the behavior. If home restriction was hypothesized to be a reliable predictor of her SIB, then her PSPA meeting minutes should reflect a discussion of how staff should respond when she is on home restriction (e.g., close supervision) to decrease the likelihood that home restriction will result in restraint in the future.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There was no mention of antecedent conditions affecting the behaviors provoking restraint in the other four PSPA meeting minutes reviewed.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with the review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. Please see section K of this report for more details regarding functional assessment. None of the PSPA minutes reviewed reflected a discussion of the functions of the behavior provoking restraints.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All of the individuals reviewed had PBSPs to address the behaviors provoking restraint. Three of the PBSPs reviewed for this provision item (Individual #391, Individual #243, and Individual #170) were found to be very good, however, the other PBSPs reviewed were determined to be not as effective as they could be (see K9 for a more detailed evaluation of these and other PBSPs). Replacement behaviors were included in all the PBSPs reviewed, however, none of the PBSPs reviewed included a training methodology (see K5), or data system to measure if replacement behaviors were occurring (K4). All the safety plans reviewed addressed the necessary conditions and specifics of each individual's restraint.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented	None of the PSPA minutes reviewed reflected a discussion of treatment integrity. Treatment integrity data were not found for any target behaviors at SGSSLC (see K11 for	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	more detailed discussion of treatment integrity at the facility).	
	(g) as necessary, assess and revise the PBSP.	There was no evidence in the PSPA minutes reviewed, or any information provided to the monitoring team (see K4), indicating that any individual's PBSP was modified (when necessary) to decrease the future probability of an individual being restrained.	Noncompliance
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.	Restraint incidents were discussed at unit meetings each weekday and then presented at the Incident Management Review Team (IMRT) meeting for review. Restraint incidents that occurred during the weekend were reviewed at these meetings on Monday mornings. The monitoring team attended morning unit meetings and IMRT meetings during the week of the monitoring visit. It was observed that restraints were routinely reviewed at the morning meetings and attendees made recommendations where appropriate regarding restraint incidents. PST meetings were held to discuss restraints. There was no indication, however, that behavior support plans or safety plans were revised when strategies were not effective in reducing the need for restraints. For example, Individual #96 had 22 restraint incidents in September 2010, indicating behavioral intervention strategies in her BSP were either not effective or not being implemented consistently. Her BSP had not been revised since 1/28/10. The restraint checklist developed by DADS had been revised for use at SGSSLC. The notification area requiring psychologist notification had been changed to "psychologist (if needed)." There were no guidelines found to identify when notification to the psychologist might be needed. Similarly, the state Face-to-Face Assessment, Debriefing, and Review Form required review by either the Chief Psychologist or the Director of Residential Services (DRS). In order to revise behavior support plans when appropriate, psychology staff need to review each restraint incident to determine when behavior strategies are no longer effective or when staff may not be implementing plans as written. The facility had just developed a restraint monitoring tool, but it had not yet been implemented. Completed monitoring tools will be reviewed by the Restraint Reduction Committee to address any procedural trends identified. The facility was rated as being in out of compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance

Recommendations:

1. Behavior support plans should identify which behaviors indicate a true risk for potential harm to the individual or others and train support staff to recognize those behaviors.

2. The facility needs to look at engagement levels for individuals frequently restrained for self-injurious or aggressive behaviors and develop plans to increase engagement levels when indicated.

3. Utilization of the Crisis Intervention Team should be documented on restraint checklists with a description of intervention procedures used by the team.

4. The facility needs to develop a plan to ensure that monitoring and post restraint reviews of vital signs and mental status are conducted as required and documented consistently.

5. Include specific desensitization strategies in PSPs for individuals who require restraints for routine medical and dental appointments. Monitor and document progress on plans and modify plans as necessary.

6. Ensure that a restraint monitor is present within 15 minutes of the start of a restraint to assess the individual and monitor restraint application when necessary.

7. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

8. Behavior support plans should be reviewed and revised when strategies are not effective for reducing the number of restraints implemented.

9. Ensure that psychology staff review restraint incidents and have the opportunity to make recommendations regarding interventions used in behavioral crisis.

10. Conduct and document reviews of individuals who have had more than three restraints in any rolling 30-day period as required by provision item C7.

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:** <u>Documents Reviewed</u>: ○ DADS Policy: Incident Management #002.2, dated 6/18/10 ○ DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 ○ SGSSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021SGS dated 8/26/10 ○ SGSSLC Policy: Spurious Allegations of Abuse, Neglect, and Exploitation revised 8/26/10 ○ DADS JRC Pre-screening Criteria of Name-Based Criminal History Guidelines revised 10/19/10 ○ DADS Required Minimum Hiring Activities dated 10/19/10 ○ Incident Management Committee meeting minutes for July 2010 – September 2010. ○ List of incidents of peer to peer aggression ○ Training transcripts 45 employees, including 18 facility investigators ○ Acknowledgement of Obligation to Report Abuse form for 24 employees ○ Training transcripts for DFPS investigators ○ Current list of individuals for whom DFPS conducts streamlined investigations ○ Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable. ○ Background check for the last three volunteers ○ List of injuries by individual since 1/1/10 ○ List of individual who sustained a bone fracture since 1/1/10 ○ List of individuals who incurred an injury requiring closure by suture or Dermabond since 1/1/10 ○ The three most recent investigations of injuries completed entirely by the facility investigator ○ Client Injury Reports: ○ Individual #316, All injuries since 8/1/10 ○ Individual #288, All injuries since 8/1/10 ○ Individual #313, All injuries since 8/1/10 ○ Individual #186, All injuries since 8/1/10 ○ Individual #346, All injuries since 8/1/10 ○ Individual #200, All injuries since 8/1/10 ○ Individual #116, All injuries since 8/1/10 ○ Individual #202, All injuries since 8/1/10 ○ Individual #385, 6/15/10 ○ Individual #159, 2/4/10 ○ Individual #123, 9/1/10 • Log of all A/N/E allegations since 1/1/10 including case disposition and any employee disciplinary action taken • Log of employees reassigned due to ANE allegations since 1/1/10 • A sample of 19 Adult Protective Services Referral Forms for cases referred back to the facility

- Documentation from the following 54 completed investigations:

Case	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
UIR 3342	Sexual Abuse (3)	Unconfirmed (3)	7/28/10 7:31pm	7/29/10 12:35pm	8/4/10
UIR 3343	Neglect (2)	Confirmed	8/2/10 11:34am	8/3/10 11:08am	8/12/10
UIR 3359	Sexual Incident	No DFPS investigation	Occurred 8/2/10 4:00pm	8/2/10 4:15pm	8/3/10
UIR 3360	Sexual Abuse	Unconfirmed	8/3/10 1:29am	8/3/10 1:32 pm	8/13/10
UIR 3361	Sexual Abuse	Unconfirmed	8/3/10 2:33pm	8/6/10* 11:31am	8/13/10
UIR 3368	Neglect	Confirmed	8/5/10 12:23 am	8/5/10 9:45 pm	8/13/10
UIR 3377	Emotional/Verbal Abuse Physical Abuse (2) Sexual Abuse	Unconfirmed Unconfirmed (2) Unfounded	8/6/10 10:05 am	1st attempt 8/6/10 11:50am 8/9/10* 11:56 am	8/12/10
UIR 3378	Physical Abuse (2) Sexual Abuse	Unconfirmed (2) Unconfirmed	8/6/10 11:41 am	8/6/10 4:53 pm	8/16/10
UIR 3379	Neglect	Confirmed	8/6/10 11:31 pm	8/9/10* 1:00pm	8/16/10
UIR 3382	Neglect	Unconfirmed	8/7/10 10:14 am	8/9/10* 8:50pm	8/16/10
UIR 3384	Sexual Abuse	Unconfirmed	8/7/10 10:24 pm	8/8/10 5:01 pm	8/16/10
UIR 3389	Emotional/Verbal Sexual Abuse	Unconfirmed Unconfirmed	8/9/10 7:20 pm	8/10/10 6:44 pm	8/19/10
UIR 3394	Sexual Incident Offender	No DFPS investigation	8/11/10 11:20 am	8/11/10 11:20am	8/16/10
UIR 3400	Sexual Abuse	Unconfirmed	8/16/10 9:10 pm	8/17/10 1:46 pm	8/26/10
UIR 3401	Physical Abuse Sexual Abuse	Unconfirmed	8/17/10 5:40 am	8/17/10 1:48 pm	8/23/10
UIR 3403	Sexual Incident	No DFPS investigation	8/17/10 3:33 pm		

UIR 3408	Sexual Abuse	Unconfirmed	8/19/10 6:31 pm	8/21/10* 9:45 pm	8/29/10
UIR 3409	(7) Sexual Abuse	(3) Unconfirmed (4) Unfounded	8/20/10 2:58 pm	8/21/10 12:30 pm	8/30/10
UIR 3297	(2) Emotional /Verbal (3) Sexual	(5) Unconfirmed	7/18/10 8:36 pm	7/20/10* 6:58 pm	7/28/10
UIR 3308	Unauthorized Departure	No DFPS Investigation	7/19/10 5:20 pm		7/20/10
UIR 3304	Sexual Abuse	Unfounded	7/20/10 12:21 am	7/20/10 1:18 pm	7/27/10
UIR 3313	Sexual Incident	Unconfirmed	7/20/10 9:44 pm	7/22/10* 3:34 pm	7/30/10
UIR 3319	Sexual Abuse	Unconfirmed	7/22/10 10:36 pm	7/23/10 6:53 pm	7/31/10
UIR 3325	(2) Physical Abuse (1) Sexual Abuse	(3) Unconfirmed	7/24/10 7:08 am	7/24/10 5:27 pm	8/3/10
UIR 3330	Sexual Abuse	Unconfirmed	7/25/10 2:00 pm	7/25/10 6:08 pm	8/3/10
UIR 3331	Sexual Abuse	Unfounded	7/25/10 3:59 pm	7/25/10 6:19 pm	8/4/10
UIR 3337	(2) Sexual Abuse	Unconfirmed	7/26/10 12:30 am	7/26/10 1:38 pm	8/5/10
UIR 3341	Sexual Abuse	Unfounded	7/28/10 2:01 pm	7/29/10 11:00 am	8/3/10
DFPS 36896903	(3) Neglect (2) Physical Abuse	Unconfirmed Inconclusive Inconclusive Confirmed Confirmed	7/3/10 4:10 pm	7/4/10* 4:29 pm	7/13/10
DFPS 37520220	Neglect Physical Abuse	Unconfirmed Unconfirmed	8/18/10 9:33 pm	8/20/10* 9:24 pm	8/28/10
UIR 3258	Sexual Abuse	Unconfirmed	7/6/10 10:57pm	7/7/10 2:10 pm	7/13/10
UIR 3259	Sexual Abuse	Unfounded	7/7/10 2:26 am	7/7//10 1:31 pm	7/12/10
UIR 3270	Sexual Incident	No DFPS Investigation	7/11/10 8:55 am	7/11/10 9:00 am	7/15/10
UIR 3267	(1) Physical Abuse (1) Sexual Abuse	Unconfirmed Unconfirmed	7/12/10 8:07 am	7/12/10 1:24 pm	7/16/10
UIR 3271	Sexual Incident	No DFPS Investigation	7/12/10	7/12/10	7/12/10

			7:15 pm	7:35 pm	
UIR 3274	Sexual Abuse	Unconfirmed	7/13/10 4:00 pm	7/14/10 1:35 pm	7/23/10
DFPS 37044829	(2) Neglect (1) Physical Abuse	Confirmed Confirmed Confirmed	7/16/10 4:57 am	7/16/10 10:11 am	7/26/10
UIR 3280	Sexual Abuse	Unconfirmed	7/17/10 11:25 am	7/18/10 11:20 am	7/27/10
DFPS 37063032	(2) Physical Abuse (2) Sexual Abuse	Unconfirmed Unfounded Unconfirmed Unfounded	7/18/10 7:59 am	7/18/10 2:38pm	7/28/10
DFPS 37063210	Neglect	Unconfirmed	7/18/10 9:47 am	7/18/10 2:38 pm	7/28/10
DFPS 37063809	(2) Physical Abuse	Unconfirmed Unconfirmed	7/18/10 2:23 pm	7/18/10 4:25 pm	7/28/10
UIR 3293	(2) Physical Abuse	Unfounded Unconfirmed	7/18/10 5:26 pm	7/20/10* 5:21 pm	7/28/10
UIR 3294	Sexual Abuse	Unconfirmed	7/18/10 5:46 pm	7/20/10* 5:21 pm	7/28/10
DFPS 37064831	(3) Neglect	Unconfirmed Unconfirmed Unconfirmed	7/18/10 7:08 pm	7/19/10 6:45 pm	7/28/10
DFPS 37095194	(2) Neglect	Confirmed Confirmed	7/20/10 6:24 pm	7/21/10 5:53 pm	8/4/10* Ext filed unknown
DFPS 37265542	Sexual Abuse	Unconfirmed	8/3/10 1:29 am	8/3/10 1:32 pm	8/13/10
DFPS 37276881	Sexual Abuse	Unconfirmed	8/3/10 2:33 pm	8/6/10* 11:31 am	8/13/10
DFPS 37284200	(3) Emotional /Verbal Abuse	Unconfirmed Unconfirmed Unconfirmed	8/3/10 11:25 pm	8/4/10 3:17 pm	8/12/10
DFPS 37285980	(2) Neglect	Confirmed Inconclusive	8/4/10 7:15 am	1st attempt 8/5/10* 1:38 pm	8/27/10* Ext filed 8/23 & 8/27
DFPS 37289880	Emotional/Verbal	Unconfirmed	8/4/10 11:32 am	8/4/10* 3:40 pm	8/11/10
DFPS 37307061	Emotional/Verbal Physical Abuse	Unconfirmed Unconfirmed	8/5/10 9:39 am	8/6/10* 5:08 pm	8/13/10

DFPS 37388780	Physical Abuse	Unconfirmed	8/11/10 10:29am	8/16/10* 4:09pm	8/21/10
DFPS 37341140	Neglect	Confirmed	8/7/2010 1:32 pm	8/9/10* 7:43 pm *1st attempt 8/8/10 5:14	8/25/10*
UIR 3406	Sexual Incident	Referred Back	8/19/10 12:16pm	8/18/10 5:20 pm by facility	8/24/10

(#) indicates multiple allegations
* indicates late

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Sidney R. Lyle, OIG Sergeant of Internal Affairs
- Dr. Philip Baugh, Facility Director
- Jalown McCleery, Program and Management Support
- Natalie Montalvo, Director of Residential Services
- Mary Barrera, Risk Manager
- Mary Holmes, Lead Investigator
- Brendi Gentry, Facility Investigator
- Charles Njemanze, Assistant Director of Programs
- Michael Davila, QMRP Coordinator
- Melissa Deere, Ombudsman
- Roy Smith, Human Rights Officer
- Noel Zapata, Vocational Training Director
- James Reid, Residential Coordinator

Observations Conducted:

- Observations at residences and day programs
- Health Status Team Meeting
- Daily Incident Management Review Team Meeting 11/17/10
- Daily Incident Management Review Team Meeting 11/19/10
- Human Rights Committee Meeting 11/18/10
- Restraint Reduction Committee Meeting 11/18/10
- PSPA meeting for Individual #346
- PST annual meeting for Individual #327
- Self-advocacy Meeting
- Observation of video surveillance

	Facility Self-Assessment: The facility's self-assessment, its POI, for section D indicated that some items for this provision were in noncompliance and some were in substantial compliance. Some of the facility's self-assessed substantial compliance ratings were justified by the facility's mandate to provide training to all staff, though as evidenced throughout the findings in section D described below, training was not being provided as mandated by state policy. The POI acknowledged that the facility was in the beginning stages of developing corrective action plans to address deficiencies. Corrective action plans being developed at the time of the monitoring visit included establishing a focus group to develop more meaningful day and evening active treatment options and involving the facility self-advocacy group in problem solving in this area.
	Summary of Monitor's Assessment: According to a summary of abuse, neglect, and exploitation trends for FY10 provided to the monitoring team, investigation of 844 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/09 through 8/31/10. These 844 cases included 1597 allegations involving 405 individuals identified as potential victims, and 335 staff at SGSSLC identified as possible perpetrators. Of these 844 cases, 51 (6%) were confirmed by DFPS. These 51 confirmed cases involved 92 allegations of abuse or neglect. Fifty-seven additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The remainder of the cases included 465 unconfirmed cases, 204 cases referred back to the facility, and 44 unfounded cases. There was an increase of 6% in the total number of cases reported to DFPS from FY09. Trends reports showed a steady increase in the number of cases reported to DFPS for each quarter of FY10, with the fourth quarter total being the highest in the past two years (263 cases). There were a total of 3597 injuries reported at the facility in FY10. A total of 1030 of these injuries occurred in the 4th quarter of FY10. This was an increase of 19% from the 4th quarter in FY09 and an increase of 11% from the 3rd quarter of FY10. Of the 3597 injuries reported during FY10, 42 were considered serious injuries (less than 2%), 2701 were non-serious injuries requiring first aid, and 852 required no treatment. The most recent monthly trend analysis from September 2010 was also reviewed. There had been 348 injuries reported for September 2010 involving 147 individuals. Of those injuries, 187 were self-caused and 80 were peer-caused. There had been four serious injuries documented in September 2010 alone, with two fractures and two requiring sutures or staples. Video surveillance cameras had been installed in common areas throughout the facility since the baseline monitoring visit. A review of incident investigations indicated evidence from the surveillance cameras was being used in investigations. It was reported in interviews during the monitoring visit that this evidence was beneficial for confirming abuse and neglect in cases where evidence might not otherwise have been available to support the allegations. It was reported to the monitoring team that individuals living in some of the homes routinely damaged the cameras. The facility had replaced 11 damaged cameras since

	installation. The facility was trying to address this problem by making some of the cameras less accessible to individuals in the home. The facility was hoping to eventually get cameras placed in outside areas due to the number of incidents that occur outside on facility grounds. This would further assist DFPS, OIG, and facility investigator in confirming or ruling out abuse or neglect in a great number of cases. There were concerns that the facility only employed two full time investigators. Abuse and neglect reports alone averaged 70 cases per month at the facility. When considering that many investigations involved injuries, sexual incidents, unauthorized departures, and other incidents to be investigated, the two investigators had multiple cases to investigate almost every day. The two facility investigators were responsible for completing all Unusual Incident Reports (UIRs), reviewing investigations completed by outside entities, and following up on any recommendations. Facility management should review the workload of the two investigators and determine if thorough investigation of all incidents is a reasonable expectation for two facility investigators. Unfortunately, the number of spurious allegations at the facility drained facility resources and created an environment where abuse and neglect could go unnoticed. It was evident throughout the monitoring review that SGSSLC, DFPS, and OIG worked cooperatively together to address issues identified in the incident management process. The continuing of this cooperative relationship will be essential in meeting the requirements of section D given the significant number of incidents reported at the facility, and the resulting strain placed on the staff of all three entities. Some provisions in section D were not rated as being in noncompliance based on current DFPS policies and procedures. These issues were discussed in a meeting with DFPS, DADS, and the monitoring teams on 12/2/10. DFPS had already addressed a number of concerns raised by the monitoring team. The monitoring team anticipates that DFPS will continue to work cooperatively with DADS to address issues as they are presented in subsequent monitoring reports.

#	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.	Assessment of this item required review of policies and an examination of implementation of those policies. The state had updated policies regarding incident management and protection from harm. The Incident Management Policy was numbered 002.2, and was dated 6/18/10. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and client injury reporting procedures. The Protection from Harm - Abuse, Neglect, and Exploitation policy was also Revised 6/18/10 and numbered 021. SGSSLC had updated the facility protection from harm policy on 8/26/10. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated the same commitment of zero tolerance. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted throughout the facility. In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the reviewer questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they would protect the individual from further harm, seek medical attention if needed, and then report the incident to DFPS and the facility director. Employees at SGSSLC were required to sign an Acknowledgement of SGSSLC Employee Responsibility for Reporting Abuse/Neglect Incident(s) form annually. A sample of these forms was reviewed by the monitoring team for 24 employees. Current forms were in place for 22 of the 24 employees (92%). Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 45 current employees at the facility were reviewed for current ABU0100 training. All 45 employees (100%) had completed the course ABU0100 in the past 12 months. It was evident that the facility stressed a zero tolerance policy for all employees at SGSSLC. The facility was rated as being in compliance with this provision item.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices		

#	Provision	Assessment of Status	Compliance
	shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The state policy specified reporting requirements for all serious incidents and was in line with this provision item. The facility policy included a section on incident reporting responsibilities for determining to whom incidents should be reported and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Unusual Incident Reports documented notification to the Director/Designee, After-Hours Duty Officer, Unit Director, QMRP, Correspondent, DFPS, Law Enforcement, State Office, OIG, and DADS Regulatory, as applicable. DFPS was responsible for notifying local law enforcement or OIG, though according to the OIG Investigator assigned to SGSSLC, the facility typically notified OIG in most cases. Client Injury Reports included documentation of Facility Director/Designee notification. According to Jalown McCleery, Incident Management Coordinator, the Facility Director or his designee was to be notified of all serious incidents immediately. The facility had a Director on Call after hours, weekends, and holidays. Nine DFPS cases with confirmed allegations (#375251900, #37303860, #37337200, #37559640, #37095194, #36896903, #3706301, #37702760, and #37895620) were reviewed for timeliness of reporting. Three (33%) of the nine cases were not reported to DFPS within one hour. Late reporting occurred in the following cases: • Documentation of DFPS case #37337200 indicated that an incident involving neglect occurred at 8:00 pm when an individual was discovered missing from an outing, DFPS was not notified until 11:31 pm though both the director designee and the facility Administrator on Duty were notified within an hour. The individual was on enhanced supervision when in the community and also had a BSP that addressed unauthorized departure. The UIR indicated that she was discovered missing and the SSLC was notified at approximately 8:00 pm. Neglect should have been suspected immediately due to the breach in supervision. DFPS was not notified until 11:31 PM. • Documentation of DFPS case #375251900 indicated that a sexual incident involving neglect occurred at 2:07 pm on 7/30/10. It was reported to the director designee at 2:09 pm, but not reported to DFPS until 8/2/10 at 11:45 am. Further, the UIR noted that, "There is a hall monitor to prevent residents from going into other resident's rooms. However the hall monitor staff was in training during the incident." This information was available to the facility investigator at the time of the facility preliminary investigation. No additional information would have been needed to suspect neglect in this case. The incident was reported to DFPS three days later. • Documentation of DFPS case #37895620 indicated that an incident of alleged neglect and abuse occurred on 9/10/10. DFPS was not notified of the incident	Noncompliance

#	Provision	Assessment of Status	Compliance
		until 9/13/10 at 12:38 pm. The investigator noted that an intake was supposed to have been called in by the facility on Friday 9/10/10. A supervisor, had emailed her about it, but the intake never came in. Additionally, an SGSSLC trained CIT leader had the individual released from a two hour and 20 minute mechanical restraint when he was notified of the restraint. The CIT leader was aware that this was not an approved restraint, but did not report the incident as possible neglect. Client Injury Reports (CIR) were reviewed for a sample of seven serious injuries (all described below). Injury reports for Individual #123 dated 9/1/10, Individual #288 dated 4/26/10, and Individual #186, dated 9/12/10 and 10/15/10, were designated as serious injuries by the physician. Documentation did not indicate that the facility director or his designee had been notified of the incident in any of these cases (0%). • CIRs for Individual #3 dated 1/8/10 and Individual #385 dated 6/15/10 indicated that the Assistant Director of Programs was notified, but did not indicate when notification was made. • A CIR for Individual #316 dated 10/10/10 indicated that the facility director or designee was notified but did not give the time of notification. • It was documented that the PST met two days following CIR #1736 for Individual #186 to review the incident and the team made recommendations for follow-up. The three most recent serious injury investigations were reviewed. Two of the cases (67%) involved late reporting. • UIR #3133 involved an injury requiring sutures to the head due to peer-to-peer aggression. The incident occurred on 5/27/10 at 5:20 pm. It was not reported to the facility director until 8:30 am the following day and DFPS was not notified until 1:00 pm the following day though it involved a staff neglect allegation. Issues identified by the investigator included the RN's failure to report the serious injury for investigation. • UIR #3372 involved an injury requiring sutures that was reported to the nurse at 9:40 am on 8/4/10. The nurse did not report the injury for investigation. During a review of injuries at the daily Incident Management Review Team meeting the next day, the team identified the injury as serious and an investigation was requested. The facility needs to ensure that all serious injuries are reported to the facility director and outside entities as required.	

#	Provision	Assessment of Status	Compliance
		Competency-based training incident reporting procedures (UNU0100) was required annually for all employees. Training transcripts for 45 current employees at the facility were reviewed for current UNU0100 training. Twelve (27%) employees had not had UNU0100 training in the past 12 months. The facility needs to ensure that all employees complete training within required time frames. Employees had been hired for video surveillance at the facility. Interviews with video monitors during the review indicated that they had been trained in recognizing abuse and neglect and were aware of their responsibility to report abuse if observed during video surveillance. Additionally, part of their training requirement included spending time observing individuals living at SGSSLC and getting to know them; this was good to see. It was noted that at least one allegation had been reported by video surveillance staff for investigation of abuse after viewing an incident while monitoring a home on camera. The facility was rated as not being in compliance with this provision item.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	A review of Incident Management Review Team (IMRT) meeting minutes, observation of IMRT meetings, and observation of morning unit meetings confirmed that the facility reviewed all incidents and injuries and shared information regarding those incidents. Alleged perpetrators (APs) were removed from direct contact with individuals and reassigned to other duties initially, but the facility often placed APs back on duty before investigations were completed with additional monitoring by supervisors when preliminary investigation found that there was little basis to the allegation (the facility had a detailed procedure to determine how and when an AP could be returned to work and the level of supervisor supervision required, such as every 15 minutes, or every hour, i.e., a preliminary assessment as per this provision). This was confirmed by a list of employees reassigned due to ANE investigations provided to the monitoring team. The list of employees reassigned due to allegations was reviewed at the daily Incident Management Review Team meetings. During the monitoring visit, the facility was notified by DADS regulatory staff that they would no longer be able to return APs still under investigation back to work duties involving client contact unless continuous supervision of the AP was provided. The facility will have to implement a plan to ensure that all homes and day programs are adequately staffed with employees who are trained to support at their assigned site since the implementation of the DADS regulatory directive. Nursing staff completed injury assessments on individuals involved in all serious incidents. Findings from nursing assessments were included in investigation reports.	Substantial compliance

#	Provision	Assessment of Status	Compliance
		Incidents were reviewed each day at morning unit meetings, and at daily Incident Management Review Team (IMRT) meetings. IMRT meeting notes included protections put into place for individuals during investigations or recommendations regarding injury incidents. Notes indicated that information was followed by the IMRT until investigations were finalized. Documentation reviewed by the monitoring team indicated that the facility routinely took steps to safeguard individuals when serious incidents occurred. For example: • CIR #1736 involved a serious injury to Individual #186 requiring sutures to an injury caused by a fall. The PST met to discuss the injury and requested "a brain scan to see if there was a neurological reason for her balance issues." The physician checked her medication levels and noted that her ammonia levels were high, which might have contributed to her unsteadiness. The physician reduced her Depakote level. • UIR3270 involved a sexual incident between two individuals. Both individuals were immediately assessed by a nurse for injuries and placed on enhanced supervision. • UIR3267 involved allegations of physical and sexual abuse reported on 7/12/10 at 8:24 am. A nursing assessment was completed on the individual at 8:45 am and an emotional security check was completed by the psychologist at 8:50 am. The alleged perpetrator was placed on no client contact at 8:30 am. The facility was rated as being in substantial compliance with this provision item.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. All staff was required to complete ABU0100 Abuse and Neglect and UNU0100 Unusual Incidents initially upon employment and every 12 months thereafter. Documentation of training was kept by the facility and a sample of 45 staff training transcripts was reviewed. Not all training had been completed as required. All of the records reviewed indicated employees had received ABU0100 in the past 12 months. Twelve of the 45 employees (27%) had not received UNU0100 refresher training. The facility needs to ensure that all employees receive annual training as required by the state policies on abuse and neglect and incident management. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(d) Notification of all staff when commencing employment and at least yearly of their	The policy addressed mandatory reporters. Initial staff training provided during orientation included information on recognizing and reporting abuse and neglect. All staff were required to attend refresher training annually.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The obligation to report was stressed at new employee orientation and was to be confirmed by a signed statement acknowledging the employee's duty to report. Each employee at SCSSLC was required to sign an Acknowledgement of SGSSLC Employee Responsibility for Reporting Abuse/Neglect Incident(s) form annually. This statement included a list of mandatory reportable incidents, a list of actions that must be taken if abuse or neglect was witnessed or discovered, a statement regarding reporting retaliation for reporting abuse and neglect, and a requirement to complete training on abuse and neglect annually. A copy of the signed acknowledgement form was requested by the monitoring team for 24 current employees at SCSSLC. The form was available and current for 22 (92%) of the 24 employees. The facility was rated as being in substantial compliance with this provision item.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect would be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. A self-advocacy meeting was held the week of the monitoring visit. The OIG Inspector assigned to SGSSLC spoke at the meeting and shared information about what types of incidents should be reported to DFPS and OIG, how those reports could be made, and the importance of telling the truth. A review of abuse and neglect investigations indicated many individuals at the facility routinely reported abuse and neglect by calling the DFPS hotline. The DFPS hotline number for reporting abuse was posted throughout the facility. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	Posters were found posted in common areas throughout the facility with a statement of individuals' rights. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read. Additionally, there were posters throughout most homes and other buildings on campus that identified the facility's assistant ombudsman. Many individuals were very vocal at the facility in stating what their rights were and when they were being violated as evidenced by self-reported allegations. It was clear from a review of investigations, that many individual's were competent at not only reporting violation of their own rights, but would often report violations of a peer's	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		rights. An assistant ombudsman position had been created at the facility. There was also a rights officer position. The facility was attempting to develop a more active self-advocacy group on campus. Monitoring team members had the opportunity to attend a self-advocacy group meeting during the visit. The meeting was well attended by individuals at the facility. Staff reported that the facility was looking at making some changes to the group to try to encourage greater group leadership and involvement. The facility was rated as being in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The state policies included procedures for referring, as appropriate, allegations of abuse, neglect, and other criminal acts to law enforcement. A Memorandum of Understanding (MOU) issued by the state on 5/28/10 regarding Investigations of Abuse and Neglect in State Supported Living Centers, mandated that DFPS notify local law enforcement and the Office of the Inspector General (OIG) within one hour of any allegation that may constitute criminal activity. DFPS was responsible for making the determination of when it was appropriate and to follow through with reporting. According to both the OIG investigator and the facility investigator, OIG was routinely notified of allegations and responded quickly to begin investigations. The facility had established a process for getting information gathered quickly for the OIG investigator so that he could begin and conclude his investigation in a timely manner. A self-advocacy meeting was held the week of the visit. The OIG investigator assigned to SGSSLC was invited to speak at the meeting. He explained his role to the individual's attending the meeting and gave a summary of incidents that should be reported to an investigator. It was observed prior to and after the meeting that the OIG investigator greeted numerous individuals by name indicating that his presence was well established at the facility. There was only one case for concern regarding law enforcement notification in the cases reviewed. For UIR #3406 involving a rape allegation, the investigation stated that, even though the doctor recommended reporting the incident to law enforcement, the nurse did not pass this information along to the critical incident team that met to review the incident because she did not think that the allegation was valid. The incident occurred at 5:10 pm on 8/18/10. The facility notified law enforcement of the incident at 9:45 am the following day. DFPS was not notified until 12:16 pm on 8/18/10. The nurse was retrained on incident reporting following this incident, indicating that the facility took action when reporting procedures were not followed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility was found to be in substantial compliance with this provision item.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	State policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment and were able to state which incidents of abuse, neglect, and mistreatment should be reported. No cases of retaliatory action or allegations of retaliatory action were found by the monitoring team. The acknowledgement of responsibility to report abuse or neglect signed annually by each employee included a statement regarding reporting retaliation for reporting abuse and neglect. The facility was rated as being in substantial compliance with this provision item.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There was no evidence that formal audits were conducted to determine whether significant resident injuries were reported for investigation. Incident Management Review Team notes recorded information and follow-up action for significant injuries. It was observed in daily unit meetings and IMRT meetings that injuries were reviewed and assignments were routinely made to follow up for more information on the cause of specific injuries or to prevent further injury. As noted in D2(a) above, it was not evident that the facility routinely notified the facility director when serious injuries occurred. The IMRT reviewed all serious injuries, but as evidenced by documentation on CIRs reviewed, this might not occur until a day or two after the injury. There was some concern that if injuries were not reported for investigation, this would not be noted by administrative staff until days after the injury. For example, documentation of a serious head injury requiring sutures and hospitalization for Individual #186 on 10/15/10 did not indicate that the injury had been reported to the facility director or his designee. The CIR was not reviewed by the Safety Officer or IMRT until 10/18/10. The nurse documented that the injury occurred due to a witnessed fall. The CIR did not indicate that anyone had verified the cause of the injury or that an investigation took place, though following the onsite review, the facility reported that the incident was investigated immediately and the RN's account of the incident was confirmed. Two other serious injuries noted in D2(a) were not reported for investigation until the	Noncompliance

#	Provision	Assessment of Status	Compliance
		following day when they were reviewed by the IMRT. Requiring immediate reporting of serious injuries to the facility director or his designee would insure oversight in reporting serious injuries for investigation. The facility needs to implement a process for investigating serious injuries and documenting those reviews immediately after occurrence. The facility was found to be out of compliance with this provision item.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated, "within one month of employment or assignment as an investigator and prior to completing an Unusual Incident Report (UIR), all investigators who are responsible for completing any part of the UIR must complete the courses, Comprehensive Investigator Training (CIT0100) and People with MR (MEN0300)." The policy further mandated that all Incident Management Coordinators, campus administrators, and facility investigators "must complete Conducting Serious Incident Investigations (CSI0100) or Fundamentals of Investigation training (INV0100) and a class in Root Cause Analysis." The SGSSLC policy did not address training for investigators specifically in the facility abuse and neglect policy. Both the state and facility policy did mandate that all employees must have Abuse and Neglect (ABU0100) and Unusual Incidents (UNU0100) every 12 months. Training documentation for nine employees responsible for completing investigations and eight additional employees responsible for completing at least part of the unusual incident form was reviewed. • None of the employees (0%) responsible for investigations had completed Root Cause Analysis training as required by state policy. Completion of Root Cause Analysis training, as required by state policy, was not documented in training transcripts provided to the monitoring team for employees responsible for investigations, though, subsequent to the onsite review, the facility reported that	Noncompliance

#	Provision	Assessment of Status	Compliance
		this training had occurred. Documentation will need to be reviewed during the next onsite review. • Fourteen of the 17 employees (82%) had completed UNU0100 within the past 12 months. • All employees (100%) had completed ABU0100 within the past 12 months, • All employees (100%) had completed MEN0300 and CIT0100 (these were only required to be completed one time). • All of the employees (100%) responsible for completing investigations had completed CSI0100. Training transcripts were provided to the monitoring team for 12 DFPS investigators. All of the investigators (100%) had completed a training module on MH & MR Investigation. This training, although called different names at different times according to DFPS, included basic investigation skills training and procedural training on working with individuals with developmental disabilities. DFPS investigators were only required to complete this training one time prior to participating in investigations at any of the state supported living centers. The state policy also stated that the investigator would not be in the direct line of supervision of the alleged perpetrator. This requirement was also not addressed in the facility policy. The facility policy needs to be revised to include training requirements for staff assigned to complete investigations and incident reports and clarify that investigators will not be in the direct line of supervision of the alleged perpetrator. The two facility investigators and campus coordinators (also trained in investigative procedures) did not supervise direct support staff. Shift coordinators were approved to begin preliminary investigations to ensure immediate action was taken, but did not complete investigations. The facility was rated as not being in compliance with this provision item.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff cooperate with all investigations at the facility. The facility investigator reported that the facility had a great working relationship with DFPS, local law enforcement, and OIG. Jalown McCleery, Incident Management Coordinator, and Mary Holmes, Lead Investigator, were interviewed regarding investigation procedures at the facility. Both reported a good working relationship with DFPS, local law enforcement, and OIG. Facility administrative staff had been meeting quarterly for the past two years with DFPS supervisory staff to discuss any issues regarding reports and investigations. The OIG supervisor had recently met with them.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility was rated as being in substantial compliance with this provision item.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The OIG investigator assigned to the facility and the facility lead investigator reported that the two agencies had a close working relationship. The OIG investigator reported that the facility was quick to complete any request for information and did not interfere with investigations. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The state policy mandated that the facility investigator should prioritize the collection of evidence that is at most risk of contamination. Exhibit B of the policy gave clear guidelines for the collection, identification, and storage of physical evidence that may be essential to the investigation. It was evident that facility staff were quick to react to incidents and begin preliminary investigations. Staff informally interviewed regarding procedures when abuse and neglect was suspected stated their responsibility for safeguarding evidence in an investigation. The Campus Coordinators were assigned to handle immediate protections when on duty. During the overnight shift, the Officer on Duty was to be notified immediately of all serious incidents to assure protections were put into place. In UIR #3406, an individual reported an incident of rape to a nurse. The nurse did an initial assessment, but did not report the allegation immediately and did not safeguard evidence as required. The investigation report stated that clothing collected and bagged was not correctly marked and identified. Recommendations from the IMRT included retraining the nurse on reporting unusual incidents and on proper evidence collection. Additionally, the facility developed labels with pertinent information to be obtained and documented. The labels were placed on evidence collection bags and placed in homes and nurse's stations. As noted in section D3(e) below, DFPS investigation documentation did not support that evidence was always gathered in a timely manner. The provision item was rated as being out of compliance.	Noncompliance
	(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	The Interagency Memorandum of Understanding (MOU) Regarding the Investigation of Abuse and Neglect in State Supported Living Centers specified timeframes for the investigation process consistent with this provision. As of 6/1/10, DFPS was to complete investigations within 10 days unless a written extension was granted.	Noncompliance

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	10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DFPS had a priority system in place that only required investigations to begin within 24 hours if the case was determined be a Priority I allegation. This did not meet the mandates of this provision of the Settlement Agreement. During a conference call with the monitoring team on 12/2/10, DFPS informed the monitoring team that they were reviewing this practice and would be looking at a change in policy to try to address this mandate. DFPS investigated 48 of the sample of 54 cases reviewed for this provision. Of the 48 DFPS cases reviewed in the sample, the investigation did <u>not</u> begin within 24 hours in 15 (31%) of the cases. For example: • DFPS case #37388780, involving an allegation of physical abuse, was reported on 8/11/10 at 10:29 am. The alleged victim was not interviewed until 8/16/10 at 4:09 pm. The first witness in the case was interviewed on 8/18/10, seven days after the report was received. • DFPS case #37285980 involved a confirmed case of neglect reported to DFPS on 8/4/10 at 7:15 am. The first attempted face-to-face contact in the investigation was with the alleged victim on 8/5/10 at 1:38 pm. The individual was attempting to sleep, so an interview was not completed. No further interviews with the victim, AP, or witnesses were attempted on that date. A second interview with the individual was attempted on 8/6/10 at 9:04 pm, but was refused by the individual. The first witness was then interviewed at 9:49 pm. • DFPS case #37276881 involved an allegation of sexual abuse reported on 8/3/10 at 2:33 pm. The initial face-to-face interview with the alleged victim did not take place until 8/6/10 at 11:31 am. The investigation document did not indicate that there were attempts to gather any evidence in the case prior to the interview and did not give a reason for the delay. • DFPS case #37307061 included allegations of physical and verbal abuse reported to DFPS on 8/5/10 at 9:39 am. The alleged victim was interviewed on 8/6/10 at 5:08 pm. There was no indication that there were any attempts to gather evidence by DFPS prior to the interview. The second interview was with a witness on 8/10/10, seven days after the report was initiated. In cases where the alleged victim was interviewed within 24 hours of the initial notification, additional follow-up was often delayed by several days. For example: • In DFPS case #3784200, the alleged victim was interviewed on 8/4/10 at 3:17 pm which was within 24 hours, but documentation indicated that the next contact was with the AP five days later. • In DFPS case #37064571/UIR#3294, DFPS was notified of the allegation on 7/18/20 and attempted an interview with the alleged victim within 24 hours. The investigator was unable to complete the interview, so returned the next day to complete the interview with the individual. Documentation does not show any other attempts to gather information until an interview with a potential	

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		witness occurred on 7/26/10. • In DFPS case #37044829, DFPS was notified of the allegation on 7/16/10 at 4:57 am. An interview was attempted with the alleged victim at 10:11 am on 7/16/10, but the individual refused to be interviewed. A second attempt to interview the alleged victim was made on 7/19/10 with the same results. The next attempt to gather evidence documented in the report was an interview with the AP on 7/20/10, Investigations should document all initial attempts to gather evidence and a clear timeline of activities should be documented in the report. Interviews with alleged victims, witnesses, and alleged perpetrators should be completed as quickly as possible to ensure that accounts remain accurate. The DFPS policy needs to be updated to address current timelines as outlined in the MOU implemented 6/1/10. All Unusual Incident Reports (UIR) completed by the facility indicated that internal investigations began as soon as the incident occurred or was discovered, usually within minutes. Individuals were examined by a facility nurse and evidence was gathered immediately in most cases. All investigations completed by the facility in the sample were completed within 10 days. Of the 48 DFPS investigations reviewed, only three (6%) were <u>not</u> completed within 10 days. • DFPS case #37341140 was completed in 18 days. There was no indication in the report that an extension had been filed. • DFPS case #37285980 was completed on the 29th day. The report indicated that extensions were requested on 8/23/10 and 8/27/10. A copy of the extension was not provided in the documentation. • DFPS case #37095194 was completed on the 14th day. The investigation report noted that an extension had been filed, but the date of the request was not given and a copy of the extension was not included in documentation reviewed. DFPS indicated that upcoming changes to their system will likely allow for documentation of extensions to be more readily available to the monitoring team. The Incident Management Coordinator indicated that cases were generally completed within 10 days. She reported that exceptions to the 10-day timeline typically occurred only when the investigation was delayed so that OIG could complete its investigation first. A smaller sample of 15 investigations completed by DFPS was reviewed for	

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		recommendations for corrective action. Documentation completed by DFPS indicated "n/a or none" under the heading Concerns and Recommendations in each of the reports reviewed. On the other hand, the facility UIR generally included thorough and relevant action steps to be completed by the facility with an individual assigned responsibility and a target date for completion. The report, however, did not indicate when or if action was completed. The facility needs to develop a system to track recommended action for completion and include documentation in the investigation file. Due to concerns noted in this section of the report in regards to investigations completed by DFPS, this provision is found to be in noncompliance.	
	(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	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. All investigations completed by the facility in the sample reviewed included the serious incident or allegation of wrongdoing, the name(s) of all witnesses, and the name(s) of all alleged victims and perpetrators (when known). Reports included a summary of topics discussed, a summary of all documents reviewed, and all sources of evidence considered. A log of previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency were included in evidence considered. There were some concerns noted in the investigations completed by DFPS in terms of having sufficient evidence to provide a clear basis for the disposition of the case. • UIR#3275/ DFPS#37013769 involved an incident of neglect reported to DFPS. The individual was seen in the ER for a severe adverse reaction to an antibiotic. The nurse was advised of the situation, but did not assess the individual. She referred him to the doctor the following day. After examination, the doctor sent him to the emergency room to be seen. DFPS correctly referred the case back to the facility as a clinical issue. The DFPS investigation did not indicate that the investigator had gathered evidence or requested any additional information on the case, even though the facility's investigation clearly showed that the individual did not receive care needed and sustained significant injuries due to lack of nursing care and oversight. The facility did a thorough investigation and did find that the nurse was neglectful in treatment and monitoring of the individual's health status. The facility developed an in-depth action plan to address multiple issues found during their investigation. • DFPS case #37388780 involved allegations of physical abuse with two alleged perpetrators named. DFPS investigators interviewed the victim five days after notification. In her statement, she alleged that she was pushed by one of the staff prior to being restrained by the two APs. The individual stated that another individual witnessed the event. The investigator interviewed the two APs and	Noncompliance

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	investigator's findings; and the investigator's reasons for his/her conclusions.	both stated that no abuse took place. The individual named as a witness was also interviewed and stated that she witnessed the victim being pushed into the wall by the APs. The investigator established credibility in the two APs' statements stating that their statements corroborated each others, however, the investigator deemed the victim and the witness' statement as noncredible because they were not corroborated, even though they both claimed the individual was pushed. The investigator noted that their statements did not match because the witness stated that the victim was pushed into the wall and the victim did not mention hitting a wall when she was pushed. A witness in this case originally refused to be interviewed by the investigator. This information was not mentioned in the summary. The investigator further used the shift home logs to determine credibility of the APs, but not of the victim, even though both the victim's and the APs' statements matched the details of the events leading up to the restraint and the restraint episode. There was not enough clear evidence documented in this case to corroborate the AP's denial of abuse. Although both the victim and the AP had been involved in other abuse cases in the past, evidence did not include a record of past investigations. DFPS cases did not include a summary of previous investigations involving the victim(s) and perpetrator(s), although many cases reviewed involved victims and perpetrators that had been named in other similar cases. For example: • In DFPS case #37307061, dated 8/5/10, the AP had been named in at least one similar allegation on 7/25/10. The victim had been involved in at least three other investigations in the six months prior to this case. • In case #36896903, involving a confirmed case of physical abuse, the prior history for the victim and the AP were not used, though the AP had another allegation of physical abuse against her less than three months prior to this incident. • In DFPS case #37360020/UIR #3389, both the victim and the AP had been involved in numerous investigations. The DFPS report did not include any prior history of investigations for either the alleged victim or the alleged perpetrator. These cases led to some concern over the thoroughness of DFPS investigations at the facility and the methods for gathering evidence. This issue is addressed further throughout section D of this report, however, as discussed with DFPS in December 2010, the agency is making changes to document prior case history in the case report as well as the case management system. Numerous investigations were referred to OIG and/or law enforcement, but none of the facility investigation files included findings from criminal investigations. The facility	

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		investigator reported that the facility is notified of findings from OIG via email. It is the monitoring team's understanding that OIG will begin providing a summary of their investigations to the facility. DFPS had a list of individuals for whom streamlined investigations had been approved. There were 10 individuals included on this list. For each of the individuals, it was noted that he or she had met the criteria for making frivolous and patently false allegations. DFPS was in the process of updating their policy regarding streamlined investigations. The monitoring team will have the opportunity to review the policy prior to implementation. The OIG investigator stated that he still did a thorough review of all cases for individuals on the frequent caller list because these were individuals where abuse would be easy to hide since they often "cry wolf." Due to concerns regarding the lack of analysis of past allegations, as well as concerns regarding whether or not evidence gathered supported conclusions, as noted, in DFPS investigations, the finding is being made of noncompliance with this provision.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The state policy required that the Incident Management Coordinator (IMC) review all investigations to ensure that they were thorough, accurate, coherent, and complete. All investigations were to be reviewed by the Incident Management Coordinator and the facility director or his designee. A sample of 22 UIRs was reviewed for compliance with this provision. None of the UIRs (0%) were signed by the IMC, though all included a signature for the facility director or his designee. A review of IMRT minutes supported that investigations remained an item for discussion on the Incident Management Review Team meeting agenda until cases were closed. The facility did not request further review from DFPS when evidence was not sufficient to support findings in an investigation. DFPS investigations were signed by the investigator. The supervisor was reported to be signing off electronically, so there was no shared record of that signature. As was discussed during the conference call between DFPS, DADS, and the monitoring teams, a process needs to be developed to allow the monitoring teams to assess this provision item. This provision will not be in substantial compliance until DFPS is able to provide evidence that the supervision of the DFPS investigations is occurring.	Noncompliance

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	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The state policy required the facility to complete an Unusual Incident Report (UIR) for each incident at the facility. Facility investigators completed investigations of unusual incidents that did not involve abuse, neglect, or exploitation. Documents reviewed indicated that the reports included a thorough summary of investigative procedures, relevant history, personal information about the individual, a timeline of notifications, an analysis of findings, and recommendations for remedial action to be taken. Reports were standardized, clear, and easy to follow. The facility was in substantial compliance with this provision.	Substantial compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	A log of employees reassigned due to ANE allegations and observation of unit meetings and Incident Management Review Team meetings indicated that employees were routinely reassigned to duties either not requiring contact with individuals or monitored frequently while maintaining routine assignments with individuals. A review of disciplinary action for perpetrators in a sample of 20 confirmed allegations indicated that, in all cases (100%), disciplinary action was taken by the facility. • For 11 cases of confirmed neglect, five employees were dismissed, two resigned, three were suspended, and one received a written warning. • For nine cases of physical abuse, one employee was demoted, three were suspended, two resigned, two were dismissed, and one was pending. • In one case of confirmed exploitation, the employee was suspended. Some examples of corrective action taken by the facility in response to incidents included: • In DFPS case #36896903, staff disciplinary action was taken in response to a confirmed allegation of physical abuse. Additionally, two nurses were retrained on PMAB and on reporting abuse before they were returned to duty. • Recommendations following a choking incident documented in UIR #3342 included modifications to the individual's dining plan and retraining staff in proper procedures for assisting someone who is choking. • Recommendation following an injury documented in UIR #3450 was to work with the individual on keeping the floor of his room clear of clothing, shoes, and other trip hazards. • In response to a sexual incident documented in UIR #3344, the individual who was the aggressor was placed on increased supervision. • In response to a neglect allegation documented in UIR #3368, two staff were	Noncompliance

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		disciplined for their involvement, and all staff on the home were retrained in maintaining proper supervision levels. • In response to UIR #3379, involving a missing resident, two staff were disciplined for neglect and all homes were retrained in "How to properly sign on to residents we serve." IMRT notes included a log of unusual incident/DFPS cases with a column for corrective actions/protections recommended to be tracked. There was a column for responsible person and one for due date, but those columns had not been completed on the IMRT notes reviewed. Additionally, notes reviewed did not include a completion date for actions. It was assumed that when action was completed, the item rolled off of the log. For example, the log indicated that APs were placed on NCC (no client contact) for UIR #3368 on 8/5/10 (the date the incident occurred). No further notation was made in notes throughout the month. The DFPS investigation was completed on 8/23/10 with a confirmed allegation of neglect. The UIR included recommendations for retraining all staff and shift supervisors in the home and disciplinary action for the APs. There were no follow-up notations to indicate further action was recommended. On 8/31/10, notes still indicated NCC for the APs in the case, and then on 9/1/10 the case rolled off of the log. The facility needs to develop a system to track recommended action for completion and document that action has been completed. The facility is not in compliance with this provision.	
	(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.	All investigations requested by the monitoring team were quickly accessed by the facility. Investigation reports included a summary of previous investigations involving the individual and alleged perpetrator, indicating that information was readily available to investigators. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents were trended by individual, home, cause, location, staff individual involved, outcome of investigation, and date. The facility was able to quickly pull together data requested in specific formats by the monitoring team. As evidenced by PSPAs, individual's PSTs were notified when trends were identified that needed to be addressed by the individual's team. IMRT meeting minutes indicated that	Substantial Compliance

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	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.	staff were often retrained in regards to specific incidents or trends identified by the IMRT. The facility was found to be in substantial compliance with this provision item.	
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 facility provided the monitoring team with a spreadsheet documenting fingerprinting, EMR, CANRS, NAR, and criminal background check (if fingerprint results were not obtainable) for all employees and volunteers at SGSSLC. Additionally, all employees were required to sign a form upon employment acknowledging their obligation to self report all arrests or indictments. A sample of these signed statement were requested for 24 current employees. Documentation was available for 23 of the 24 employees (96%). DADS had developed a bar to employment indicating criminal charges that would make an applicant or employee ineligible to work at a state supported living center. When employees are charged with a criminal act that is not included on the list of bars, employment was at the discretion of the facility director. A sample of documents was reviewed that indicated employees were hired when criminal charges did not meet those bars to employment. A sample was reviewed of employees who passed a criminal background check, but were determined to be unsuitable for employment because they did not accurately disclose criminal history. The facility director made the final determination in all cases. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance

Recommendations:

1. Ensure that all serious injuries are reported to the facility director and outside entities as required.
2. Revise the incident management policy to include training requirements for staff assigned to complete investigations and incident reports and clarify that investigators will not be in the direct line of supervision of the alleged perpetrator.
3. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.
4. Ensure that all DFPS investigations meet current timelines as outlined in the MOU implemented 6/1/10.

5. Develop a system to track and document the status of recommendations for corrective action made in completed investigation reports.

6. Implement an audit process to ensure all serious injuries are investigated thoroughly and reported to DFPS if evidence does not fully support how the injury occurred.

7. Examine facility trends and look at specific indicators to develop a plan of correction to address any trends identified in injuries and incidents.

8. Ensure investigation reports include a summary of the investigator's analysis of the history of the alleged victim and alleged perpetrator if relevant to the current investigation.

9. Ensure that all DFPS investigation contain a well-written summary to support any conclusions. When information in the report is not sufficient to support findings, the facility should request a revision to the report with further investigation when warranted.

10. Improvements should continue to be made with regard to the timeliness, the depth of review, and the soundness of the conclusions of investigations. Consideration should be given to including timeliness on the checklist used to evaluate investigations.

11. Consider the installation of outside video surveillance cameras where most appropriate.

The following are offered as additional suggestions to the facility:

12. Facility management needs to review the workload of the two investigators and determine if thorough investigation of all incidents is a reasonable expectation.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: ○ DADS policy #003: Quality Enhancement, dated 11/13/09 ○ Organizational chart, not dated ○ SGSSLC policy list, not dated ○ List of typical meetings that occurred at SGSSLC ○ SGSSLC policy, Quality Improvement Council, 10/6/10 ○ SGSSLC POI, October 2010 ○ SGSSLC POI Supplement, October 2010 ○ SGSSLC QA Department Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 11/15/10 ○ Description of types of monitoring, who conducted it, frequency, and oversight (four pages) ○ Completed monitoring form for section L for Individual #127, 10/18/10, and corresponding summary of data along with data from physician consultant: Medical audit and medical compliance tool, November 2010 ○ Completed documentation audit for abuse/neglect concerns or unusual incidents for four individuals in four different homes (Individual #396, Individual #340, Individual #81, Individual #48), October 2010 ○ Completed program audits for Individual #290 and Individual #287, October 2010 ○ Completed record maintenance guideline audit, for Individual #223, 10/31/10 ○ Completed tracking form for November 2010 program audits ○ Blank SGSSLC QA forms: • Individual to individual aggression follow-up • Program audit • Documentation audit for abuse/neglect or unusual incident concerns • Well-being verbal quiz • Unusual incident verbal quiz • Abuse/neglect verbal quiz • Recordkeeping • Individual support and observation interview ○ Completed data from individual support and observation interview forms, January 2010 through September 2010. Various emails and corrective action requirements for July 2010 and August 2010 findings. ○ Completed: FSPI procurement card controls, and facility plan maintenance 2010 ○ Various emails regarding follow-up and corrective actions ○ PIC meeting minutes: 5/18/10 through 9/21/10 (five meetings) ○ QI Council meeting minutes: 10/19/10, 10/25/10, and 11/15/10 ○ Medication Error PIT meeting minutes: 7/13/10 through 10/5/10 (seven meetings)

	○ Mealtime PIT meeting notes: 6/10/10 through 10/8/10 (15 meetings) ○ DADS survey of staff engagement (satisfaction) for SGSSLC staff, 2010 ○ EMPACT meeting minutes, 9/2/10 and 10/1/10 ○ Notes from active treatment workgroup session on 11/4/10 ○ Self-advocacy meeting minutes 6/8/10 through 11/17/10 (six meetings) <u>Interviews and Meetings Held</u>: ○ Dr. Philip Baugh, Facility Director ○ Angela Kissko, Director of Quality Assurance ○ Penny Bivens, Settlement Agreement Coordinator ○ Roy Smith, Rights Officer; Melissa Deere, Assistant Ombudsman; Sidney Lyle, OIG investigator; Zula White, Rights Protection Office Assistant ○ Residential Unit Directors: • Melinda Gentry, Cedric Woodruff, Vicki Hinojos ○ Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: ○ Many residences, day program, and vocational program ○ QI Council Meeting, 11/15/10 ○ Self-advocacy meeting, 11/17/10
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI listed all of the outcomes the facility hoped to measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment. Little information was provided as to what the facility did to make these determinations other than providing one or more of the same comments for most all of the items. The most frequent comment was "10/20/10: Quality Improvement Council policy was developed and will be presented to facility policy/procedure approval and review committee on 10/21/10." Given the many upcoming changes to quality assurance practices that are anticipated to occur at SGSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in all areas, except that the monitoring team noted highlights regarding some quality assurance-related activities that were occurring across the facility (e.g., initiation of the QIC, listing of all data collected at the facility, auditing). The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.

	Summary of Monitor's Assessment: SGSSLC was not in compliance with this provision. As detailed below in this section of the report, further work on the collection of data, review of data by the new QIC, the management of corrective actions, and the creation of a QA plan and a QA report are some of the activities that will be required in order for SGSSLC to be in substantial compliance with this provision. A lot of QA-related activity, however, had occurred since the baseline monitoring review. First, the PIC had been changed to the QIC. Although new (only three meetings), the plans were for the QIC to have responsibility for looking at a variety of data sets from across all operations at the facility (e.g., Settlement Agreement compliance, ICFMR regulations, Life Safety Code activities, and data from all of the operational and service departments of the facility), to determine when corrective actions were needed, and to manage and oversee implementation of those corrective actions. Second, the QA department had recently begun the task of creating a comprehensive list of all data that were collected at the facility. The intention was for this list to then be reviewed by QIC so that the QIC could determine what data it wanted to regularly review. Third, observation and monitoring of various areas by QA department staff across the facility had continued since the baseline review. Further, the monitoring team's checklist tools were being sampled and tried out by the QA staff and many other managers around the facility. Plans to modify the tools to make them more user friendly to facility staff were discussed with the monitoring team. Data collected at SGSSLC, however, were not organized under a QA plan as to what data should be collected by QA staff, what data should be submitted by facility departments to the QA department, and how those data should be handled once submitted. Regular reports were not completed by the QA department for use by senior management. Both of these activities (QA plan, QA report) will likely occur after the completion of the QA department's assembling of a comprehensive list of facility data collection, and after the QIC has made some decisions regarding which of these data it wants to regularly review. Initial attempts at CAPs were seen at the facility. The monitoring team had the opportunity to speak with the QIC, the facility director, and the QA director regarding methods to manage corrective actions as compared to formal Corrective Action Plans. This will be discussed further with DADS central office. Self-advocacy activities remained active. The group met each month. According to the minutes of the meetings, little had changed since the baseline review. That is, the meetings remained, primarily, a forum for individuals to bring up problems (e.g., need for cigarette lighter access) that facility staff solved or followed up on. The most recent meeting, however, was encouraging because it presented the self-advocacy group with a problem (safety in the evenings at the facility's on campus park area) and asked them to help solve it by generating possible solutions and volunteering to be on a committee.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	Many activities related to quality assurance were occurring at SGSSLC. Some of these were occurring during the baseline review and continued to occur at the time of this review. Others were recently initiated and although new, were likely to help SGSSLC work towards substantial compliance with this provision. This provision item, however, was found to be in noncompliance due to the recency of implementation of these activities and the need for further development of quality assurance processes as described in this section of the report. Some of the more salient points regarding quality assurance at SGSSLC are listed immediately below, followed by comments on various other aspects of the QA program at SGSSLC. First, the Quality Assurance Director (QAD) and the Settlement Agreement Coordinator (SAC) were working closely together in the coordination of data collection, corrective actions, and follow-up activities. This was a change and an improvement from the time of the baseline review. Their ongoing collaborative work will benefit the facility and the QA program. Second, the Quality Improvement Council (QIC) was formed in October 2010. Its third meeting was held during the week of the onsite review. The QIC is described below in section E2. Third, the QA department had two primary focuses at the time of this onsite review. One was to continue to collect data from a variety of facility operational areas. The other was to develop a single comprehensive listing of all data that were collected at the facility. The list was to be used by the QIC to determine which data to review and which operational areas required corrective action. Fourth, new policy revisions were being developed for the facilities by DADS central office. These had not yet been disseminated at the time of the onsite review. <u>Policies</u> The Quality Assurance Director told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. The facility also had a policy on the new Quality Improvement Council, dated 10/6/10. It detailed the purpose and activities of the QIC. The monitoring team was pleased to see that it directed the QIC to review data from a full range of operational functioning. Therefore, it set the occasion for QA to gather all of these data. The policy directed QA to collect data from the list below. The last bulleted item represents the largest data set for QA to collect and manage. • Settlement Agreement compliance reviews, • DADS ICFMR reviews,	Noncompliance

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		• the facility's own mock ICFMR reviews, • Life Safety Code reviews, • the FSPI, and • "all relevant quality assurance data from functional service areas of the facility…" (page 2). The facility did not plan to develop any additional policies for quality assurance operations. The QAD was awaiting revisions to the state policy to guide further <u>Quality Assurance Plan</u> The DADS policy required the development and implementation of a quality assurance plan (QA plan). Moreover, a QA plan will increase the likelihood of the facility meeting the requirements of this provision. The QAD stated that the QIC policy was SGSSLC's QA plan. This, however, was not a QA plan. In general, a QA plan should indicate all areas that are to be audited, the tools to be used, the frequency of audits, and the staff who are responsible for these audits. It may also include the types of data that should be submitted to the QA department from the various departments and divisions of the facility. It should also describe the type of report(s) to be generated. Again, there was no QA plan at SGSSLC and the absence of a plan should not be taken lightly by the facility. A plan needs to be developed. The QAD, however, had much of the content of a QA plan already available to her. These could be combined into a useful QA plan. For example: • the QIC policy laid out various areas for which data needed to be collected, • the QAD's four-page description of types of monitoring could be expanded to include all areas for which data needed to be collected, • additional information could be added (e.g., frequency, sample size, what happens to data after they are collected), • the list of data to be reviewed by QIC (or the process by which the QIC makes these determinations) could be described, • the process for review of data and creation of corrective action could be described, and • the procedures of corrective action (in line with Settlement Agreement sections E2, E3, E4, and E5) could be defined. The QA department should play a role as a repository for all data activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to	

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		senior management (i.e., the QIC) in a manner that is useful for decision making and efficient and effective management of all services and supports at SGSSLC. QA Department All of the staff in the QA department remained the same since the baseline review. The director, Angela Kissko, supervised three QA program auditors (one of whom was the QA nurse), the unified records coordinator, and a data analyst. Since the baseline review, incident management responsibilities were transferred from the QA department to another facility department, thereby providing the QAD with more time to devote to QA activities. Penny Bivens, the Settlement Agreement Coordinator, played a large role in the QA processes at the facility. Both the QAD and the SAC were professional, organized, and responsive to the many requests of the monitoring team during the weeks before, during, and following the onsite review. The QAD and SAC participated in a statewide meeting in September 2009. Another meeting was scheduled for December 2010. In addition, the QAD was receiving training as part of the state's Building the Bench program. She told the monitoring team that this was a nine-month program that occurred anywhere from two days per week to a full week each month. This session was for senior managers who worked at an ICFMR. The facility had also received training on ICFMR regulations and the development of a data system and mock review process from a contracted consulting agency. The QA department appeared to have a good working relationship with senior management across the facility. Even so, the QA department might also benefit from taking steps to more fully integrate into the overall operation of the facility. The monitoring team suggests that the QAD and SAC contact the QAD at the Lufkin SSLC regarding some of that facility's activities. These are also summarized in the October 2010 compliance monitoring report for Lufkin SSLC. QA Activities and Indicators Most of the tools described in the baseline monitoring report continued to be implemented at SGSSLC. In addition, the facility was working on creating a list of all of the data collected at the facility, whether collected by QA staff or program department staff. This was a major and important task. Also, the facility was incorporating the use of the monitoring tools used by the monitoring teams (see below for more comments). First, the QA department staff collected a variety of data. All of these were occurring during the baseline review and continued during the time of this onsite review. These were described in a four-page document submitted by the QAD. The document described	

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		the data collection, who collected it, the frequency of collection, and oversight. The following were included: • Environmental: ADSO inspection sheet, two homes per month • Unusual incidents: verbal quizzes, eight per month • Abuse and Neglect: verbal quizzes, eight per month • Well-being checks: verbal quizzes, eight per month • Mealtime: SGSSLC monitoring form, two meals per month • Program audit: SGSSLC monitoring form, four per month • Documentation audit for unusual incidents, injuries, or abuse/neglect: SGSSLC monitoring form, four per month • Recordkeeping maintenance: SGSSLC monitoring form and monitoring team checklist, done by URC, four per month • Individual to individual aggression: monitoring of follow through by PST for all individuals with three or more incidents in any 30 day period • Individual observation/interview tool: one per home per month • FSPI audits: Certain modules each quarter as assigned by state, data entered by facility, managed by state central office • POI sections done by QA program auditors: according to a schedule A sample of completed QA program auditor monitoring forms was submitted to the monitoring team. The sample further indicated that a number of auditing activities were occurring. • A completed monitoring form for section L for Individual #127, 10/18/10 was submitted. It was completed by the QA nurse, Lisa Owen. A number of relevant and useful comments were included regarding the rationale for the scoring of each item (e.g., his annual physical was overdue, therefore, routine care was rated as being in noncompliance). She also noted that a medical quality improvement process was not yet developed. The audit resulted in three recommendations. o Interestingly, the submission to the monitoring team included a sheet comparing the scoring of the QA nurse (an overall rating of 26%) with the facility's consulting medical reviewer (an overall rating of 100%). This raised a concern regarding potential problems with interobserver agreement. To the monitoring team, the QA nurse's ratings appeared to be the more correct of the two. The QAD should examine the reasons for these disagreements. Also see section L of this report. • A completed audit of documentation that indicated possible abuse/neglect concerns or unusual incidents that was not reported elsewhere for four individuals in four different homes (Individual #396, Individual #340, Individual #81, Individual #48) was completed in October 2010. This audit looked at	

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		observation notes, behavior data sheets, injury reports, IPNs, and home shift logs. It also looked to see that the individual's level of supervision was consistently implemented, that the BSP was current, and that target behaviors being collected were consistent with the BSP. Some missing or inconsistent information was found in this audit. Attached were recommendations and a column indicating that each recommendation had been addressed and completed. • Completed program audits for Individual #290 and Individual #287, from October 2010, were submitted. The audit examined a number of documents and their contents, including the comprehensive functional assessment, PSP, PSP meetings, QMRP functions, health risk assessment, psychology services, BSP, restraints, and rights restrictions. The nature of many of the items indicated that the facility was also trying to assess quality (i.e., not only the presence of an item). This was good to see. Moreover, some very useful comments were provided by the program auditors. The QAD should examine interobserver agreement and, if needed, provided instructions about how to determine whether the rating should be a yes or no (e.g., items, 31, 34, 41, 66, 76). • One completed record maintenance guideline audit was submitted. It was completed by the URC for Individual #223 on 10/31/10. It was a lengthy report (16 pages) and provided relevant comments by the URC. • Data and reports from the Individual support and observation interview form (six pages plus instruction sheet) were also submitted. o Monthly data for January 2010 through September 2010 showed the engagement rating for the observation and the scoring for 10 of the observation items. o Additional data, called an item analysis, showed additional engagement data and included comments, actions required, due dates, and follow-up for January 2010 through May 2010. o The data from staff interviews listed the administrator interviewer, staff member interviewee, and the ratings of their answers to 17 questions, for August 2010 and September 2010. o Various emails and corrective action requirements for July 2010 and August 2010 findings were submitted. It was not explained to the monitoring team as to why some items had a corresponding email and some did not. o Completed FSPI reviews for procurement card controls and facility plan maintenance were also submitted. Second, in addition to the QA and SAC staff, many other staff (e.g., managers, clinicians, therapists) around the facility collected data for their own departmental operations and	

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		services. Some of these data were given to the QA department, some were given to the SAC, and some were kept by the department for its own use. The QAD had begun to assemble a list of all data collected at the facility. She had a five-page document that listed a variety of data. The list appeared to be based on a DADS data set called "Data Elements." The facility should ensure that the list contains all of the data collected at SGSSLC, not just what's on the Data Elements list. For example, during discussion of this list at the QIC meeting, the monitoring team noted a variety of other types of data that should be included, such as medical and dental assessments, medical preventive care, psychiatry services, skill acquisition programming, community placement, employment, and community activities. Below are examples of other areas that might be incorporated into the SGSSLC QA program. • Set of nursing data collected by the nursing department, especially regarding the incidence of certain disorders and illnesses. • Set of data collected and managed by the medical department, including, for example, hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals. • Direct care staffing levels. In addition, other areas noted in the baseline report or in discussions at the facility should be included, such as the following: • The four provision items of the Settlement Agreement that specifically refer to the need for quality assurance (F2g, L3, T1f, and V3). • Health Care Guidelines • Dental Guidelines • Staff satisfaction (see below) • Trend analysis data (allegations of abuse and neglect, unusual incidents, injuries, and restraints). Third, comments made in the baseline report in section E1, under the heading Other Topics-QE Data, also continued to apply at the time of this onsite monitoring review, related to the reliability and validity of the QA process. Some activities regarding interobserver reliability were described by the QAD as being in process, including looking at which data needed to be recorded simultaneously by the observer (e.g., observational reviews) and which could be recorded separately (e.g., document reviews). Fourth, in the baseline report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QA system at SGSSLC. One measure should address staff satisfaction. A statewide staff satisfaction survey was conducted in	

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		February 2010 and the results were separated out for each facility. The survey was conducted by the University of Texas. It contained 71 standard items across a variety of work areas, as well as an additional 20 items specific to DADS facilities. The results provided relevant information that may be useful to the facility. About one-third of facility staff participated (348) and about half of the participants considered themselves to be in a supervisory role. Some of the items that were rated highly were about staff valuing their jobs and doing important work. Overall, the results at SGSSLC appeared to be similar to other facilities. The data for SGSLLC can be used to indicate areas for further investigation. The QAD should obtain this report from DADS central office. In addition to responding to the findings in the statewide survey, the facility should also consider ways of increasing participation in future surveys, ensuring more participation from direct care staff, and including some way for staff to make suggestions, either within the survey or through some other procedures. For example, the Mexia SSLC had suggestion boxes located throughout the facility. Each week, senior management reviewed all suggestions submitted and responded, when possible. The ongoing submission of suggestions indicated that it was likely that facility management was responsive (otherwise the number of suggestions would have likely decreased to zero). The monitoring team learned about work done at the facility to recognize exemplary staff performance. The EMPACT committee notes from September 2010 and October 2010 indicated referred to quarterly luncheons, service awards, and retirement plaques. In addition, employees of the month were recognized along with many other employees who were recognized for perfect attendance. EMPACT was an acronym for Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank. In addition to the staff survey, DADS was coordinating the development of a survey of family member satisfaction. A workgroup of staff and administrators from different facilities participated. The monitoring team had the opportunity to see the draft survey during a previous review at another facility. Overall, there were many relevant questions. Questions regarding planning for community placement, however, were not included and should be added. In addition, in November 2010, DADS posted a website for family members and LARs to answer a series of questions regarding their satisfaction with services. This may provide useful information, however, due to the anonymity of the participants, it will always remain unclear as to who completed the survey. The monitoring team did not have the opportunity to meet any family members or LARs during this onsite review. A measure to survey the satisfaction of related community agencies, providers, and vendors was not yet in place. The monitoring team continues to recommend doing so.	

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		As also noted in the baseline report, self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. It also can provide a context in which individuals can be taught group problem solving and decision-making skills. The monitoring team attended the November 2010 monthly self-advocacy meeting and also reviewed the minutes of meetings since May 2010. Overall, the minutes indicated that meetings continued to primarily address problems brought up by individuals (e.g., quality of meals, cigarette lighter availability, having more electrical outlets at the gym, holding a barbecue). More recently, however (i.e., September 2010), the meeting was used to address a problem at the facility, that is, safety at the facility's outdoor park during the evening hours. The problem was presented by management staff and then discussion ensued regarding ways to solve it. The primary solution was to create alternative interesting activities for individuals in the evenings, weekends, and at their day programs. One specific suggestion was to offer peer counseling. A list was generated and the information was also used at the senior management's planning retreat. Follow-up was presented to the self-advocacy group at the November 2010 meeting, including inviting individuals to participate in further development and implementation with the management staff. This appeared to be well received by the individuals. Continuation and expansion of these types of activities is recommended, including breaking up into smaller groups, and the teaching (and learning) of a structured group problem solving process, such as: • Define the problem in objective terms. • Generate two to four possible solutions. • Discuss the pros and cons of each solution. • Vote to choose a solution to implement. • Develop a plan to implement the solution. • Develop a plan to report on the results of implementation of the solution. The monitoring team also liked that the meetings included presentation of useful information to the individuals in attendance. At the meeting observed, the local OIG investigator made a presentation on the investigation process and the importance of always telling the truth (i.e., not making false reports). In September 2010, the minutes indicated that a presentation was made regarding the new-style PSP process. The monitoring team was pleased to see that SGSSLC had made some efforts to incorporate the contents of many of the tools used by members of the monitoring team. As discussed at length with the QA director, please remember that these tools were designed for use by the monitoring team and, therefore, many items will need to be adapted for use by facility staff. Additional points are listed below. • The monitoring tools do not include instruction sheets or guidelines. These	

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		would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of monitoring team members with substantial subject matter knowledge. If they are going to be used by, for example, QA staff, who had more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. • These tools should not be used to generate a cumulative score with regard to substantial compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. • Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise or who engaged in specific activities during the week of the onsite monitoring review. • At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet likely would assist in this process. <u>QA-Related Committees</u> The DADS policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation) at SGSSLC, according to the QA director. The policy required a program improvement council; this was in place at SGSSLC and is described in section E2 below. It was changed to a new title, the QI council and it is likely the new policy for this area will describe the QI council. <u>QA Reports</u> The DADS policy also required performance improvement reports. These were to be	

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		self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report at SGSSLC. The monitoring team believes that a QA report will help the facility to achieve substantial compliance with this provision.	
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.	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. Based upon a review of documents, interviews with facility staff, and observations at the facility, SGSSLC was not in compliance with this provision item. The facility's POI also indicated noncompliance. Further, the comments provided in the baseline report in section E2 continued to be relevant. Overall, the facility was at the initial stages of determining what data to analyze. The facility had only recently implemented corrective actions in some areas (described below), however, the facility will need to look at a full and comprehensive set of data (as was the intention of the QIC) in order to achieve substantial compliance with this provision item. A quality assurance report did not exist and was not in the process of being developed or created. A quality assurance report should include data, line graphs, and narrative, at a minimum. SGSSLC did not have any type of quality assurance report. The QAD described the facility's system for auditing, tracking of audits, and tracking of audit recommendations that were conducted by the QA staff only for the set of measures listed above in section E1. "Currently there is a tracking system in place for audits conducted. The audit recommendations are placed into a tracking system as well so that all recommendations are tracked to resolution. When an audit is completed, an email with a copy of the audit is sent to the applicable party (e.g. RN, Home Manager, QMRP, Psychologist, CNE, Unit Director, Unit Nurse Manager, Pharmacy Director, or Medical Director). A copy of the email is saved as evidence that a notification was sent. The same method is used to track the status of a recommendation. Additionally, interviews and onsite observations are conducted as needed to verify implementation of a recommendation. While tracking systems are in place, trending and analysis is not being conducted. Some of this is due to the recent implementation of the monitor's checklist tools and not enough data is available. When enough is data is available, tracking, trending, and analysis of this data to look at systemic recommendations will be presented to the QIC." The tracking system audit file was submitted to the monitoring team for November 2010 program audits. It had two tabs (spreadsheets) within it. The first listed, for two individuals whose records were reviewed, their scores on each of the program audit items. The second listed recommendations and follow-up as to whether the recommendations were completed. This was a very organized and detailed way of	Noncompliance

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		managing audits for this one area (i.e., program audits). The table submitted to the monitoring team listed all 11 areas of QA-collected data (e.g., audits. The monitoring team recommends that a way of managing QA-collected data (e.g., audits) for the other measures be created and implemented (if not already in place) and shared with the monitoring team during the next onsite review. <u>Performance Improvement Council and QI Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Assurance. As noted above, the purpose of the meeting had changed at SGSSLC to have a facility-wide focus. This change had recently begun at SGSSLC and the group was called the Quality Improvement Council (QIC). Based upon a review of minutes from the first three QIC meetings (including the one attended by the monitoring team), the QIC appeared to be off to a good start, but was not yet meeting the goals required of it (e.g., determination of data to review, review of data, determination of need for corrective action, monitoring of corrective action). There was good attendance and participation by members of the council. The monitoring team attended the monthly meeting of the QI Council during the week of the onsite review. The meeting lasted for about an hour and a half was led by the facility director. The agenda and topics were all related directly to QA. The lengthiest part of the meeting was a discussion of the list of data collected at the facility, what to include on the list, and what of this list should be reported to the QIC. The QIC then reviewed the currently functioning activities that were receiving extra attention at SGSSLC. These included the following; • Life Safety Code deficiencies • Mock ICFMR survey • Settlement Agreement activities • PNM during mealtimes • Restraint reduction • Medication errors • Pretreatment sedation Special performance improvement teams were formed for PNM during mealtimes, restraint reduction, medication errors, and pretreatment sedation. Discussion also occurred regarding forming another performance improvement team for spurious allegations of abuse.	

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		<u>CAPs, PITs, and PETs</u> There was no organized system of generating, developing, disseminating, implementing, monitoring, documenting, modifying, or managing corrective action plans (CAPs) at SGSSLC. The facility, however, was preparing to begin to do so. During the onsite review, the monitoring team spoke with the QIC, the QAD, and the facility director regarding the management of corrective actions at SGSSLC. It may be that an organized method to track areas in need of corrective action so that the requirements of provisions E2, E3, E4, and E5 can be met, may provide the facility with a more effective way of managing corrective actions as compared to completing a set of Corrective Action Plan forms and a Corrective Action Plan tracking tool form. The monitoring team would like to discuss this further with central office DADS staff. SGSSLC facility management appeared to have a good understanding of CAPs, PITs, and PETs. That is, that the QIC was to direct the initiation of corrective action. In many, but not all cases, the corrective action would require the formation of a PIT. The PIT was to then report back to the QIC on its activities and progress. The PIT could, if its members so chose, form a PET to do further activities and data collection. The monitoring team expects that an organized system of managing corrective actions will be created and maintained in the future and be available for review for the next monitoring review.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
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.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement new state policy when disseminated.

2. Continue to develop and implement the new QIC process. Including, but not limited to:
    a. Review comprehensive listing of all data collected at facility once completed (see recommendation #3 below).
    b. Determine what data to review at QIC meetings.
    c. Decide the areas of service for which corrective actions are needed.
    d. Develop and monitor corrective actions in a way that meets the requirements of the Settlement Agreement (see recommendation #9 below).

3. Complete the task of creating a single comprehensive listing of all data that are collected at the facility. See the many comments in section E1 above. Note that this will be an ever-evolving activity, that is, the listing, once complete, will need to be updated periodically.

4. Create a facility QA plan that is functional, meaningful, and useful to SGSSLC managers, administrators, and clinicians regarding Settlement Agreement provisions and other areas of service provision.

5. Ensure validity and reliability of data collected at the facility and by the QA program.

6. Examine the difference in scores between the QA nurse and the medical consultant in the one case noted in E1 above.

7. Collect data regarding the satisfaction of individuals, staff, family members and LARs, and affiliated agencies and providers. Implement satisfaction surveys for individuals, staff, families/LARs, and affiliated agencies. Incorporate those data already being collected by state office (e.g., staff and family) into the QA plan of the facility.

8. Develop a QA report that includes a summary of all activities, data, trends, and narrative that describes important points about the data. See the description in section E2 above.

9. Develop a system to develop and manage corrective actions, following all requirements of provision items E1, E2, E3, E4, and E5.

10. Expand the summarizing and tracking of QA-collected data, and tracking of the completion of recommendations, to the other 11 areas of QA-collected data.

The following are offered as additional suggestions to the facility:

11. Further develop the problem-solving component of the self-advocacy meeting as noted in section E1 above.

12. Take actions for the QA department to more fully integrate into the overall operation of the facility. The monitoring team suggests that the QAD and SAC contact the QAD at the Lufkin SSLC

13. Implement a procedure to obtain suggestions from staff members.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: • Supported Visions: Personal Support Planning Curriculum • DADS Policy #004: Personal Support Plan Process • SGSSLC List of PSP development dates • The following documents for a sample of individuals: o Individual #123 – PSP dated 9/14/10, PFW, Assessments, SPOs o Individual #337 – PSP dated 6/29/10, PFW, PSPAs, Assessments, SPOs o Individual #252 – PSP dated 10/1/10 o Individual #197 – PSP dated 8/3/10, Assessments, SPOs o Individual #75 – PSP dated 10/8/10, SPOs o Individual #132 – PSP dated 9/13/10, PSPAs, Assessments, SPOs o Individual #379 – PSP dated 9/9/10, PFW, Assessments, SPOs o Individual #15 – PSP dated 8/17/10, PFW, Assessments, SPOs o Individual #315 – PSP dated 8/4/10, Assessments, SPOs o Individual #60 – PSP dated 9/20/10, PFW, Assessments, SPOs o Individual #18 – PSP dated 8/3/10, PFW, Assessments, SPOs o Individual #344 – PSP dated 7/22/10 o Individual #292 – PSP dated 10/6/10 o Individual #264 – PSP dated 9/27/10 o Individual #321 – PSP dated 9/24/10 o Individual #120 – PSP dated 10/5/10 o Individual #298 – PSP dated 9/28/10 o Individual #265 – PSP dated 10/6/10 o Individual #193 – PSP dated 10/7/10 o Individual #194 – PSP dated 9/22/10 o Individual #57 – PSP dated 10/5/10 o Individual #213 – PSP dated 10/13/10 o Individual #294 – PSP dated 9/30/10 o Individual #239 – PSP dated 9/22/10 o Individual #283 – PSP dated 9/1/10, PFW, Assessments, SPOs <u>Interviews Held:</u> o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Dr. Philip Baugh, Facility Director o Jalown McCleery, Program and Management Support

	○ Natalie Montalvo, Director of Residential Services ○ Charles Njemanze, Assistant Director of Programs ○ Michael Davila, QMRP Coordinator ○ Melissa Deere, Ombudsman ○ Roy Smith, Human Rights Officer ○ Noel Zapata, Vocational Training Director ○ James Reid, Residential Coordinator <u>Observations Conducted</u>: ○ Observations at residences and day programs ○ Health Status Team Meeting ○ Daily Incident Management Review Team Meeting 11/17/10 ○ Daily Incident Management Review Team Meeting 11/19/10 ○ Human Rights Committee Meeting 11/18/10 ○ Restraint Reduction Committee Meeting 11/18/10 ○ PSPA meeting for Individual #346 ○ PSP annual meeting for Individual #327 ○ Self-advocacy Meeting
	Facility Self-Assessment: The facility POI indicated that PST members received training related to the new Personal Support Plan Process beginning 9/7/10. The majority of all team members had received this training. QMRPs began facilitating the new process for PSPs scheduled the week of 9/14/10. The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet fully implemented. As a result, noncompliance was the rating determined by the facility for most of the items in this provision. Some of the POI items were self-rated as being in substantial compliance solely due to the existence of the new state policy. The monitoring team concurred with the facility's POI.
	Summary of Monitor's Assessment: Compliance with section F of the Settlement Agreement will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised

	in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. Administrative staff at SGSSLC had taken some positive steps towards evaluating and revamping the service delivery system in regards to active treatment at the facility including: • Beginning implementation of the new statewide person centered planning process. • Developing a focus group to look at person centered programming at the facility in terms of needs specific to the population served at SGSSLC. • Identifying gaps in present programming and service delivery with input from individuals served by the facility. • Developing plans to address some of the gaps in services identified through this process. Although the facility was found to be out of compliance with the provisions in this section of the Settlement Agreement, it was promising to see that administrative staff was working to develop a comprehensive plan to address service delivery rather than using a short-term approach to fixing specific problems noted in each provision item of the Settlement Agreement. The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings. PST meetings observed the week of the monitoring visit were in the new-style format. For all QMRPs facilitating the meetings, this was a new process for them, as well as for other team members participating in the meetings. As expected, the meeting format was not completely comfortable for the QMRPs and the other team members. Discussion with QMRPs throughout the visit indicated that they were becoming more comfortable with the process, and other team members were learning how to contribute information at the meetings that would facilitate development of a plan that included supports necessary for individuals to achieve specific outcomes relevant to their preferences and identified needs. At PST meetings observed during the baseline visit, meetings were formatted so that they began with each discipline present at the meeting presenting assessment results, then, almost as an afterthought, the team discussed the individual's preferences and vision for the future. During this visit, however, the format had noticeably changed. At the PSP meeting observed for Individual #327, the individual led his meeting by discussing his preferences and vision for the future. As he described what he would like to participate in and achieve, each discipline raised for discussion the barriers to achieving his vision, the supports that he would need throughout his day to overcome barriers, and how those supports could be provided. As noted throughout section F of this report, however, this information was not always reflected in great enough detail in PSPs to guide staff in providing all necessary supports. Quality Enhancement activities with regards to PSPs were in the initial stages of development. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual.

	A sample of 25 Personal Support Plans (PSPs) was reviewed. Sixteen of the plans in the sample were developed in the new style; the remainder was developed prior to implementation of the new PSP policies. The format of the plans indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding the individual's diagnosis and support needs were much more clearly stated in terms of how those needs would be addressed on a daily basis to ensure the individual's health, safety, and ability to function more independently. As noted throughout section F, while there was positive movement towards developing more meaningful support plans, the plans reviewed were still not comprehensive plans in compliance with the new DADS policy or this provision of the Settlement Agreement. The state and the facility have acknowledged the failure of the previous PSP system to comply with the requirements of section F as evidenced by major revisions of policies and facility wide efforts at addressing PSP development, programming, and the integration of supports and services. The monitoring team does not feel that focusing on compliance percentages for specific individuals reviewed in the sample would be meaningful or advantageous to the facility because the facility was in the initial stages of implementation of these changes. Throughout section F, the monitoring team has instead focused on trying to provide the facility with examples of where, when applicable, changes have been effective in producing desired outcomes and examples of areas where problems have been identified and will need to be addressed as new procedures are developed. The monitoring team looks forward to seeing how systemic changes will impact specific outcomes for individuals once the facility has had a chance to implement these changes.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs at the facility were responsible for facilitating PST meetings, and for developing, monitoring, and revising treatments, services, and supports. All three PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings as required. The annual PST meeting for Individual #327 occurred during the week of the monitoring visit. The individual led his meeting with minimal assistance from the QMRP required in order to ensure that the meeting moved along and that all topics were discussed. This was a great example of person centered planning at the facility. The individual led the discussion and informed the team what he would like to focus on for the upcoming year. A full range of representatives from each discipline attended the meeting and contributed information that would be relevant in planning.	Noncompliance

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		As discussed in other sections of this report, it was not evident that assessments relevant to planning for each individual were being completed prior to PSP development, nor were plans or services consistently revised when not adequate or effective. See comments throughout this report regarding plan implementation, monitoring of plans, and revision of treatments, services, and supports. As a result, the facility was not in compliance with this provision item of the Settlement Agreement.	
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.	Not all PSPs reviewed included sign in sheets that indicated who had attended and participated in the development of the PSPs reviewed. A review of the sample of attendance sign in sheets provided indicated that in some cases, but not all, relevant team members were present at annual PST meetings: • The annual PST meeting observed for Individual #327 supported that the PST was comprised of an interdisciplinary team based on the individual's strengths, preferences, and needs. A full range of representatives from each discipline attended the meeting and contributed information that was relevant in planning. • For Individual #337, all relevant team members were present at the annual PST meeting. • For Individual #60, there was a full range of representatives from each discipline applicable in attendance at this meeting. • For Individual #123, the individual's mother was able to attend over teleconference. Assessments indicated that work was a priority for the individual, but there was no indication that vocational staff attended the meeting. There were several OT/PT recommendations included in his plan. Neither the OT nor PT attended the annual meeting. Obstacles to community placement included physical aggression, unauthorized departure, and self-injurious behaviors. According to his nursing assessment, he was taking Geodon, Depakote, and Tegretol for aggression. There were plans to try to taper him off two of the medications indicating a need for discussion around possible behavioral changes. Psychology and psychiatry staff were not in attendance at his annual PST meeting. • For Individual #197, his parents and designated MRA were able to attend her annual PST meeting by teleconference. The HST had determined that she was high risk for challenging behaviors. Psychology and psychiatry staff were not in attendance at her annual PST meeting. The attendance sheet did not indicate that direct care professionals were in attendance at her meeting. • For Individual #132, there was no indication that day habilitation staff were in attendance at his meeting. Furthermore, PNM staff did not attend the meeting, even though he had a modified dining plan in place to address his risk for choking. Psychiatry staff did not attend the meeting, though he was taking Geodon and Lithium "to assist him in having a good day." His PSP further stated	Noncompliance

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		that they suspected that he may suffer from schizophrenia and the team had requested a new evaluation. • For Individual #379, there was no indication that PNM staff attended his meeting, even though it was noted that he had experienced an increase in falls recently, needed an updated PT/OT assessment, and was on a modified diet with adaptive dining equipment due to his risk for choking. There was no SLP involvement, even though it was noted that he was "nonverbal for the most part." • For Individual #15, her attendance sheet did not indicate that she attended her PST meeting. There was also not indication of attendance by direct support staff from either the day or residential program, psychiatry, psychology, or PNM staff; all were relevant to planning for her. • There was no indication that direct support staff were in attendance at the annual PSP meeting for Individual #283. When key members of the PST are unable to attend meetings, it is suggested that the team documents any attempts to get input before the meeting and include recommendations from the team member not attending in the individual's PSP. The facility was rated as being out of compliance with this provision item.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	The Personal Focus Worksheet (PFW) was the individualized assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. For the majority of plans reviewed, this list was individualized, fairly comprehensive, and offered a good starting point for plan development. Information gathered from the PFW was used as a basis for PSP development in the new style format. This led to plans that were more individualized with a greater number of priorities being addressed. As discussed throughout this section, plans still did not always address priorities for work and community living. Assessments for work and community living did not adequately address the lack of exposure to work and living opportunities. It is essential that assessments provide opportunities for individuals to participate in a variety of experiences relative to areas assessed. For example, vocational assessments tended to focus on how the individual performed on specific tasks available at the facility's sheltered workshop without regards as to whether or not the task was of interest to the particular individual. When performance was poor in that setting, it was determined that the individual did not have necessary skills to participate in supported employment. Vocational assessments should include situational assessment based on the individual's known skills and interests to	Noncompliance

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		determine if the person is truly interested in possible work in an alternative setting. The quality of assessments is thoroughly discussed throughout this report. See sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, and section R regarding communication assessments. The monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs. Compliance will need to be demonstrated in these other areas regarding the development, monitoring, and revising of assessments in order to achieve compliance with section F1c.	
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.	A wide variety of assessments were performed prior to PSP development. The older PSP format included a summary of those assessments, while the newer PSPs showed an attempt to integrate the information into the plan where relevant. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychological, psychiatric, and therapy services, along with a schedule of when these services will be provided, where they will be provided, and what types of supports the individual will need throughout the day to support participation. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan. Some examples are provided below. • Individual #132 had a "new" style PSP that was a good example of a plan that integrated assessment information into a discussion of activities that he	Noncompliance

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		preferred and offered guidelines for supporting him in his preferred activities including monitoring for risk. His SPOs addressed outcomes identified throughout his PSP as priorities for him. Although not comprehensive in scope, it was one of the better PSPs reviewed in the sample. It was noted that the picture in his PSP showed him wearing a helmet. It was assumed that this was a protective device. His plan did not mention why or when he wore the helmet. The plan also did not include a clear picture of how he spent his days, evenings, or weekends. • Individual #60's PSP was another good example of a plan that integrated assessment information in a meaningful way throughout the plan. The plan described how he liked to spend his day, what activities were important to him, and then described supports that staff would need to provide while he was engaged in activities. His risks were defined so that staff supporting him knew what to watch for to safeguard his health. For example, he was on a gluten free diet and his plan noted that "his stomach will become distended when he has obtained items that he should not consume per his diet. He will let staff know when he is not feeling well and at times will cry. He requires medical attention when this happens. Medical will assess and make a decision to send to ER as necessary." While his plan demonstrated a good move towards a more integrated comprehensive plan, there were important supports not addressed in his plan, such as his need for support when bathing and toileting. His plan should describe what supports are needed to complete daily tasks. He also used a walker and gait belt. Neither was mentioned in his plan. • Individual #193's PSP included a good discussion of the individual's preferences, how those preferences would be incorporated into her day, and what medical and behavioral supports staff would need to provide throughout her day. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, it was not apparent that this information was used to develop and implement protections, services, and supports for the individual. • A wide range of assessments were completed for Individual #123, including a rights assessment, medical assessment, nutritional assessment, rehab therapy assessment, speech/language assessment, vocational assessment, nursing assessment, dental assessment, SAM assessment, audiological evaluation, functional skill assessment, and residential living skills assessment. His vocational assessment noted that he liked to work and would like a job outside. His vocational assessment further noted that his only barrier to employment was "getting to work on time or at all due to staff shortage." Employment was	

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		not addressed in his outcomes. Several assessments noted that he enjoyed being outside and gardening. This was not addressed as an outcome. He was morbidly obese and on a low-fat diet. His outcome to prepare a snack did not include strategies for choosing a healthy low-fat snack. • Individual #75's ISP indicated that work was important to her. The possibility of supported employment was not addressed. In her discussion of community living, it was noted that she did not want to meet with her MRA, so the team did not address further assessment to identify any obstacles or barriers to community living. • The PSP for Individual #379 indicated that "he had had increased falls lately." The team made a referral to the transfer committee to move him to a safer environment. The PSP stated the transfer had been denied because "challenges would continue regardless of home he is on." It further noted that a referral would be made to OT/PT. It was not evident if this occurred and, if it did, whether there were recommendations made from that assessment. Other than increased LOS, there were not recommendations included to address this increase in falls. His PSP noted that he was non-verbal, but did not list communication as a priority or address communication strategies. • Individual #15's assessments indicated that she needed specific supports in regards to personal hygiene and oral hygiene. These were not addressed in her PSP. • Individual #18's PSP included a "cut and paste" summary from most of his assessments without regards to whether or not information was applicable or provided any information that staff could use to provide supports. This resulted in multiple pages of hard to decipher information that was useless to direct support staff in trying to determine what supports they should be providing to him throughout his day. For example, the nursing assessment section included four pages of clinical notes from the past year, but no direction on what signs or symptoms staff should look for to identify when he might be at risk, even though he had many significant medical diagnoses that support staff needed to be able to monitor. His communication section included the name of another individual stating that his communication dictionary was accurate and worked for the other individual. His SLP and dental assessment sections just noted that he needed an annual evaluation. Assessments should be obtained prior to PSP development and used in planning for supports. • Individual #344's assessment section and living option section included another individual's name, making it difficult to determine if the supports were needed by him or by the other individual. • Individual #321's PSP did not include any outcomes or action plans. • Individual #120's PSP stated that he had not shown any interest in attending	

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		programming. It noted that a motivational assessment needed to be done. This assessment should have been completed prior to PSP development to help the team determine what type of programming to plan for the upcoming year. • Individual #298's PSP states that he was enrolled in the sheltered workshop to provide him with vocational skills that would further assist him when he was able to return to community living. The PSP did not refer to his vocational assessment or specific skill development that was occurring at the sheltered workshop. PNM assessment information was "cut and pasted" into the PSP, including clinical information that was not necessary for providing daily supports. Support needs should be stated so that direct support staff can clearly identify what supports are needed and when staff should provide the needed supports. Although progress has been made in this area since the baseline visit, this provision item was rated as being out of compliance.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The new DADS policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. PSPs indicated that community placement was discussed at all PST meetings, though little action was taken to move forward with community placement when determined appropriate by the team. Home visits had been scheduled for individuals in the sample, but additional movement towards actual placement was not evident. PSPs indicated that individuals and their LARs were provided with information regarding community placement as required. There was no consideration of community-based day programs or supported employment by the team in PSPs reviewed. Although trips were planned in the community each week, there was limited focus on active treatment occurring in the community. Observation at the sheltered workshop on campus indicated that attendance at the workshop was low. Although some individuals at the workshop indicated that they enjoyed their jobs, many other individuals indicated that work was boring, they did not enjoy their job, and the pay was too low. There was no indication that employment outside of the facility had been actively pursued for any of the individuals in the sample. The Vocational Director indicated that the facility had not been successful at community employment due in part to the depressed economic status of the community and competition with other sheltered workshops in the area seeking supported employment opportunities. He also reported that the facility had not been able to establish a relationship with DARS, the state entity responsible for providing employment services	Noncompliance

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		to individuals with disabilities. DARS response to referrals reportedly had been that individuals at the facility were not candidates for supported employment services without completing a job assessment to determine eligibility. This is an issue that the state will have to address among agencies to facilitate the coordination of services. In the meantime, it might benefit vocational staff at SGSSLC to attend updated job coach training to learn new skills for working with individuals interested in obtaining supported employment For additional comments regarding compliance with this provision, see section T. The facility was rated as being in out of compliance with this provision item.	
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 monitoring team looks forward to reviewing this provision once there is further implementation of newly developed state policies to address PSP development and implementation.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The PSPs reviewed included a list of "What's most important to the person?" As noted in F2c, this was a fairly comprehensive list of the individual's preferences in the sample reviewed. It was not evident that this list was always the central focus in planning for the person. Teams should use the "What's most important to the person?" section of the PSP to then develop outcomes, include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to occurrence. Interviews with the director of residential services and the vocational director indicated that a lack of meaningful person directed programming at the facility led to poor attendance and low engagement levels in active treatment and recreational programming. This was an excellent observation. Further, staff interviewed at the facility attributed the high number of behavioral incidents at SGSSLC to this lack of meaningful programming based on the preferences of the individuals served. It was observed during the week of the monitoring visit that attendance at the sheltered workshop and other day options on campus was low and individuals spent much of their	Noncompliance

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		day just hanging out engaged in little activity. The facility administration (including the director of residential services and the vocational director) had recently begun to address this issue by establishing a focus group to look at day and recreational programming. The work group had met with individuals during a recent self-advocacy meeting to find out the types of activities in which they would prefer to be involved. A review of PSPs confirmed that individuals had many preferences and needs that were not being addressed through programming at the facility. Vocational programming was high on the priority list for many individuals, but the facility had few options to address vocational services. The vocational director indicated that this had been a topic of discussion recently and the facility was actively looking at developing a vocational program that would meet the needs of a greater number of individuals at the facility, including developing a program that would offer meaningful job skills training. According to the vocational director, some individuals were employed on campus at jobs outside of the sheltered workshop. Some of these jobs included employment at the canteen, beauty shop, and on the grounds crew. Another area of programming that SGSSLC had begun to focus on to try to offer activities that would encourage increased engagement was recreation and leisure activities available at the facility. Changes were already underway to the arts and crafts program on campus to bring activities offered more in line with individual's preferences, age, skills, and interests. The facility was renovating Building Imagination (the arts and craft center) to offer areas for classes, individual activities, small group craft, and sewing projects. Additionally, they had plans for the arts and crafts center to be open on Friday evenings to offer additional evening activities. The facility had also developed a small library open to individuals at the facility. Exercise classes had just begun on campus and massage therapy was being offered. Renovation was well underway to the recreation center to include a coffee house where individuals could hang out during the evenings and weekends. Plans included a sitting area and video arcade. Additionally, the recreation center had pool tables, basketball courts, and card playing tables. Consideration was also being given to providing more meaningful retirement activities at the facility. Although, the monitoring team agrees that the facility needs to develop more meaningful programming options at the facility, we would like to caution the facility that the expectation for this provision is that functional learning should be taking place in the community. Activities at SGSSLC should not take the place of activities that could be provided more naturally in community settings. For example, while the coffee house on campus is a great way to teach skills necessary for appropriate socialization and integration in the community, coffee houses in the community offer a better setting for learning integration skills in the community.	

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		PSPs reviewed were reflective of the lack of programming available at SGLLC. PSPs did not address work and day programming in any detail other than to state the individual's interest. Barriers to participating in work activities were not addressed and meaningful supports and services were not put into place. The following are examples of PSPs chosen from the sample reviewed that did not address services and supports based on individual's preferences, strengths, and needs. • Individual #252: Information from the Personal Focus Worksheet was incorporated into the PSP in terms of priorities and preferences. Outcomes were developed based on her preferences with the exception of supported employment. The plan did not include vocational outcomes that would move her closer to securing a job in the community. Outcomes reflected skills that she would need to develop to reach her long-term outcome to move into the community, as well as preferences that she expressed, such as learning to read and improving her social skills. "Behavioral concerns" was the only identified barrier to reaching her outcome to live in the community. The PSP included general supports that she currently needed, but it did not discuss specific supports that staff needed to provide throughout her day. • Individual #197's PSP did not indicate what supports she needed to attend school, even though her PSP indicated that, "there was discussion at her ARD meeting regarding the fact that she would not graduate this semester due to her lack of attendance." It was further noted that she would like to go to school with her brother as soon as possible. There was no plan in place to support her to achieve this outcome. Her community living options discussion indicated that she told her team that she would like to live in a group home closer to her family and her main goal was for community living. Exploring community options, however, was not discussed as an outcome. • Individual #15's PFW indicated that she enjoyed shopping and going out to eat. There were no outcomes developed to ensure that she would have the opportunity to go into the community. • Individual #337's PSP indicated that his vision for the future included working in the community. His PSP outcomes did not address job training or work. • Individual #344's PSP did not address vocational services. It was not clear from a review of his PSP what day service he was receiving. • Individual #264's community living discussion indicated that he was provided with the opportunity to tour homes in the community this past year to offer exposure to options so that he could make a better informed choice regarding where he would like to live. The discussion concluded with the team agreeing that he will be offered the opportunity to visit group homes in the community	

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		annually. There was no further discussion on moving to the next step, though the team agreed living in the community was a reasonable option for him. • Individual #321's PSP stated that she had good work skills and could complete any task assigned. It continued to note that she had refused to attend the workshop for four months or more. There was no discussion around developing job supports that would be more meaningful to her. • Individual #57's PSP offered little direction for staff as to how his preferences should be incorporated into his day or what supports were needed. His plan stated that he was enrolled in the sheltered workshop to provide him with vocational skills, but did not include information from vocational assessments addressing what skills training should focus on developing. His PNM discussion was "cut and pasted" from his assessment and offered no clear directions for staff assigned to support him throughout his day. His PSP did not include a schedule describing his typical day, when training would occur, or when supports should be provided. The facility was rated as being in out of compliance with this provision item.	
	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;	As discussed in F2a1, outcomes were not always related to the individual's preferences and long-term vision, and plans were not consistent in addressing supports needed to achieve outcomes. Additionally, teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Strategies included limited supports needed for implementation, but as noted in information regarding assessments throughout this report, adequate supports were not always identified in assessment or, if they were identified, they were not included in planning. Due to the lack of integration among disciplines at the facility, it was difficult to assess if plans were carried out consistently as written. As noted in the summary section and throughout numerous PSPs reviewed, individuals often chose not to attend day programming, so there was limited opportunity to implement outcomes consistently. See section K4 for more detail on implementation. The limited interventions provided by OT, PT, or ST at this time were not reflected in the PSPs by integrating recommendations into training strategies or as training objectives when appropriate. Recommendations for supports and services were generally listed under the assessment sections based on the annual review, but in the case that these needs were identified in the interim between annual PSPs, they were not integrated into the PSP via addendum. Progress or change relative to OT/PT/ST were not routinely documented in a progress note or tracked quarterly by the QMRP.	Noncompliance

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		The facility was rated as being out of compliance with this provision item.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. Treatment plans and clinical care plans were often stand alone documents that were not integrated into an overall plan. PSPs developed following the new person centered training did, however, showed progress in this area. Risk for individuals was not adequately identified and consistently addressed throughout the PSP to ensure that staff knew how to provide safe supports for each individual. See section I of this report for specific examples. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. It is expected that full implementation of new state policies and training on person centered planning will guide QMRPs in developing more meaningful plans. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline. Target dates for completing objectives were not included in plans reviewed. SPOs contained instructions for implementation, but these instructions were not detailed enough to ensure consistent implementation of outcomes. For example, Individual #337 was working on an objective to "state name of medication," the instructions were: "Announce to the individual that it is time to take your medication. Please state individual's name to the nurse when you arrive at the med station." It was not clear if he had to ask for his medication by name, tell the trainer the medications that he was taking, or identify medications as they were handed to him. Implementation instructions need to be clear enough to ensure that all staff are implementing the outcome consistently in order to provide consistent data for determining completion of outcomes. The team should assign completion dates that correspond with the individual's rate of learning and assign specific staff to implement plans. Specific training strategies should be included in the PSP. See sections K and S for additional comments on implementation strategies.	Noncompliance

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		The facility was rated as being in noncompliance with this provision item.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As noted in previous sections, a majority of outcomes in the PSPs reviewed did not adequately address supports needed by the individual to achieve outcomes and did not consider what the individual would need to learn to become more independent in the community. As noted throughout this report, gaps in services available at the facility impacted whether or not needed services were addressed in PSPs. Further, it was not evident that community settings were always considered as an option for implementing outcomes. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	All SPOs reviewed had a list of data codes that were to be used to indicate progress or lack of progress on implementation. Each SPO included a description of when outcomes should be implemented. SPOs named who would be responsible for implementation of each outcome, and indicated that the QMRP would review implementation. Please also see section S of this report for further discussion of SPO data collection. Individual #283's SPO for the outcome "outings and social activities" indicated that it should be implemented "as frequent as there are enough staff to execute it." Implementation should be based on the needs of the individual. The facility was rated as being in compliance with this provision item.	Substantial Compliance
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.	This provision of the Settlement Agreement will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, R, and T. Please refer to these sections of the report regarding the coordination of services. The facility is encouraged to implement a monitoring process that reviews which services and supports are needed by an individual and assess whether or not those services are addressed in the PSP. The monitoring team found a lack of coordinated supports and services throughout the facility. Although team members from various disciplines met together to develop the PSP, it was not evident that supports were integrated into one plan. The facility did not have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility was not rated as being in noncompliance with this provision item.	
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.	PSPs in each home were accessible and current. As noted throughout this report, PSPs did not offer staff clear guidance on providing a range of supports to each individual to ensure training was consistently implemented and the person would remain safe and healthy. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. It was not evident that the facility had a system in place to monitor implementation monthly and revise the PSP when there was a lack of progress. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QMRPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP. The facility was rated as being in noncompliance with this provision item.	Noncompliance
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	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing meeting facilitation and the development of a comprehensive PSP document. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual specific plans initially or when they were updated or modified. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	All PSPs in the sample of 25 reviewed had been developed within the past 365 days. A list of PSP dates for all 252 individuals living at SGSSLC, however, indicated that 37 (15%) individuals did not have a plan developed within 365 days of their prior PSP. New admission PSPs were developed within 30 days of admission for all individuals in the sample reviewed that were admitted in the last 365 days. As noted throughout this report, plans were not revised as needed. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E above). As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	Noncompliance

Recommendations:

1. QMRPs should ensure that all assessments relevant to planning for each individual are completed prior to PSP development.

2. QMRPs should monitor the effectiveness of plans and request updated assessments and recommendations when an individual is not making progress on outcomes.

3. Ensure all relevant team members are present at PST meetings. If members cannot attend, the QMRP should seek input prior to the planning meeting, document in the PSP how participation occurred and incorporate any recommendations into the PSP.

4. Ensure all PSTs meet at least annually to review and revise PSPs.

5. Ensure assessment results are addressed in PSPs and recommendations are used to develop strategies for the achievement of outcomes.

6. Encourage joint assessments and planning among multiple disciplines as appropriate.

7. Ensure that individuals have outcomes to address any barriers to participation in activities important to the individual.

8. Include a description of the individual's day, weekend, and evening schedule in the PSP with a description of any supports (including adaptive equipment) needed throughout his or her day.

9. Develop a vocational assessment process that focuses on potential work skills that may be of interest to the individual including situational assessments and interest inventories. Include assessment results in vocational outcome development.

10. Ensure training is occurring in the community and consistently documented.

11. Ensure that at least monthly, and more often as needed, PST members assess progress of related interventions, and take action as needed if there is a lack of expected progress or significant changes in the individual's health or behavioral status.

12. Ensure strategies for implementing outcomes are clearly written so that all staff can consistently implement strategies and document progress.

13. For individuals who receive educational services, document how the individual's IEP will be supported and integrated into the PSP.

14. Integrate psychiatry into the treatment planning process

15. Include information regarding the individual's psychotropic medication regimen in the PSP. This information should be documented in collaboration between psychology and psychiatry to ensure the accuracy of information promulgated.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Organizational chart, not dated o SGSSLC policy list, not dated o List of typical meetings that occurred at SGSSLC o SGSSLC policy, Quality Improvement Council, 10/6/10 o SGSSLC POI, October 2010 o SGSSLC POI Supplement, October 2010 o SGSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 11/15/10 o PIC meeting minutes: 5/18/10 through 9/21/10 (five meetings) o QI Council meeting minutes: 10/19/10, 10/25/10, and 11/15/10 o List of clinical positions, staff and consultants Interviews and Meetings Held: o Dr. Philip Baugh, Facility Director o Charles Njemanze, Assistant Director of Programs o Rebecca McKown, MD, Medical Director o David Bessman, MD, Primary Care Physician o Lisa Busbee, RN, Nurse Operations Officer o David Ann Knight, RN, HST Coordinator o Melody Gelsomino, medical secretary o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator o Residential Unit Directors: Melinda Gentry, Cedric Woodruff, Vicki Hinojos o Facility psychiatrists o Colleen Glass, manager of campus token store o Penny Bivens, Settlement Agreement Coordinators o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Presentation made to monitoring team by senior staff at SGSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o QI Council Meeting, 11/15/10 o Psychiatry clinics

	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in and measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment. The monitoring team concurred with this self-assessment. Even so, many of the items had information in the comments section that provided the monitoring team with some details about what the facility had done, and what it planned to do. The comments indicated a number of activities were occurring, or were planned to occur, to work towards the provision of integrated services.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, and a number of activities had occurred regarding this provision item since the baseline review. Clinicians across the facility were becoming familiar with this provision. A number of examples of ways in which SGSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. It is likely that a specific focus to ensure that all areas of clinical service provision as specified in provision item G1 are included in the facility's provision of integrated clinical services. During the onsite review, the monitoring team had a lengthy discussion with medical and nursing staff regarding the documentation of non-facility consultations. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals	A plan was not in place to address this item, policies and procedures did not exist, and there was an absence of integrated clinical services to the extent required by this provision item. Even so, the facility had made progress in this area as demonstrated by examples of new activities towards integration of clinical services. More work needed to be done, as acknowledged by the facility and described below. Consequently, this provision item is rated as being in noncompliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. Policy might include specific examples for the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	Clinical staff at SGSSLC were aware of this provision of the Settlement Agreement; the medical director had been assigned lead responsibility for this provision, and some actions had occurred towards addressing this provision. The monitoring team met with Dr. McKown, Dr. Bessman, Lisa Busbee, David Ann Knight, and Melody Gelsomino to discuss provisions G and H. Valerie Kipfer, the DADS central office Director of Nursing Services was also on campus and participated in this meeting. SGSSLC staff described facility activities towards meeting the requirements of both section G and H and noted that they were in early development. In addition, the monitoring team observed, or heard about, efforts to provide integrated clinical services. These are listed below (in no particular order of importance). • There had been one meeting between psychiatry and psychology, but there was a plan to do this each month. Psychiatry and psychology interacted in clinic and in the rare PST meetings psychiatry was able to attend. • Unit Directors met weekly with the Assistant Director of Programs. This had been occurring for about one year. • There were proposed new policies for process, lab matrix, and enhanced consultation with a neurologist. • Medical worked with OT, PT, and dietary on the relationship between feeding tubes and dental issues. • Dietary was working with the canteen and token store regarding appropriate snacks, diabetes, and other relevant topics. • Polypharmacy meetings were being initiated. • P&T meetings were scheduled to occur every three months. • An individual with a complicated medical and behavioral presentation was the subject of frequent interdisciplinary meetings (Individual #346). • The medical director had established a good working relationship with the emergency room and admissions department at the local hospital, Shannon Medical Center, over the past year. • Unit Directors reported that they worked very well with the other departments at SGSSLC. They cited the addition of the new director of psychology as the most recent example. • A facility incident management review meeting occurred each day to review incidents and other important information. The meeting was led by the facility director. • Integrated progress notes (IPN) were being used in an attempt to improve integrated service provision. • A new multidisciplinary team was assembled to study the problem of poor engagement and activities.	

#	Provision	Assessment of Status	Compliance
		• Psychologists appeared to be better integrated in homes and appeared to have an improved working relationship with direct care staff and their supervisors. • The current system of PNMP Clinic was an integrated process with OT, PT, SLPs, dietitian, audiology, direct support staff nursing and often the physician participating. • Psychiatrists were beginning to integrate with the primary care physicians. The POI and Supplemental POI described other ways in which the facility was working towards the provision of integrated clinical services. • Monthly meeting between psychiatrist and psychologists began in September 2010 to include difficult patient discussions and significant change in condition or behavior. • Medical providers met weekly to discuss difficult patients, polypharmacy, and to share information of interest. • Nursing, medical, psychiatry, and residential lead staff meet together weekly with the ADOP to discuss clinical issues, barriers to integrated care, and solutions to overcoming barriers. Other examples indicated that more work needed to be done • The POI indicated that documentation using integrated progress notes was evolving, but needed much improvement. • Discussions and the entrance presentation by the medical director indicated the recent use of an outside consultant to do medical record reviews and audits. This did not, to the monitoring team, appear to be a helpful activity at this point. See comments in sections L regarding the depth and breadth of the review, and section E regarding disagreement with the ratings done by the facility's own auditor. • Overall, there appeared to be a lack of integration of medical services. The medical department had not established daily meetings with psychiatry, psychology, and nursing services to promote integration. • Primary care providers were not routinely attending annual PSPs, PSP addendums, and psychiatry clinic. • Neurology services were provided in the community making integration of psychiatry and neurology difficult. • Due to the lack of integration among disciplines at the facility, it was difficult to assess if personal support plans, training objectives, and service objectives were carried out consistently as written. • The facility psychology staff were not producing useful data for the psychiatrists to base decisions regarding medication adjustments. While some graphs were being created, there were issues with the addition of medication adjustment	

#	Provision	Assessment of Status	Compliance
		information and sentinel events (i.e. social stressors) that were not included on the graph. • There was a need for collaborative case formulation and diagnostics, as well as for the collaborative development of a behavioral/psychopharmacological treatment hypothesis. • During annual PST/PSP meetings, there was no evidence that the individual's nurse provided a comprehensive overview of the individual's health status, needs, and risks, and/or summary of their response to treatment interventions and their progress/lack of progress toward achievement of their desired health outcomes. In addition, in four of the 25 records reviewed, there was no input by nursing. • There was no evidence that the SLPs collaborated with psychology regarding communication limitations that set the occasion for problem behaviors. • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting communication and language programming. There was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. Under the leadership of the facility director, SGSSLC should address the need for integration of clinical services. Modifications to the PIC meeting into the QI Council may contribute to setting the occasion for this integration to occur.	
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.	The facility appeared to be responsive to recommendations from non-facility clinicians. SGSSLC, however, should include in its operating procedures the requirement for an explicit statement, in the integrated progress notes, of the PCPs' agreement or disagreement with each of these recommendations. There was a lengthy discussion during the meeting described above in G1 addressing this topic. The medical director acknowledged that information from some consultations "slips through the cracks." She commented that the physician looks at the consultations and makes comments and that the consultations are looked at during the physician's rounds. Consultation forms, however, sometimes go into a filing box and don't always surface on rounds. Nevertheless, after much discussion, the medical director and other health care professionals present at the meeting understood that the physician needed to write each recommendation into the IPN and indicate whether he or she agreed or disagreed with each recommendation. If the physician disagreed, a reason needed to be	Noncompliance

#	Provision	Assessment of Status	Compliance
		provided, too. Physicians were no longer going to write, "see consultation note" in the IPN. Further, the facility should consider the formal incorporation of two other areas of non-Facility clinician involvement in care of the individuals. • The Hospital Liaison: She regularly communicated with external health care providers and clinical professionals to ensure continuity and quality of care. She reported that she conducted daily visits to individuals who were in the hospital. During her visits, she observed residents, reviewed records, and received reports from the members of the external health care facility. The Hospital Liaison communicated the results of her reviews via electronic mail to facility staff. She was in the process, however, of adopting a strategy to ensure that her notes/reports were incorporated into the individuals' records • Outside consultants for modified barium swallow studies (MBSS): These were conducted by a radiologist and SLP in the local hospital to assess the integrity of the swallow and make recommendations as to diet texture and liquid consistency. This information along with the functional mealtime assessment were used to develop the Dining Plans.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

3. Ensure explicit statement of agreement or disagreement with each recommendation from non-facility clinicians is included in the integrated progress notes.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Organizational chart, not dated o SGSSLC policy list, not dated o List of typical meetings that occurred at SGSSLC o SGSSLC policy, Quality Improvement Council, 10/6/10 o SGSSLC POI, October 2010 o SGSSLC POI Supplement, October 2010 o SGSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 11/15/10 o PIC meeting minutes: 5/18/10 through 9/21/10 (five meetings) o QI Council meeting minutes: 10/19/10, 10/25/10, and 11/15/10 o List of clinical positions, staff and consultants o Medical audit and medical compliance tool, November 2010 Interviews and Meetings Held: o Dr. Philip Baugh, Facility Director o Charles Njemanze, Assistant Director of Programs o Rebecca McKown, MD, Medical Director o David Bessman, MD, Primary Care Physician o Lisa Busbee, RN, Nurse Operations Officer o David Ann Knight, RN, HST Coordinator o Melody Gelsomino, medical secretary o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator o Residential Unit Directors: Melinda Gentry, Cedric Woodruff, Vicki Hinojos o Colleen Glass, manager of campus token store o Penny Bivens, Settlement Agreement Coordinators o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Presentation made to monitoring team by senior staff at SGSSLC at opening meeting o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program, and vocational program o QI Council Meeting, 11/15/10

	Facility Self-Assessment: The facility's self-assessment was called the POI. It listed all of the outcomes the facility hoped to engage in and measure to work towards achieving substantial compliance with this provision. The facility rated itself as being in noncompliance with every item in its self-assessment of this provision. The monitoring team concurred with the facility's self-assessment. The content of the POI comments for these provision items was minimal and provided the monitoring team with no information as to what the facility had done to specifically address the required actions and items of provision H.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. Even so, some activities were occurring at SGSSLC. Similar to section G described above, medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. Across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. It is recommended that the facility's QA play a role in addressing this provision.

#	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.	A plan was not in place to address this provision item and the facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status, however, according to the facility's POI, new processes were being put in place: FROM SGSSLC POI Section H: • 10/21/10 OTPT assessments are completed upon change of physical status. The comprehensive OTPT modified assessments provide functional analysis of skills as well as therapy needs including measurable goals. • 10/21/10: Monitoring of psychiatric treatment is provided as often as necessary, based on the individual's current status and/or changing needs. • Nursing assessment processes are in place and are being performed. Monitoring of all clinical processes begun October 2010.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• New HMP assessment forms introduced this summer and in use. Monitoring of process begun October 2010. The monitoring team found that primary care providers provided little documentation of regular assessments of individuals. Annual medical assessments were not being conducted in a timely manner and there was poor documentation of physician response to changes in status. In many instances, physicians were not being notified appropriately of status changes. There was a lack of physician documentation following status changes that involved hospitalization and emergency department evaluations. See section L of this report for more detail. As discussed in the psychiatry section of this report (section J), the facility had not begun completing annual psychiatric evaluations. This is an area, however, that could be amenable to collaboration with psychology for the creation of a diagnostic formulation. It is also an area that could be impacted via quality assurance or peer review processes. Currently, the facility psychiatric physicians reported that individuals were seen at least quarterly, however, documentation of all of these clinical contacts was lacking. As the facility has not begun the comprehensive psychiatric assessment of individuals via the Appendix B format, and only minimal documentation was available in the record, this in an area in need of attention. There was a pattern of failure by the nursing department to ensure that emergent changes in individuals' health status, risks, and needs were identified, assessed, and addressed in a timely manner, reported to physicians, and closely monitored and evaluated until resolution. There was also evidence of failure to ensure that ACPs were developed and implemented in a timely manner, and/or HMPs were reviewed and revised as significant changes occurred. See section M of this report for more detail. The facilities functional assessments (K5), PBSPs (K9), and psychological assessments (K5, K6, K7) were not consistent with generally accepted professional standards of care. OT, PT, and ST assessments were completed annually as an update for individuals requiring some level of supports or services, such as assistive equipment with interim reviews through the PNMP Clinic. Some were done quarterly, others were done semi-annually. Issue-specific assessment as a result of changes in an individual's health status was noted less consistently. In addition, the documentation of these varied greatly from a note in the integrated progress note section of the personal record to an update or consult report filed in the Rehabilitation Therapy section of the individual's record.	
H2	Commencing within six months of the Effective Date hereof and with	There was no policy in place to require or guide the activities required to meet this provision item. SGSSLC was not tracking or monitoring this requirement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The facility medical director noted that they were working towards being more in line with the requirements of this provision item now that they were more fully staffed (or were soon to be). She said that diagnoses were more fitting corresponding assessments, and corresponding more to physicals. Physicians were supposed to look at medication as to whether they were all still needed. The monitoring team will look at this again during the next onsite monitoring review. For psychiatric diagnoses, this was impossible to determine because there were no diagnostic formulations outlining the specific symptoms that individuals were experiencing, such that the met criteria for a specific diagnosis. For additional information regarding this issue, please refer to the discussion of provision J8 Often, nursing assessments failed to result in a complete or accurate list of nursing diagnoses in accordance with NANDA.	
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.	SGSSLC did not have a plan or procedure in place to ensure that treatments and interventions were implemented timely and were clinically appropriate. The facility did not, at the time of this onsite review, have a way to manage this requirement. The medical director reported that treatments were implemented timely, such as via follow-up on doctor's rounds, and telephone orders. The monitoring team found that there was poor documentation that appropriate evaluations and treatments were being provided. In some instances, a verbal physician order was noted, but there was no physician documentation to support the order (see section L). As it was difficult to determine the accuracy of psychiatric diagnoses, it was also difficult to determine the appropriateness of medication due to the paucity of psychiatric documentation. (see section J). In over 80% of the records reviewed, nursing assessments were incomplete and/or failed to accurately portray the health status of the individual, including, but not limited to the severity of their high risk behaviors, self-injurious conduct, traumatic injuries sustained during behavior episodes, their heightened risk of infection due to other health risks, alteration in skin integrity, and non-adherence to clinical professionals' recommendations. There were also consistent failures to provide complete, accurate assessments of the individuals' responses to their treatment regimens, including, but not limited to evaluations of their responses to medications and treatment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The rationale for OT, PT, and ST interventions was improved within the annual assessment updates and the PNMP Clinic notes particularly for OT and PT but this was less evident in the issue-specific concerns that occurred in the interim. For example, direct therapy or other supports were initiated and/or terminated without the establishment of measurable goals. As result, there was no clear evidence-based justification documented. See specific examples in section P.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	Neither a plan nor activities were in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. Consequently, this provision item was rated as being in noncompliance. The medical department had initiated outside review by a physician, however, as noted in sections L and E of this report, problems with this system were evident to the monitoring team. Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. As stated above the rationale for interventions was not consistently evident in the documentation by the rehabilitation therapists and specific measurable goals were typically not specified. The facility and state should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and had numerous problems as indicated in other sections of this report. SGSSLC lead medical staff, however, talked about the facility's use of the HST and lamented that it was going to be discontinued. The group, including the state DADS central office director of nursing services spoke about the change to a PST-based review of risk and health status.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with	Neither a plan nor activities were in place to address this item and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	response to clinical indicators. Most of the 25 individuals reviewed in section M of this report had "mini" medical disorder plans, also known as "stock" care plans, added to their HMPs. The stock care plans were not adequately customized and/or personalized to address individuals' specific health problems and risks. Four of the 25 individuals' stock care plans referenced names of other individuals, and two of the 25 referenced interventions that were not appropriate and/or dangerous to the individuals if implemented.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. Facility management also acknowledged that this provision item was not yet being addressed even though there were a variety of other healthcare-related policies and procedures in place at SGSSLC.	Noncompliance

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Draft Policy #006: At Risk Individuals dated 11/2/10 o DADS SSLC Risk Guidelines (Draft) o Risk Process Flowchart (Draft) o DADS Integrated Risk Rating Form (Draft) o DADS Risk Assessment Tools, dated 8/31/09 o List of individuals requiring sutures/dermabond since 1/1/10 o List of individuals with fractures since 1/1/10 o List of all injuries since 1/1/10 o List of individuals hospitalized since 1/1/10 o List of individuals seen in the ER since 1/1/10 o List of individuals in the infirmary since 1/1/10 o List of individuals with pneumonia since 1/1/10 o List of individuals who have had a swallowing incident since 1/1/10 o List of individuals who have had an unauthorized departure since 1/1/0 o List of individuals at risk for weight loss or weight gain o List of individuals with poor oral hygiene status o List of individuals requiring mealtime assistance o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals who are at risk for seizures o List of individuals who are at risk for osteopenia/osteoporosis o List of individuals who are at risk for dehydration o List of individuals who are at risk for impaction/bowel obstruction/constipation o List of individuals who are at risk for skin breakdown o List of individuals who are at risk for choking/aspiration/pneumonia/dysphagia o List of individuals who are at risk for challenging behaviors o List of individuals who are at risk for cardiac concerns o List of individuals who are at risk for hypothermia o List of individuals who are at risk for diabetes o List of individuals who are at risk for UTIs o List of individuals who are at risk for injury o List of individuals with the highest number of injuries o List of individuals who are at risk for polypharmacy o List of individuals who have caused the most injuries to peers o Incident Management Team meeting minutes 8/1/10-8/30/10 o List of individuals with pica o List of individuals who receive nutrition enterally o HST Meeting Minutes 7/14/10 through 10/10/10

	○ PSPs for the following individuals • Individual #346, Individual #18, Individual #186, Individual #163, Individual #379, Individual #178, Individual #197, Individual #283, Individual #123, Individual #202, Individual #304, Individual #252, Individual #132, Individual #239. Individual #64, and Individual #321 <u>Interviews and Meetings Held</u>: ○ Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs ○ David Bessman, MD, Primary Care Physician ○ Jalown McCleery, Program and Management Support ○ Natalie Montalvo, Director of Residential Services ○ Michael Davila, QMRP Coordinator <u>Observations Conducted</u>: ○ Observations at residences and day programs ○ Health Status Team Meeting ○ Daily Incident Management Review Team Meeting 11/17/10 ○ Daily Incident Management Review Team Meeting 11/19/10 ○ Human Rights Committee Meeting 11/18/10 ○ Restraint Reduction Committee Meeting 11/18/10 ○ PSPA meeting for Individual #346 ○ PST annual meeting for Individual #327
	Facility Self-Assessment: The facility POI indicated that the facility was not in compliance with the provisions of section I. Notations in the POI indicated that the HST procedure was being revised by the state DADS office. They further noted that the current HST system assigned risk levels and developed treatment plans based upon risk level. The monitoring team agreed with the self-ratings in the facility's POI for this provision.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk, even with a plan in place.

	The facility had a system in place to address risk in 18 specific areas including: aspiration, choking, weight, cardiac, constipation, dehydration, diabetes, GI concerns, hyperthermia, medical concerns, osteoporosis, respiratory, seizures, skin integrity, UTIs, polypharmacy, challenging behaviors, and injury. A Health Status Team was actively reviewing individuals for risk in all of these areas. It was noted, however, that not all medical concerns were addressed for each individual. A risk area of concern that was identified in the review of unusual incidents at the facility was the potential spread of sexually transmitted disease due to the high number of sexual incidents reported at the facility. There was no indication that this had been identified for a number of individuals involved in multiple sexual incidents other than to try to reinforce the facility's "no sex" policy. Safe sex practices had not been supported or encouraged at the facility for individuals whose rights to engage in consensual relationship had not been formally restricted. The state had recently revised the policy regarding risk identification. It was now in draft form and was being piloted at two other SSLCs. The hope is that this will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Per current state policy a risk review at least every six months for each individual was conducted by the SGSSLC Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. The implementation and ongoing revisions to the process were facilitated by the Health Status Team Coordinator. A list of indicators for each of 16 risk areas had been identified and individuals were rated according to how many risk indicators applied in each areas. A risk level of high, moderate, or low was assigned for each category. The HST at SGLLC met weekly to review all of the individuals living in a particular home. Staff regularly assigned to the home from each discipline attended the meeting and contributed assessment findings to the discussion. The HST then assigned and recorded a rating for each risk factor. Observation of the HST meeting the week of the monitoring visit indicated that determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. This resulted in what appeared to be incorrect ratings of risk for many individuals in important areas of risk and/or failure to increase level of risk in a timely manner, such that the likelihood of harm and negative health outcomes was minimized. This led to concerns over whether or not support staff were aware of risks for individuals who they supported and if they knew appropriate risk signs to monitor for each individual. The facility is rated as being out of compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The HST meeting observed by the monitoring team on included all the appropriate team members. The physician led the meeting. The review of each individual involved the physician stating the risk category and an appropriate team member making a health risk rating recommendation. There was some discussion around appropriate ratings for some individuals. If there was no discussion, the next risk category was read, and so on for all the risk categories. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. As noted in section I3 below, not all risks were identified by the HST. Additional sections throughout this report discuss issues specific to risk identification and the development of plans to address and monitor identified risk. In regards to risk level assignment, review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels be assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. One of the most important aspects of a health risk assessment process is that it effectively prevent the preventable and reduce the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. This feature of health risk assessment is in need of improvement at SGSSLC. The facility was not in compliance with this provision item.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. It was found that some identified risks had individualized plans developed to address them. Rarely were all the relevant clinical indicators to be monitored, and the monitoring frequency, clearly specified in individuals' PSPs or Health Management Plans (HMPs). See sections M1 and M3 of this report for examples. An overriding concern of the monitoring team was the ability of direct support staff to	Noncompliance

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	interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	identify and provide supports necessary to keep individuals safe and healthy. PSPs need to clearly define risk for each person and what supports staff need to provide throughout the individual's day to safeguard that individual. The monitoring team found that it often took hours to comb through an individual's records to determine what risks each person had and how those risks were being addressed. Healthcare and therapy information was frequently "cut and pasted" into PSPs resulting in fragmented instructions blended in with clinical information that would be difficult for direct support staff to even interpret, much less, use as a guide for providing supports. As the new person centered plan development process is being implemented, it will be important to involve professionals from all disciplines in the development of PSPs that clearly identify risk and describe supports in a manner that all staff can understand and implement consistently. The narrative portion of the PSP should incorporate recommendations from all disciplines for supporting individuals and include a clearly defined schedule of when those supports should be provided. The following are some examples of where PSPs did not clearly describe risk and/or supports that were needed to address those risks: • Individual #346 was appropriately rated by the HST as at high risk for diabetes, skin integrity, challenging behaviors and injury. He was rated at moderate risk for choking and medical concerns. His team was meeting weekly to review risk factors for him and to monitor plans addressing his risks. It was clear from observation during the monitoring team's visit that many supports were in place to address his risk, but his PSP was not reflective of how supports were being implemented. His PSP did not adequately describe his risks factors or provide staff with strategies for implementing consistent supports throughout his day to minimize risks. • The HST had determined that Individual #18 was at high risk for aspiration and at moderate risk for choking, constipation, and GI concerns. Other diagnoses not addressed in the risk section included hypertension, other cardiac issues, urinary detention, skin integrity, osteoporosis, agitation, and anxiety. His nursing assessment summary section of the PSP contained four pages of clinical notes that commented on a myriad of other health care findings. Information was indecipherable in terms of what other healthcare risks he might have and how staff should monitor and support those risks. • The HST had correctly identified Individual #186 as being at high risk for challenging behaviors and injuries. She was determined to be at moderate risk for choking. Her PSP indentified that her BSP was in place to address her challenging behaviors and a dining plan had been implemented to address her risk for choking. She had at least 38 injuries documented since 1/1/10, with	

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		three serious injuries. The PST had met numerous times to address injuries and challenging behaviors and try to put protections in place to address these risks. The PSP did not identify her as being at risk for polypharmacy, though she was taking Risperdal, Klonopin, Topamax, Remeron, and Depakote. • The PSP for Individual #163 was one of the better examples reviewed for how risks should be incorporated into the PSP to describe supports needed to address her identified risks. She was diagnosed with diabetes and monitoring of her diet was addressed in her PSP. Including additional signs and symptoms specific to her in her PSP that would help the team monitor her diabetes would offer further protection. • For Individual #379, the HST assessment provided to the monitoring team was dated 3/17/10. It was not an accurate assessment at the time of his PST meeting on 8/6/10. The HST had determined that Individual #379 was at moderate risk for choking. He was assessed as low risk in all other areas. He had an increase in falls and injuries, with three falls documented between 4/7/10 and 5/30/10. His diagnosis of osteopenia contributed to his risk for injury. His PSP indicated that the team had met following fall incidents and implemented protections to address these risks. He had additional diagnoses of diabetes, hyperlipidema, constipation, and hypertension. Supports needed to monitor these conditions were not addressed in his PSP, other than to note that they were being monitored by medical staff annually. • Individual #178 was identified as having moderate risk for challenging behaviors and low risk in all other areas by the HST. His risk rating for challenging behaviors was elevated due to self-injurious behaviors, which should have also placed him at high risk for injury. There were three incidents of ER visits documented since 3/11/10, two occurred prior to the development of his PSP involving head trauma and one occurred just days after the development of his PSP. His BSP included strategies to address SIB. He was on a modified textured diet and used adaptive equipment at mealtime. His dining plan indicated that he was at risk for choking and aspiration. According to his PSP, the HST had not identified risk in those areas. Additional diagnoses not addressed by the HST included asthma, ulcerative colitis, and dyspepsia. • The HST had correctly determined that Individual #197 was at risk for challenging behaviors. Strategies were in place in her BSP to address these behaviors. Her dental assessment indicated that she had poor oral hygiene. It was evident from HST notes that the HST had been informed of her oral hygiene status, but it was not identified as a risk area by the HST nor had supports been put into place in her PSP to address this. • Individual #283's PSP noted that the major barrier for community placement was "physical aggression and SIB which exposes him to immense danger." The	

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		HST had rated him low for challenging behaviors and risk for injury. The team needs to address this conflict in information by either updating his risk information to reflect this risk or updating his living options discussion to reflect that there are no barriers to community placement (which appeared to be the case). • A review of assessments for Individual #123 indicated that he had many areas of risk that needed monitoring and supports including GERD, weight concerns, hypertension, hyperlipidemia, and challenging behaviors. His PSP did not offer a clear plan for staff to implement necessary supports and monitoring of these risks. • The PSP for Individual #202 included contradictory information regarding risk levels in several categories including choking, weight concerns, risk for injury, and osteoporosis. For example, the HST did not determine that she was at risk for injury, but the PNM assessment recommended the use of a walker and gait belt to prevent falls. Information should be consistent throughout the PSP. • Individual #304's PSP was written in such a way that it was difficult to determine what her health and behavioral risks were and what types of supports direct care staff needed to provide. Her nursing assessment summary stated that plans were to discontinue the HMPs as stated above (but it was not clear whether that meant all HMPs), including her HMP for aspiration, choking, and cardiac that were discussed above the statement. The OT/PT assessment section indicated that she was still at risk for aspiration and choking. Her outcomes included a plan to address cardiac concerns. • Individual #321's PSP was incomplete in regards to risk status, behavioral and health care concerns. SGSSLC and the DADS central office also recognized that they were not in compliance with this provision item of the Settlement.	

Recommendations:

1. Implement new statewide policies and procedures once they are disseminated to SGSSLC.

2. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

3. All staff should receive individual specific training on each safety and health care risk identified for the individuals they are assigned to support and implementation of plans should be routinely monitored.

4. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues, provide any needed supports, and determine when to seek medical support.

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:** <u>Documents Reviewed</u> ○ Policies, procedures, and/or other documents addressing the use of pretreatment sedation medication. ○ List of individuals who received pretreatment sedation medication for medical or dental procedures that included date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pretreatment sedation medication. ○ Any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication. ○ A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols. ○ A spreadsheet of individuals prescribed psychotropic/psychiatric medication, listing name of individual, residence/home diagnoses, and medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). ○ A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use. ○ A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use. ○ A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. ○ Facility-wide data regarding polypharmacy, including intra-class polypharmacy. ○ A list of individuals being monitored for tardive dyskinesia. ○ A list of individuals with tardive dyskinesia. ○ A separate list of individuals being prescribed: • Anti-epileptic medication being used as a psychotropic medication, Lithium, Tricyclic antidepressants, Trazodone, Beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Serentil ○ List of new admissions since 1/1/10, and whether a Reiss scale was used. ○ List of new admissions since 1/1/10 and whether a Reiss scale was used. ○ For five individuals most recently admitted, and for the seven other individuals • Their most recent psychiatric assessment; • Last three psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members; and • For the past year, Dates of all Psychiatric Treatment Reviews, Health Services Team notes, MOSES and DISCUS exams, Neurology consults (if any); and The most recent Medical, Pharmacy, and Nursing summaries.

	• Across these individuals, at least one individual from each psychiatrist's caseload. o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations. o Description of availability of genetic screening for individuals. o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects, such as AIMS, MOSES, and DISCUS. o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o Job description of psychiatrists. o A list of all psychiatrists, including board status, whether employed or contracted, and number of hours worked each week. o Example of contract with contracted psychiatrists. o CVs of all psychiatrists, including any special training such as forensics and disabilities o Overview of psychiatrists' weekly schedule. o Over the past 12 month, a list of continuing medical education activities attended by medical and psychiatry staff. o Academic affiliations with educational institutions. o For the past six months, minutes from the committee that addresses polypharmacy. o For the last 10 newly prescribed psychotropic medications: • Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication, • signed consent form, • PBSP, and • HRC documentation o Since 1/1/10, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). o Facility policy and procedure manual, and any related departmental manuals. o Since 1/1/10, any log, audits, or summary reports that the facility has generated with regard to the use of restraints. o For the past six months, a list, by individual, of all restraints that have been utilized, including the date, time, type of restraint applied, the reason for the restraint, and duration of restraint. Including (a) all emergency use of psychotropic medication on a PRN, STAT, or emergency basis, including the name of medication, dosage and route; and (b) all uses of medical/dental restraint. o A list of individuals with medical or dental desensitization plans in place, including the date on which the plan was developed. <u>Additional Documents Reviewed That Were Requested Onsite</u> o List of individuals on the psychiatric caseload who were age 16 or younger. o All psychology data presented, and other information provided, as well as doctor's progress notes from Dr. Bazzell's clinics dated 11/15/10 and 11/16/10, regarding the following individuals:

	• Individual #114, Individual #75, and Individual #304 o Names of all individuals who had TIVA in the last three months o Dental hygienist's list of individuals who may benefit from desensitization plans o Master monitor tracker for the past three months from nursing department regarding: Clozaril monitoring, MOSES, DISCUS, and psychiatric medication consent o Minutes of the monthly meeting between psychiatry and psychology o Minutes of the weekly meeting between nursing, medical staff, psychiatry, and the Assistant Director of Programs. o Minutes of the monthly meeting between psychiatry and Dual Diagnosis Services o Poly regarding "Information, flow and content to and from the neurologist" o Updated lab matrix o Caseload for psychiatrist and advance practice nurse. o Clinic schedule for psychiatrist and advance practice nurse. o List of all individuals evaluated per Appendix B. o If available, five examples of evaluations per Appendix B. o These documents: • Face sheet • Social History (most recent) • Consent for psychotropics. • Current PSP and addendums. • Functional Assessment Report • Behavioral Psychological Summary • BSP and BSP progress notes • Health data • HST section • X-ray section • Lab/EKG section • Psychiatry progress notes • MOSES/DISCUS section • Pharmacy Quarterly Drug Regimen Review • All consults • Physicians orders • Interdisciplinary Progress Notes • Nursing Annual Assessment and last Quarterly Assessment • Dental section o For the following individuals: Individual #76, Individual #96, Individual #302, Individual #75, Individual #243, Individual #346, Individual #385, Individual #105, Individual #193, Individual #325, Individual #292, Individual #148, Individual #294, Individual #251, Individual #163, Individual #99, Individual #142, Individual #252, Individual #120, Individual #298, and Individual #114. o Copy of doctor's order, nurses note and doctor's progress note for the last 10 individuals given

	emergency IM or PO medications for/by psychiatry. o Copies of five medical and five dental desensitization plans. o Five examples of informed consent performed by psychiatry. o Tracking/attendance for psychiatry in PSP, PSPA, and BSP meetings. o Data provided to psychiatry assistant by dental clinic (one month). o List of strategies utilized for individuals who refuse or no-show for dental clinic. o Cope of the most recent QA audit for psychiatry. o Copy of the presentation book for Section J <u>Individual Interviews and Meetings Held</u>: o William Bazzell, M.D., facility psychiatrist o Misty Mendez, psychiatry assistant o Lisa Busbee, RN, Nurse Operations Officer o Dental Clinic staff including: Thomas Anderson, D.D.S., Kim Woodward, R.D.A., and Belinda Lendermon, R.D.H. o Group meeting with facility medical staff and psychiatric staff o Pamela Tanner, A.P.R.N., advance practice nurse o Robb Weiss, Psy.D., Chief Psychologist with Bruce Weinheimer, Ph.D., BCBA, Coordinator of Psychological and Behavioral Services DADS o Don Conoly, R.Ph., Pharmacy Director o Rebecca McKown, MD, Medical Director <u>Observations Conducted</u>: o Observation of two psychiatry clinics with Dr. Bazzell for following individuals: • Individual #114, Individual #75, and Individual #304 o PST for Individual #327 o Observation of clinic with Nurse Tanner for the following individuals: • Individual #235, Individual #131, and Individual #302 o Behavior Support Committee o Polypharmacy Committee
	Facility Self-Assessment: The facility's self-assessment, its POI, for section J indicated substantial compliance in subsections of three areas, J1 (having qualified psychiatric physicians), J2 (diagnosis by a qualified physician prior to treatment with psychotropic medication), and J6 (psychiatric assessment as described in Appendix B). The facility reported substantial compliance in two subsections of J1, specifically having qualified psychiatric treatment providers and that these providers participate in the interdisciplinary process. The facility reported compliance in one subsection of J2, specifically the presence of the policy and procedure regarding psychiatric services. They reported compliance in one subsection of J6, again, the presence of policy and procedure regarding psychiatric services. The facility did not find themselves in full compliance

	with any of the areas indicated under section J. As will follow in the report below, the monitoring team's review of this provision was congruent with the facility's self-assessment. The monitoring team's review was based upon observation, interview, and review of sample of documents. The facility will need to do the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, SGSSLC was found to be in noncompliance with all but one of the items in this provision of the Settlement Agreement. The facility did have a physician and a physician extender (advance practice nurse) providing care, however, they were overwhelmed with the current clinical and administrative responsibilities. A recently recruited lead psychiatrist was reportedly joining the psychiatric team in December 2010, much to the relief of the current practitioners. The current psychiatric practitioners had integrated themselves well with the primary care physicians. The physicians reported frequent informal reviews of the cases of individuals who were experiencing behavioral challenges or medication side effects that did not rise to the level of requiring inpatient or infirmary care. This was the area where integration was most developed. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., informed consent and risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of a lack of clinical resources in psychiatry, which did not lend itself to close collaboration. What was most striking during the review, was that staff overall were caring and invested in the treatment of the individuals and had the desire to see the individuals benefit from treatment. It was, however, impossible to determine this investment via document review because, in many records, there were no psychiatric records to review. The psychiatric providers were overwhelmed with the amount of delinquent dictation and documentation. As some of these dictations were months in arrears, it was suggested that as providers would likely not be able to accurately recall the details of so many past clinical encounters, that the providers dictate one note covering care over a period of time and "start fresh." This, while not optimal, is better than the current lack of documentation. It is hoped that the new lead psychiatrist can infuse the department with the vigor and tenacity they will need to complete their documentation requirements, integrate themselves with the other team members, and collaborate fully with psychology in the treatment of the individuals assigned to their caseload. Even with the noted deficits, there were some "bright spots" that were specific to individual employees. The current psychiatric assistant was doing an excellent job with regard to organizing and tabulating data.

	She does need some direction in this manner, but she was energetic and enthusiastic.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	SGSSLC had a total of two FTE (full time equivalent) psychiatric practitioners. One of these was a board eligible adult psychiatrist, the other an advance practice nurse (physician extender). The advance practice nurse was receiving weekly supervision via the psychiatrist. As such, the physicians were qualified. There was, however, one difficulty in that there were four individuals at the facility age 16 or younger prescribed psychotropic medication. The facility psychiatrist was clear that he did not feel comfortable treating these individuals. The facility will need to provide child psychiatry services in a manner that meets the requirement of this provision item, that is, by persons who are qualified. The facility can determine how to accomplish this, whether it be by contract, consultation, consultative supervision of current psychiatry staff, or other method. Of the two providers, the psychiatrist had been providing services onsite for almost one year. The advance practice nurse had been providing services onsite for approximately 15 months. Both were frustrated by the workload and having difficulty meeting clinical requirements. Both were relieved by the possibility of a new lead psychiatrist scheduled to begin work at the facility 12/13/10. Practicing psychiatry in a supports and services center is different than clinical practices in other settings. It may be helpful to provide the newer physicians with some mentoring from other physicians who are more experienced in the supports and services living center model. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff. Although the psychiatrists practicing at the facility were either board eligible, or being supervised by a board eligible clinician, the report that follows will indicate areas of concern with regard to their practice at the facility. It was recognized that many of the challenges to providing care in the facility were out of the physician's control. For example, the lack of clinical resources, the lack of appropriate data the physicians were provided, and the lack of their integration into the overall facility treatment program. It was apparent that there were other difficulties with the physician's practice as well (e.g., documentation issues) that were directly within physician control. Improvements necessary in the quality of services provided will be reviewed over the course of subsequent monitoring visits.	Noncompliance
J2	Commencing within six months of	The advance practice nurse had reportedly begun comprehensive psychiatric	Noncompliance

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	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.	assessments per Appendix B (only one had been completed at the time of this onsite review), however, documentation of this encounter was not available during the current review. While all individuals prescribed psychotropic medication had diagnoses documented somewhere in the medical chart (in the medical notes, psychology notes, in the PSP), there was overall a lack of psychiatric documentation that made a determination of the evaluation and diagnosis requirements challenging. It is hoped that as the facility had recently recruited a new full time lead psychiatrist that the increased clinical consultation time will allow for improvements in overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring and/or the implementation of a peer review process for psychiatric documentation. For further discussion regarding diagnostic practices, see the discussion below in sections J6 and J10.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Per this provision, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In all records reviewed, individuals prescribed medication did have a PBSP on file. It will be important for collaboration to occur between psychology and psychiatry in the case formulation, the joint determination of target symptoms, and the descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. Further discussion regarding the quality and utility of the PBSP is the subject of provisions relating to psychological services, discussed in section K of this report. As indicated in section K, overall, the PBSPs did not meet the generally accepted professional standard of care. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a comprehensive treatment program. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses, the indications for psychotropic medications prescribed to address the diagnoses, and documentation of the clinical review of psychotropic medications by the psychiatric staff. For further discussion regarding this issue, please see the discussions below in sections J8 and J13. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. There were concerns regarding the lack of documentation of treatment integration between psychiatry and psychology and the need for improved treatment team functioning. Review of the list of emergency psychotropic medications utilized at the facility since 4/1/10 revealed that there were 120 instances of the use of intramuscular or oral medication for the indication of chemical restraint. Unfortunately, review of the individual's record did not reveal documentation of the strategies	Noncompliance

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		employed in an effort to avoid additional/emergency medication, nor did they reveal a psychiatric progress note regarding the additional medication, nor was the use of additional medications reviewed in the psychology data. As there were no specific behavioral-pharmacological hypotheses regarding the individual's treatment located in the 20 records available for off site review, the monitoring team could not determine the justification for the psychotropic medications that were prescribed. In addition to the absence of hypotheses, there was a paucity of records regarding psychiatric treatment in general. As a result, it was difficulty to determine the basis for a specific diagnosis or a specific treatment. This specific provision item requires the presence of both a diagnosis and a specific behavioral-pharmacological hypothesis. It was difficult to determine either given the lack of documentation. It will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and, in the process, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. It is also imperative that this information is documented in the individual's record in a timely manner. The paucity of psychiatric documentation in the records was a limiting factor in the overall monitoring and document review for this monitoring report.	
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.	As part of the document request, any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication was requested. In response to this request, information regarding the use of restraints for medical or dental clinic at the facility was provided. A review of these data revealed that since 1/1/10, there were 131 incidents of restraint for medical/dental procedures. This number of restraint episodes occurred for a total of 51 individuals, with 26 of the restraint episodes documented as occurring during dental clinic. Also, information regarding TIVA was requested. Per this documentation, since 9/15/10, there were three TIVA clinics at the facility. During these three clinics, 10 individuals had received TIVA for dental clinic. All but one of these incidents was included in the overall restraint data noted in the previous paragraph. Interestingly, a review of the listing of all individuals requiring restraints of any type for either medical or dental clinic revealed that of the 51 individuals, 86% were also receiving psychotropic medication management. A request to review medical and dental desensitization plans revealed that the facility	Noncompliance

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		currently did not employ medical desensitization plans. Per an interview with the facility Dental Director, and the dental clinic staff, the dental hygienist had developed a list of individuals whom the dental clinic was proposing as being in need of a desensitization plan. Dental staff reported that, while some dental desensitization plans had been authored, they were not being implemented because, "we were told that psychology can't implement the plan without the functional assessment report addendum." This was frustrating to dental clinic staff as they were aware of which individuals were in need of the desensitization plan based on their need for TIVA, pretreatment sedation, or refusal to participate in clinic. Dental staff reported that they had participated in collaborative meetings with psychology in the creation of some desensitization plans for the individuals, but there had not been implementation or follow through. With regard to the inclusion of the treating psychiatrist in the informational loop regarding pretreatment sedation for dental clinic, it was suggested that this information be provided to the psychiatrist (e.g. the individual's scheduled for TIVA on a particular date) so that the psychiatrist will be aware of the plan and can review the psychotropic medication regimen for any potential contraindications. Other individuals were receiving pretreatment sedation for clinic (e.g., Ativan) and this information would be useful to the psychiatric practitioners as well, given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. As medications utilized for pretreatment sedation could result in unwanted challenging behaviors or sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen, and as 86% of the individuals requiring pretreatment sedation were also treated with psychotropic medications, communication regarding the utilization of pretreatment sedation must be improved.	
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.	At the time of this onsite review, there was one psychiatric physician providing 40 hours of service per week. He was onsite five days per week and took all on call responsibility for the facility. This physician was board eligible in adult psychiatry. The second clinical practitioner was an advanced practice nurse who provided services approximately 40 hours per week under the supervision of the facility psychiatric physician as a physician extender. Both of these practitioners were open and honest regarding the limited resources in psychiatry and their delinquency in specific areas, most notably in the area documentation. The staff reported that, prior to 10/1/10, there was a lead psychiatrist working at the facility, but his replacement was not scheduled to start at the facility until 12/13/10.	Noncompliance

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		At the time of this monitoring review, there were 196 individuals prescribed psychotropic medication. With this volume of individuals, it was uncertain what the optimal number of FTEs would be for this facility. Similar to Mexia SSLC and Lufkin SSLC, psychotropic medications were being reviewed by psychiatry at SGSSLC a minimum of quarterly, as opposed to monthly. Individuals were reportedly seen more frequently, however, if they had adjustments to their medication regimen or were experiencing increased psychiatric symptoms or behavioral challenges. Documentation of these clinical contacts, however, were practically nonexistent, often consisting of one line in the integrated progress notes with dictation of the full progress note indicated as pending. Therefore, it would be useful to develop workload indicators to determine optimal staffing, taking into account not only clinical responsibility, but also documentation and required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency PSP, supervision of physician extenders). To reiterate, there were 196 individuals being followed by psychiatry. As medication reviews were being performed quarterly, this equated to 32.6 hours of consultation time per month, assuming that the consultation can be performed in two hours. The reason for this amount in allowable time was the fact that, rather than being reviewed monthly, the facility was performing reviews quarterly. This also equated to 16.3 annual psychiatric evaluations per month. Allowing for three hours per re-evaluation, this equals 48.9 hours of clinical consultation time per month, assuming that the re-evaluation can be performed in three hours. Therefore, in the absence of the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and/or any other clinical activity, 81.5 physician hours are consumed by clinical consultation. This indicated that 19.4 hours of physician time per week (or 0.5 FTE) are required for this activity (allowing for a total of 4.2 weeks per month). Given these basic considerations, and the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology, a minimum of 3.0 FTE physicians appears to be necessary at this facility. The monitoring team can be available to further discuss the determination of optimal FTEs if the state would like.	
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,	A review of the facility's current policy and procedure manual did not reveal a policy and procedure regarding the provision of psychiatric care. In response to a document request for all policies, protocols, procedures and guidelines that relate to the role of psychiatrist at the facility, it was reported that there were "no local policies." As such, it appeared that the overarching DADS policy regarding Psychiatric Services dated 7/20/10 would outline psychiatric services at the facility.	Noncompliance

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	and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The facility psychiatric assistant reported that the psychiatric practitioners had performed one comprehensive assessment according to the requirements and outline of Appendix B. Documentation of this evaluation was requested, however, per the psychiatric assistant, the evaluation had not yet been transcribed. As such, during future monitoring visits, a review of completed assessments will be performed. During the review, three psychiatric clinics were observed (for additional information regarding this please see the discussion regarding J8). In all three instances, the physician or advance practice nurse along with the assigned psychologist, nurse case manager, direct care staff, and QMRP met with the individual for psychiatry clinic. Appropriate clinical observation/discussion, lasting anywhere from 20 to 40 minutes, was held with the team and the individual. It was obvious from the interaction that the individual was a participant in the clinic. In all three clinic observations, the physician or advanced practice nurse appeared to be familiar with the individual's history, and had the medical record open, reviewing documents from the record during clinic. In all three observations, other staff, including the nursing case manager, QMRP, psychology, and direct care staff were in attendance. In all three observations, the psychiatric practitioner led the discussion and interacted with other team members, but primarily with the individual. While data were provided to the psychiatric practitioner, the assigned psychologist was not noted to participate other than providing data. One issue observed in one of the three clinics, was the overall level of inattention and disrespect for both the psychiatric interaction and for the individual. In one 15-minute span, when Individual #75 was tearfully discussing her significant other's recent surgery and her concerns regarding his physical health, various staff cell phones rang eight separate times. In four instances, the staff member remained seated in the room, conversing on the telephone. While it was understandable that staff must be accessible, the use of vibration or silent settings, text messaging, or if necessary, stepping out of the room to hold a side conversation is preferable. Following the multitude of interruptions, the individual was discussing her work situation and stated, "I feel like I am nothing…everybody treats me like I am nothing." It was interesting that this statement followed the multiple interruptions of her clinical experience. Another issue observed during psychiatric clinic with Individual #75 was the physician attempting to discuss diagnostic challenges with other treatment team staff. The physician stated that he questioned the individual's documented diagnosis. It was discussed that this, or similar cases, would be good starting points for the comprehensive psychiatric evaluation per Appendix B, and that an integrated case formulation could be	

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		developed during that process inclusive of psychological testing. Other issues, observed during the clinical encounter with Individual #114, were illustrative of the lack of integration between the various team disciplines. This individual had been receiving enhanced supervision (one-to-one) as a result of suicidal ideation and threats. Even with this status, she had been allowed to go leave the facility for an unsupervised home pass. Per the team, "yes…she was on a 1:1…but she went home to her family…they would watch her." It was apparent from this discussion that the team members were not considering safety issues thoroughly enough in the clinical decision making process. While some staff members approved of the home pass, others were obviously more concerned regarding the lack of supervision. It was understandable that treatment team interactions at the facility were flat, in that there was no hierarchy of personnel with respect to input or decision-making. There needs to be one specified team member who is empowered to act as a parliamentarian, ensuring that conversations occur one at a time, that all input is heard and respected, and that the schedule is determined and followed. Otherwise, clinical interactions are hampered and time is wasted.	
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.	The Reiss screen is an instrument that was developed to identify individuals who may need a psychiatric evaluation. Per the documentation provided by the facility in response to a request for a list of all new admissions since 1/1/10 and an indication of whether a Reiss screen had been performed, there had been a total of 17 admissions since 1/1/10. Of these 17, only one was documented as having undergone a Reiss Screen. Unfortunately, the documentation did not include why the screen was not performed for the other 16. In an effort to assist in the data reporting, it was suggested that if a screen is not performed, that the documentation provided to the monitoring team include the reason why it was not done. When comparing the list of individuals for whom a Reiss screen was not completed to the list of individuals prescribed medication at the facility, there were 13 individuals currently prescribed medication. Whether this medication was prescribed at the time of admission, thus requiring an admission psychiatric evaluation as a matter of policy, or was prescribed at some time following admission, is not known. There were, however, four individuals not current prescribed medication, of which only one received a screen. Again, whether these individuals entered the facility prescribed medication, received an initial psychiatric evaluation as a matter of policy on admission, and then the medication was discontinued over the course of their stay in the facility was not known. Given the need for additional information in order to determine compliance with this	Noncompliance

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		provision, this provision will remain in noncompliance. Additional information regarding this provision will be requested during future monitoring reviews.	
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.	The facility did not have a system to integrate pharmacological treatment with behavioral and other interventions. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings. There were also opportunities for interaction during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review and were a base upon which to build integration. One area of integration that required attention was regarding the use of data. Both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the choice of individual target behaviors. It was also notable that, while there were graphs of data presented to the physician, these did not include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Also see section K of this report. An interview with the newly hired Chief Psychologist revealed his agreement with "the need to communicate and educate psychiatry regarding what psychology can do…to establish a relationship with them…and integrate the departments…and collaborate...then it should all be data based decision making." Medication decisions made during clinic observations conducted during this onsite monitoring review were based on lengthy (minimum 20 minute) observations/interactions with the individuals as well as the review of information provided during the time of the clinic. In all three of the clinic observations performed during this onsite review, the psychiatrist or advance practice nurse met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the prescription regimen During the clinic meeting (including psychology, social work, direct care staff, nursing, and the individual) the team spent a significant amount of time discussing the individual's treatment regimen. A review of the available psychological and psychiatric documentation for 21 individual records, however, did not reveal case formulations that tied together the information regarding a particular individual's case. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no	Noncompliance

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		documentation located regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. Again, what was challenging was the general lack of psychiatric documentation, without which it was difficult to determine the overall integration of treatment and the adequacy of the 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, 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.	Per interviews of psychiatrists and psychology staff, psychiatry was not currently involved in the PBSP process to the degree that would satisfy the intent of this provision item. It is the generally accepted professional standard of care that the individual's psychiatric physician participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan with regard to target behaviors for monitoring, symptom monitoring, and the behavioral-pharmacological hypothesis for the individual's clinical presentation. The physician may also be a valuable resource for development of novel approaches for behavioral intervention for specific individuals. This would allow for collaboration with regard to the identification and definition of target symptoms for monitoring. It may also serve to decrease the reliance on psychotropic medication. A review of the PBSP documentation provided in the records of 21 individuals available for offsite review, revealed some documentation of psychiatric participation in the formulation of the BSP. This participation, however, was physician specific. This was concerning, because participation of the individual's actual treating psychiatrist is the generally accepted professional standard of care. This would allow for collaboration with regard to the identification and definition of target symptoms for monitoring. It may also serve to decrease the reliance on psychotropic medication. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications. This was evident in psychiatric documentation for Individual #190. In the most recent 90-day psychiatric progress note authored regarding this individual, dated 6/16/10, "he has a diagnosis of chronic paranoid schizophrenia…with session refusal as a target symptoms…mild mental retardation. We have discussed the need for a more appropriate target symptoms since he is not aggressive, but his team has not come up with one yet and will keep working on it." This same verbiage was documented in progress notes regarding this individual dated 12/30/09, 9/16/09, and 6/17/09. Throughout that period of time, the target symptom for monitoring remained session refusal. This	Noncompliance

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		individual was being treated with psychotropic medication including Clozapine and Sertraline. There was documentation that this individual had been experiencing other difficulties including sedation, possible lack of interest in activities, and psychosis, however, these behaviors (or their observable symptoms) were not being tracked. In 20 of the above records reviewed, psychotropic medication was being prescribed. It was difficult from the data reported to discern the benefits of the medication with regard to the target symptoms identified for monitoring. In some BSPs, where medication was a treatment modality, a document entitled "Variables Attachment to Behavior Intervention Program" was included. This document consisted of a list of dates of alterations to the individual's medication regimen and a brief statement regarding an individual's behavior following a medication alteration. It was essentially a timeline of psychiatric consultation, contact, and medication adjustments. This document could be useful for a quick review of the individual's facility treatment history. It also appeared that this document may have been utilized in the past in conjunction with, or in place of, symptom/target behavior graphing. The psychology staff had begun to utilize graphs for the reporting of data trends over time. For psychiatry, these graphs would be most useful if they included specific time markers (e.g. , start dates of medication, stop dates of medication, dosage adjustments, specific life stressors that may affect behavior) and if they included data up to the date of the psychiatric review. This was only one of numerous areas where psychiatry and psychology will need to develop methods to share information and collaborate regarding the treatment of the individuals at the facility.	
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	A review of the records of 21 individuals at the facility who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. Again, as stated in several other areas of this report, the paucity of psychiatric documentation made the review challenging. There were brief comments regarding the risk/benefit analysis for treatment with psychotropic medications included in the positive behavioral support plans, however, these did not satisfy the requirements of this provision item. As expected, they were incomplete with regard to the inclusion of specific risks, and did not generally include other alternative treatment strategies (other than the BSP where the documentation was included.) What was curious was that the risk/benefit/alternatives to medication were being authored and presented to the individuals or their legally authorized representative by psychology staff. This was akin to the issue discussed above, where psychology staff,	Noncompliance

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	the medications.	psychiatric assistants, or social work staff were, in most cases, responsible for completing forms documenting consent to treatment with psychotropic medication (more recently, psychiatric practitioners have reportedly begun instituting either a conversation with individual or a telephone call to their legally authorized representative regarding medication consent). The above illustrated the need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. As discussed with facility staff during the monitoring review, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician review said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Per interviews with facility staff, the facility level review of psychotropic medication regimens that met the criteria for polypharmacy was just beginning. The facility did not currently have a clinical pharmacist on staff. As such, the psychiatric assistant had assumed the responsibility for gathering data regarding polypharmacy and scheduling the meetings of the polypharmacy committee. There were committee minutes submitted for review as part of the document request. These were rudimentary and did not include review of the individual's regimen or document the justification for said regimen. The first meeting where review of an individual's regimen and discussion of the rationale for polypharmacy was held during the monitoring review. The plan, per the psychiatry assistant, was to review 10 regimens per week, and document the rationale for polypharmacy following the meeting/discussion. While the meeting was well attended and included representatives from pharmacy, nursing, psychiatry, and medicine, the discussions regarding the rationale for a particular medication were minimal and lacked substance. There were some acceptable written justifications presented, however, as stated below, these will need to be formally approved and included in the individual's medical record. Regardless, a more robust discussion regarding the rationale for the utilization of a particular regimen was	Noncompliance

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		necessary, as for example during the meeting observed by the monitoring team, attempts to initiate discussion regarding a particular regimen were met with either silence or the statement, "read the paper...it is self explanatory." It was impossible to determine the justification for polypharmacy in the 21 records available for offsite review due to the paucity of clinical documentation by psychiatric practitioners. There were some psychiatric progress notes that were submitted attached to a document request regarding "progress notes documenting the rationale for a particular medication." These notes were generally acceptable with regard to a description of a rationale. Similar documentation, however, was not located in the records available for offsite review. Polypharmacy data provided by the facility for the months of October 2010 and November 2010 revealed that in November 2010, there were: • nine individuals prescribed two medications in the same class, • 21 individuals prescribed three medications, • 10 individuals prescribed four medications, and • one individual prescribed five medications. A review of the spreadsheet of individuals prescribed psychotropic medications submitted in response to the document request revealed that, as of the time of this monitoring review, there were actually nine individuals prescribed five or more medications. The reason for the discrepancy between the monitoring team's count of polypharmacy and the facility data was considered. It was apparent that the facility was not including seizure medication (which has a contribution to the psychiatric drug regimen and side effect profile) in the overall polypharmacy determination. For example: • Individual #76 was noted in the facility data as meeting criteria for polypharmacy due to the prescription of three medications, Clozapine, Lithium and Quetiapine. He was, however, also prescribed Zonisamine for seizures, which also has mood stabilizing qualities. As such, this individual should be noted as receiving four medications. • Individual #385 was noted in the facility data as meeting criteria for polypharmacy due to the prescription of four medications: Clonazepan, Propranolol, Quetiapine and Sertraline. Review of her medication regimen revealed that this individual was also prescribed Lamotrigine and Valproic acid for seizures, both of which have mood stabilizing properties. As such, she was currently receiving six medications. It was not noted in the facility data if medications were prescribed by psychiatry or	

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		neurology. It would be helpful to delineate this in future polypharmacy reports. If medications were prescribed by psychiatry, then they must be counted toward polypharmacy. Other medications prescribed by other practitioners (neurology, primary care) should be reviewed by the psychiatrist in a clinical context. It is hoped that the recently hired clinical pharmacist (expected to start 11/29/10) will be able to address the further development of the facility level review for polypharmacy. Given the interviews and document review noted above, the facility was in the early stages of development with regard to a facility level review to monitor polypharmacy. In order to meet the requirements of this provision of the Settlement Agreement, the facility level review will need to occur monthly, and include a review of the medication regimen for individuals determined to meet criteria for polypharmacy, so that clinical justification for each regimen can be determined and documented in the individual record. A review of the records of 21 individuals prescribed psychotropic medication revealed that in each record, there was a quarterly medication review document authored by the facility pharmacist. The current pharmacist reported that while he was not a clinical pharmacist, he had been making attempts at authoring the documents. As would be expected, there was room for improvement with regard to the usefulness/clinical utility of the information provided. Again, it is opined that the recently hired clinical pharmacist would be able to further develop this process at the facility. The acknowledgement of the pharmacy quarterly drug regimen review by the prescribing psychiatrist was documented greater than 90% of the time (as per the prescriber's signature on the document). As stated above, however, it was difficult to discern how the information was integrated into the clinical decisions making process for a particular individual, as there was a general paucity of psychiatric documentation. From a review of the discussion above, it was apparent that the determination of polypharmacy via the review committee, pharmacy, and the physicians must be instituted. Also, ultimately there must be justification for polypharmacy (i.e., the rationale for the current regimen) included in the individual's record.	
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 review of a sample of 21 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) were being performed by the Nurse Case Manager. The facility had a tracking system for documentation of completion of these items. Interviews with nursing administration at the facility revealed difficulties in determining who was scheduled for a particular examination at a particular time. It was suggested that the facility could consider a semi-annual schedule for MOSES examinations (i.e., January and June) and a quarterly schedule for DISCUS examinations, so that case managers would know to	Noncompliance

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	the individual's current status and/or changing needs, but at least quarterly.	perform an examination for everyone on their caseload who required examination during that period While the vast majority of MOSES and DISCUS documentation in the 21 records reviewed revealed signature of the prescriber, only in approximately 20% of the signed examples available for review had the prescriber completed the attached box indicating what his or her opinion was as to the reported results. As stated in the discussions for other areas in section J, the paucity of psychiatric documentation made it difficult to determine how the data were utilized or incorporated into the clinical decision making process for a particular individual. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than	At the time of the onsite monitoring review, the facility psychiatrists were reportedly participating in minimal PSP activities. In response to an onsite document request, to provide tracking of the psychiatric practitioners participation in PSP, PSPA and BSP meetings, a sign in sheet and meeting documentation was provided for one individual, Individual #16. A review of the 21 records available offsite revealed four examples of signatures of psychiatric practitioners in the PSP, PSPA or BSP documentation (Individual #294, Individual #120, Individual #142, and Individual #243). Per interviews with the facility psychiatrist, "I go to some of them…if they call and tell me when they are having it…either the Q [indicating the QMRP] or the psychologist from the home would call." Interview of psychiatric support staff revealed that the physician and the advance practice nurse were not able to attend the meetings, because "of time…I am monitoring and trying to encourage them to go to the PSP meetings." Further interviews with the psychiatric practitioners revealed that time was a scarce commodity, "I would like to go to the PSPs and have been to a few…but I don't know how we could go to all…maybe if they would discuss the medical and psychiatric up front…then it wouldn't be a waste of resources…it is hard to stay and discuss things like preferences or what kind of clothes the person wants to wear." There was not a separate treatment planning document regarding psychotropic medications. Instead, this was done via the quarterly medication reviews, according to staff interviews. Unfortunately, recent examples of psychiatric documentation were scarce in the records available for offsite review. Per discussions with both the	Noncompliance

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	quarterly.	psychiatric prescribers and psychiatric support staff, the documentation of quarterly medication reviews was very delinquent. There were references to psychotropic medications in some of the PSP documents reviewed. This review included documents that were authored via the revised PSP process implemented at the facility in September 2010. Of the 21 records available for offsite review, nine were also noted to have had the PSP performed via the revised system. Of those nine, documentation of the plan was noted in the record of seven individuals (Individual #75, Individual #294, Individual #251, Individual #120, Individual #163, Individual #252, Individual #298). Even with the new system in place, documentation regarding psychiatry and mental health was scarce, and limited to a record review. There were no signatures indicating the participation of psychiatry in any of the PSP documents reviewed. In review of the psychiatric documentation from the records of 21 individuals, the information contained in the quarterly psychotropic medication reviews regarding the case formulation, diagnostic impression, and psychiatric treatment planning varied from record to record. This monitoring review was additionally complicated by the lack of psychiatric documentation in the records available for offsite review: • The records of 10 individuals had no psychiatric documentation included • 11 had the most recent 90-day review documented in 2009, and • seven had documentation of 90- day reviews in 2010. Whether this lack of documentation was the result of a copy error or due to the reported delinquency of the dictation of physician encounters was unknown. There was reportedly one individual whose initial psychiatric evaluation had been completed according to the requirements of Appendix B, however, the transcription of this evaluation was not available at the time of the review. Given the paucity of psychiatric information available in the record, it was difficult to determine the departmental adequacy of case formulation and diagnosis. As a result, it was also impossible to determine the appropriateness of medication selection and target symptom identification. During the review, it was discussed with members of both the psychiatry and psychology staff that improved integration of their departments will be necessary in order to fulfill the requirements of this provision. Currently, both departments were unsure of how they can assist each other and what information/services they can obtain from the other. The facility had recently recruited a new Director of Psychology who was experienced and enthusiastic, and who may be able to bring cohesion to the two currently divergent	

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		departments. As additional resources are allotted to the psychiatric department at the facility and documentation improves, it is hoped that there will be: • 90-day reviews of psychotropic medication that include medication treatment plans • a justification for a diagnosis • a thoughtful planned approach to psychopharmacological interventions • the monitoring of specific target symptoms to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment.	
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.	In response to the monitoring team's document request regarding a listing of all facility-wide policy and procedures, the facility provided a listing of policies including one entitled "Informed Consent, Explanation, Education and Due Process." This policy was dated 5/10/02, however, there were noted updates in the psychoactive medication section, dated 4/13/07. Per this document, "basic elements of information necessary to informed consent, and ongoing counseling with the patient…must be provided by the treating physician or…designee." The policy further stated that the "home psychologist will submit the content [of the consent form] to the…social worker to obtain guardian approval." There was also a flow sheet attached, which designated the staff who would be appropriate participants in the explanation and education regarding psychotropic medications. Psychiatry was not indicated as having responsibility or required participation in this process. Review of similarly titled policy and procedure at other DADS facilities revealed the use of a reference to Texas Administrative Code Title 25, Part I, Chapter 414 Subchapter II as delineating procedures regarding consent to treatment with psychotropic medications. An internet search revealed that per this Code "the treating physician, registered nurse, licensed vocational nurse, physician's assistant, or registered pharmacist" is responsible for obtaining informed consent for treatment with psychotropic medications. The policy further stated, that if the information was not provided by the treating physician, the physician must "confirm the explanation with the patient and the patient's legally authorized representative, within two working days." Given this Administrative Code, it appeared that the current policy and procedure in effect at the facility did not conform to Administrative requirements.	Noncompliance

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		A review of 21 individual records (20 prescribed psychotropic medication) selected for offsite review revealed that in 16 records, there was documentation of informed consent (the records of Individual #325, Individual #298, and Individual #346 did not include informed consent documentation). None of the informed consent documentation in the 16 records included the signature of the psychiatrist or the advance practice nurse. Per interviews with facility staff, as well as review of facility medical records, psychology and/or social work staff were responsible for completing the consent form for medication and presenting same to the individual or his or her legally authorized representative for signature. Approximately two months prior to the facility review, psychiatric treatment providers (the facility psychiatrist and the advance practice nurse) instituted the practice of reviewing informed consent information with the individual, or the individual's guardian. The facility psychiatrist was reportedly performing the telephone call and having the discussion with the guardian, however, the documentation of the discussion via the completion of the consent form was being delegated to another staff member. The two full time psychotropic medication prescribers interviewed were aware of the need for them to actively perform the informed consent discussion with both individuals and their legally authorized representative. This was good to see and, as stated above, was a practice that had only recently been instituted, but documentation consisted of a brief progress note located in the integrated progress notes. Reportedly, information included on the actual consent form was still being entered by psychology in some cases. There was, however, evidence that the advance practice nurse was completing consent forms for individuals on her caseload. In response to an onsite document request for five examples of informed consent being performed by psychiatry: • Individual #96 – "add Adderall 5 mg in the am. Consent by telephone this am for mother." This was documented in the progress note dated 10/20/10 by the treating psychiatrist. • Individual #292 – "consent from mother today obtained for Risperdal. Mother refused to allow Abilify." This documented by the treating psychiatrist in the progress note dated 10/20/10. • Individual #313 – The consent form for this individual dated 10/12/10 was notably specific to the case presentation, "Klonopin has been prescribed…a benzodiazepine used to treat seizures and symptoms associated with anxiety…may also be used for purposes other than those listed here…has been receiving it for akathesia – a side effect of antipsychotics…this is getting resolved, but the medication needs to be continued for a short term basis to manage anxiety, agitation, and as augmentation of the Clozaril she is receiving."	

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		The description of the potential adverse or side effects regarding the medication was adequate. The consent included the telephone number of the prescriber for further questions. The form included the signature of the prescriber. • Individual #216 - The consent form for this individual, dated 7/2/10 was again specific to the case presentation, including justification for the use of the specific medication, Seroquel. Unfortunately, it did not provide a sufficient description of the potential adverse or side effects. Serious side effects including elevations in lipids, Tardive Dyskinesia, and Neuroleptic malignant syndrome were not included. The document was, however, signed by the prescriber. The informed consent process at the facility was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the individual's record. To delegate this responsibility to psychology staff, social work staff, or psychiatric assistants, who do not have prescriptive authority and would not be able to respond to specific questions an individual or legally authorized representative may have regarding the specific medication, was inappropriate. It was recognized that the psychiatric practitioners were making recent efforts to increase their participation in the informed consent process, however, this involvement must expand in order to satisfy the requirements of this provision item. In an effort to address the deficit in these informed consent practices, it was recommended that the facility consult with the state office, who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice. In a separate, but related issue, review of the medical records revealed information regarding the individual and his or her guardianship status documented on the client chart face sheet. Easy identification of an individual's guardianship status for the purposes of consent is necessary. Inclusion of this information in the demographic data located in the beginning of the psychiatric evaluations/progress notes may assist in this regard.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the	Per an interview with the facility lead psychiatrist, the coordination of treatment between neurology and psychiatry was occurring via the primary care physician. Individuals who required neurology consultation were referred to a neurologist in the community. In preparation for the clinical encounter, a primary care physician authored	Noncompliance

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	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.	a brief consultative information sheet for the individuals scheduled for neurology clinic on a particular day. Documentation regarding the outcome of the neurology consultation was dictated and returned to the facility for both primary care and psychiatric review. Per the interviews with both the facility psychiatrist, primary care physicians and advanced practice nurse, there ere opportunities for direct communication with the community neurologist should the need arise. Per the interview with the advance practice nurse, she indicated that she had visited the neurologist's office in order to meet him. In a few cases she has called his office with questions and "they always got back to me." In an effort to formalize this process, the facility has authored a draft policy and procedure regarding "Communication with Neurologist." This policy outlined how information will be transmitted to and from the community neurologist and detailed how notation of the review of documentation should be made. The policy detailed specific procedural requirements for psychiatric review of neurological consultation documentation. This policy was pending approval at the time of this onsite review. Of the 21 records regarding individuals receiving psychiatric treatment available for offsite review, eight were diagnosed with seizure disorders. Their records were reviewed and revealed documentation of neurology consultation within the calendar year. The reports authored by the neurologist mentioned psychiatric diagnoses and medications prescribed for psychiatric illness. A review of the list of medications prescribed to the individuals, as well as the indications for said medication, revealed that 196 individuals were prescribed psychotropic medication and that 77 of these individuals (39%) were also prescribed medication for seizure disorder. While this alone would indicate the need for clinical coordination and consultation, there were other neurological disorders diagnosed that would have been amenable to close clinical contact between neurology and psychiatry (e.g., headache, EPS, tremors, various syndromes). Per interviews and observation of medical staff, there were attempts at coordination of care occurring specifically between primary care and psychiatry. The physicians met together informally to review cases regarding individuals who were currently hospitalized, or who were experiencing difficulties or challenges. While these attempts at communication were laudable, the risk was for transmission of non-emergent information to be hindered by the indirect contact between psychiatry and neurology. A review of records chosen for review due to comorbid diagnoses of psychiatric illness and seizure disorder where seizure medications were reportedly being utilized for a dual	

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		purpose (e.g. seizure diagnosis and psychiatric diagnosis) revealed that review of neurology consultation documentation was not noted in the psychiatric progress notes. Various challenges that were likely attributable to the lack of sufficient neurological consultation and collaboration were noted. There were confounding difficulties, such as, in some cases, psychiatric progress notes were not included in the record copies. Whether this was a copy error, or the result of delinquent dictation and progress note authorship, was unknown. Interviews with psychiatric practitioners noted above revealed their admission of documentation delinquencies. For example: • Individual #163 was seen by the neurologist 1/8/10. At that time, the neurologist noted her treatment with medications, including Depakote ER and Lexapro. He noted concerns regarding her obesity, and indicated, "there are a number of other seizure medications that we could switch her to…several seizure medications that are also mood stabilizers…has had excellent seizure control on Depakote…reevaluate her in six months." Per the facility Integrated Progress Notes, a Valproic Acid level on 6/21/10 was sub therapeutic at 24.8 (50-100). This individual was next seen in neurology clinic 7/2/10. At that time, the "patient states that the Depakote makes her sleepy…she would like to go off of the medication." At that time, the neurologist recommended a reduction in the dosage of medication with a taper to discontinuation. No alternate seizure medication was recommended. Review of this individual's record revealed ongoing behavioral challenges with self-injurious behavior and physical aggression. Per the provided list of individuals and their prescribed medications, this individual was current prescribed Depakote and Remeron. Apparently, Lexapro was discontinued and Remeron added, but psychiatric documentation of this medication regimen adjustment was not located in the medical record. This was concerning because obesity had been a documented issue for this individual, and weight gain is a common side effect with the antidepressant medication Remeron. Documentation from the neurologist revealed the possibility of alternate antiepileptic medications that could be considered to address aggressive/impulsive behavior with less incidence of weight gain. A review of the behavioral data revealed that this individual continued to experience behavioral challenges. • Individual #302 was referred to neurology clinic 7/22/10 because he "has developed movement disorder with asterixis like movements of outstretched hands, staggering with tandem gait and positive Rhomberg." The individual was evaluated by neurology 8/20/10. Per this evaluation, "little evidence for a movement disorder…but it sounds as if he has a mild Neuroleptic drug induced movement disorder, which fluctuates in severity…obviously, the Neuroleptic drug therapy should be kept to the lowest possible dose…reevaluate…in six	

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		months." Review of the remainder of the record provided did not reveal psychiatric documentation of a review of this consultation, or plans to address the possibly medication induced movement symptoms. The most recent psychiatric progress note available for review in this record was dated 1/6/09. Unfortunately, the review of the documentation regarding this provision was hampered by the lack of psychiatric physician progress notes. This has been discussed throughout this section of the report and must be addressed. In an effort to better address the requirements of this provision, it would be beneficial to determine the amount of clinical neurology time needed via an examination of the number of individuals in need of neurology consultation (including those not prescribed concomitant psychotropic medication) and the recommended follow-up frequency. It was apparent that, in some cases, the burden for review of medications specifically prescribed for seizure disorder diagnoses fell upon the primary care physician. The facility may want to consider options for improving neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities.	

Recommendations:

1. Improve psychiatric documentation.

2. Integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in discussions regarding treatment planning and behavioral support planning.

3. Review those individuals requiring pretreatment sedation for medical and dental clinic and prepare/implement individualized desensitization plans for them.

4. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes.

5. Review with staff/treatment teams the safety issues surrounding individuals who require enhanced supervision in order to improve the decision making process with regard to their activities outside of the facility supervision.

6. Use silent settings for pagers and cell phones during clinical encounters with individuals. If a telephone conversation is necessary, step out of the room, in respect of the clinical interaction that is occurring.

7. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate. This must include a detailed case formulation and discussion that is collaborative with other team members. In addition, there should be a detailed psychopharmacological treatment plan. When diagnoses or medications are changed, there should documentation of what symptoms or criteria was met in order to justify an alteration of diagnosis. When a medication is added, or a dosage is changed, there should also be documentation regarding potential difficulties that may occur and symptoms that are being targeted with these changes.

8. Draft and implement policy and procedure governing psychiatric clinic at the facility to include requirements of the Settlement Agreement, Appendix B, and the overarching DADS policy.

9. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. These must include detailed case formulations and treatment plans for psychotropic medication.

10. If the Reiss screen is completed, document the outcome of the screen and the referrals made as a result. Also document the Reiss screen results for facility residents who are not currently a patient in psychiatry clinic.

11. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. This data must be presented in a manner that is useful to the physician (i.e., in graph form, with medication adjustments, identified antecedents, and specific stressors identified).

12. Formalization of the BSP process to review risk/benefit ratios for the prescription of psychotropic medications that are authored either by psychiatry or at a minimum in collaboration with psychiatry.

13. Formalize the facility level review of polypharmacy with the assistance of the newly recruited clinical Pharmacist.

14. Review the method of reporting polypharmacy data for accuracy and completeness.

15. Increase the frequency of the polypharmacy meeting to monthly.

16. Improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

17. Improve documentation of psychiatric review and clinical use of DISCUS and MOSES examination results.

18. Improve psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis.

19. Review the target behavioral data for each individual to determine if appropriate data points are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start dates of medication, stop dates of medication, and dosage adjustments) included.

20. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom

data points are being monitored.

21. Individualize the process for Informed Consent.

22. Develop a statewide Informed Consent Policy and Procedure that is consistent with Texas law and generally accepted practice of medicine.

23. Improve timeliness of psychiatric documentation.

24. Explore options to increase the availability of neurology consultation.

The following are offered as additional suggestions to the facility:

25. If the incoming lead psychiatrist is not trained in child/adolescent psychiatry or does not have experience in same, consider obtaining clinical consultation with a child and adolescent psychiatrist for those individuals who are under age 16. This could be performed via telemedicine consultation from another DADS facility where child and adolescent psychiatrists are available.

26. Consider structured scheduling of MOSES and DISCUS examinations (i.e. designate specific months for the performance of the examinations).

27. Consider monitoring the psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines.

28. Develop a recruitment/retention plan for psychiatry. The facility should consider the development of a "pearls of practice" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff.

29. Consider the utilization of scales and screeners normed for this population in an effort to obtain objective data regarding symptoms as well as to monitor symptom response to targeted interventions.

30. Consider the designation of a "parliamentarian" for psychiatric clinic to ensure that all participants' opinions are heard and respected.

31. Consider making the identification of the individual's legal status and the identify/contact information of their legally authorized representative (if any) part of the regular demographic information included in the psychiatric assessment and progress notes. This will make the informed consent process and the regular contact of families/legal representatives during treatment a simpler process.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans (PBSPs) for: • Individual #316, Individual #331, Individual #391, Individual #9, Individual #249, Individual #243, Individual #48, Individual #34, Individual #351, Individual #274, Individual #382, Individual #75, Individual #135, Individual #248, Individual #198, Individual #377, Individual #200, Individual #76, Individual #214, Individual #159, Individual #205, Individual #96, Individual #346, Individual #215, Individual #164, Individual #323, Individual #385, Individual #165, Individual #38, Individual #26, Individual #170, Individual #186, Individual #117, Individual #327 o Functional Assessments for: • Individual #316, Individual #331, Individual #391, Individual #9, Individual #249, Individual #243, Individual #48, Individual #34, Individual #351, Individual #198, Individual #96, Individual #346, Individual #215, Individual #164, Individual 323, Individual #385, Individual #165, Individual #261, Individual #382, Individual #38, Individual #26, Individual #205 o Behavioral/Psychological Summaries for: • Individual #215, Individual #382, Individual #38, Individual #261, Individual #96, Individual #26, Individual #205, Individual #341, Individual #330, Individual #316, Individual #331, Individual #391, Individual #9, Individual #249, Individual #243, Individual #48, Individual #34, Individual #351, Individual #341, Individual #330 o Six month reviews of Positive Behavior Support Plans (PBSPs) for: • Individual #215, Individual #382, Individual #38, Individual #96, Individual #26, Individual #261 o Personal Support Plan Addendum (PSPA) for: • Individual #316, Individual #331, Individual #391, Individual #9, Individual #249, Individual #243, Individual #348, Individual #34, Individual #351 o Structural and Functional Assessment Report- DADS Policy: 08, 11/30/09 o Behavior Support Plan Competency Assessment, dated January 2009 o Spreadsheet of individuals and most recent psychological assessments, undated <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., Director of Psychology o Amanda Rodriguez, MA, Associate Psychologist o Donald Johnson, Psychological Assistant o Cari Stallings, MS, Associate Psychologist o Michael Dennis, Psychological Assistant

	○ Psychology Department Staff ○ Colleen Glass, Token Store Manager <u>Observations Conducted</u>: ○ Psychiatry Clinic Rounds: • Staff attending: Dr. Bazzell, Psychiatrist; Karen Brest, RN; Camille Hewitt, MA, Psychologist; Vanessa Barrientes, QMRP; Amanda Rodriques, MA, Psychologist; Robb Weiss, Chief Psychologist • Individuals Presented: Individual #75 ○ Psychology Behavior Support Plan Committee Meeting • Staff Present: - Dr. Weiss, Director of Psychology; Alfonso Bermea, Associate Psychologist; Mandy Rodrigues, Associate Psychologist; Spencer Washington, Associate Psychologist; Angela Kirsler, Quality Enhancement Director; Lynn Zaruba, Associate Psychologist; Thomas Talbott, Associate Psychologist; Irma Rangel, Psychology Secretary; Patrick Durgin, Psychology Tech; Christina Thomas, Associate Psychologist • Individual Presented: - Individual #346, Individual #327, Individual #283, Individual #117 ○ Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans
	Facility Self-Assessment: SGSSLC's Plan of Improvement (POI) indicated noncompliance for each item of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI findings of noncompliance in all areas. The only exception was provision item K2 (qualified director of psychology) which the monitoring team determined was in substantial compliance with the Settlement Agreement. The POI established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will likely take some time for SGSSLC to make these changes, it may be useful for the facility to also establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

	Summary of Monitor's Assessment: Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was however, progress in several items. The monitoring team noted several positive developments at SGSSLC since the baseline review. These include: • Commitment of the department to become competent in Applied Behavior Analysis (ABA) as measured by the completion of one psychologist's coursework for board certified behavior analyst (BCBA) certification, enrollment of eight psychologists in BCBA coursework, and the obvious enthusiasm of the psychology department to learn more about the field of ABA (K1) • The addition of a qualified director of psychology (K2) • The establishment of the foundation of internal peer review (K3) • Improvements to the data collection system (K4) There were also areas that the monitoring team believes require immediate attention. Those areas include: • Enhance the accountability of the data collection system by requiring direct care professionals (DCPs) to mark every interval of the data card (K4) • Simplify the data system by reserving the collection of ABC data for assessment purposes only (K4) • Expand the data system by adding duration and time sampling measures (K4) • Incorporate the use of potent contingencies (e.g., positive reinforcement, differential reinforcement, response cost) into PBSPs to both increase desirable behaviors and decrease dangerous and undesirable behaviors (K9)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure	This provision item was rated as being in noncompliance because the psychologists at SGSSLC were not yet demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the lack of consistent quality of the positive behavior support plans (see K9). At the time of the onsite review, one of the facility's 12 psychologists responsible for writing PBSPs had been approved to sit for the board certified behavior analyst (BCBA) exam, and eight psychologists were enrolled in course work toward becoming BCBAs. Additionally, a consulting psychologist with expertise in ABA and certified as a BCBA was recently hired to assist in the development of PBSPs, and to provide supervision of psychologists enrolled in the BCBA program. SGSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. It is recommended that the facility develop a plan to ensure that the remaining	Noncompliance

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	reasonable safety, security, and freedom from undue use of restraint.	psychologists attain BCBA certification.	
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.	The facility has attained substantial compliance with this item. A director of psychology began on 10/1/10. Dr Weiss had a Psy.D., was licensed in several states and, at the time of the onsite review, was seeking licensure as a psychologist in the state of Texas. Additionally, Dr. Weiss's CV indicated that he had 15 years experience working with individuals with developmental disabilities. Based on observations of Dr. Weiss interacting with other departmental psychologists, and discussions of how to achieve compliance with this provision of the Settlement Agreement, the monitoring team believes that he possessed the experience, skills, and focus to be an effective director of psychology.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	SGSSLC's Behavior Support Plan Committee (BSPC) had the foundation for internal peer review, but requires some additional components and an external peer review component, to be rated as being in substantial compliance. During the BSPC meeting observed by the monitoring team, there was active discussion and several examples of staff sharing strategies and suggestions to improve positive behavior support plans (PBSPs). The BSPC meetings, however, primarily reviewed cases that required annual approval of PBSPs or safety plans, or contained modifications that required approval. Although reported to be presented on occasion, peer review should consistently include the opportunity to present cases that are not progressing as expected. Additionally, typically only those psychologists that were scheduled to present attended the meeting. It is recommended that peer review meetings be extended, from primarily annual reviews, to include any case that a psychologist (or his or her supervisor) believes would benefit from the input of other psychologists. Additionally, all psychologists should be encouraged to attend the meeting. This could be accomplished by adding a specific weekly peer review meeting, or expanding the BSPC meetings. At the time of the onsite review, the facility was planning to have the BCBA consultant attend BSPC/peer review meetings. The monitoring team agrees that this represents a good use of the consultant's time, and is an excellent way to improve the overall quality of the PBSPs. Because the consultant will help oversee and develop the facility's PBSPs, however, the monitoring team would not consider this to be external peer review. External peer review involves review by other professionals who are not directly responsible for the development and implementation of the PBSP, such as external peer review by other Texas DADS BCBAs and supervisors (perhaps by teleconference). It is	Noncompliance

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		recommended that the facility establish external peer review. The monitoring team remains available to DADS to further discuss ways to set up an external peer review system. Operating procedures for both internal and external peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The data collection methodology used at SGSSLC did not conform to ABA generally accepted professional standards and, therefore, this provision item has been rated as being in noncompliance. During the onsite review, the facility continued the use of the Habscan cards. As discussed in the baseline review, these cards have the advantage of being scanned and used to produce graphs of recorded data. Since the baseline review, the facility had improved its data collection by shortening the data collection interval with the Habscan cards, and extending data collection across all three shifts. Data, however, were not required to be recorded in each interval. The monitoring team recommends that direct care professionals (DCPs) be required to record a zero in each recording interval if neither target or replacement behaviors occur. This would ensure that the absence of target or replacement behaviors in any given interval did not occur because staff forgot to record data. For example, the monitoring team found that a note in Individual #243's individual record indicated that she engaged in physical aggression on 11/17/10. Her Habscan card, however, did not contain any instances of physical aggression on 11/17/10. The requirement of a recording (i.e., either indicating the frequency of the target or replacement behavior, or a zero indicating that the target or replacement behavior did not occur) in each interval of the Habscan card would allow the psychologist to review cards and determine if DCPs are recording data at the intervals specified. Another improvement in the data system since the baseline review was the introduction of individual data books (that included each individual's PBSP and data sheets) that followed each individual throughout the day. The advantage of this system for data collection is that it should improve the reliability of data collection by allowing DCPs to record data immediately after it occurs, rather than waiting to return to the location of the data sheets before recording individual data and potentially forgetting the details of the behavior that occurred. The monitoring team found, however that the data books did not consistently follow the individuals that were out of the home for recreational activities. Therefore, if target or replacement behaviors occurred during these activities, DCPs would need to wait until they returned to the home to record data. It is recommended that the individual data books follow individuals throughout the day, and that data are recorded as soon as possible after it occurs (also see section V below on	Noncompliance

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		Recordkeeping practices). As discussed in the baseline review, in order to achieve compliance with this item of the Settlement Agreement, the data system at SGSSLC needs to be more flexible. An adequate data system needs to be sensitive to each individual's needs. That is, it needs to be able to accurately collect behaviors that occur at low rates, but may reflect high intensity behaviors (e.g., eloping from the facility, severe physical aggression), as well as behaviors that occur at very high rates (e.g., stereotypies, undesirable verbal behavior, noncompliance). Often very high frequency data require the use of a different system of data collection, such as time sampling or a duration system, in addition to the frequency measures that were present at the time of the onsite review. It is recommended that the facility expand its data system to include duration and time sampling measures of target and replacement. Additionally, the data system would benefit from simplifying the collection of frequency data. In addition to the use of the Habscan cards to collect frequency, DCPs were required to record antecedents, the target behavior, and the consequences (also known as an unstructured ABC data system) for each target behavior that occurred. It is suggested that the facility consider a simpler alternative to the ABC system for routine frequency recording. The ABC system is typically used, and is well suited, for direct descriptive assessments to better understand the antecedents and functions of target behaviors (see K5). Its routine use as a frequency measure, however, can result in poor data collection integrity and confusion from DCPs. The most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex (e.g., ABC systems) for some DCPs to collect data reliably. Under those conditions, the data system may need to be modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the onsite review of SGSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. Another improvement to the data system since the baseline review is the addition of the of replacement behaviors to each individuals Habscan card. The monitoring team, however, could not find examples of the collection of replacement behaviors. Reports from staff indicated that these data were not being consistently recorded at the time of the onsite review. It is recommended that DCPs consistently collect replacement behavior for each individual with a PBSP.	

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		None of the DCPs interviewed indicated that they had input in the establishment of data collection systems. It is recommended that DCP input in data system development be sought and documented. Finally, while target behaviors were consistently graphed at SGSSLC, replacement behaviors were not consistently graphed. For example none of the PBSP graphs reviewed contained replacement data. It is recommended that all replacement behaviors be graphed. Additionally, all PBSP target behaviors were graphed in monthly increments. That is, each datum point represented one month of data. Some target and replacement behaviors, however, need to be graphed more frequently to ensure sufficient data-based decision-making. For example, the monitoring team observed a psychiatry clinic in which Individual #75 was being discussed because of a dramatic increase in physical aggression (requiring the use of three restraints) in the 30 days previous to the psychiatry meeting. Because the target behaviors were graphed in monthly increments, the psychiatrist could not use the psychologist's data to make data-based decisions. If the psychologist had graphed Individual #75' data daily during this period, indicating the presence of potentially important environment changes, the psychiatrist (and the entire treatment team) would likely have been better able to understand this increase in physical aggression and, therefore, better determine if a change in her PBSP, medication, or some other modification was warranted. Although the monitoring team was told that PBSPs were modified based on the absence of progress or increase in undesirable behavior, the only modifications in PBSPs reviewed were at the annual reviews. The majority of PBSP data reviewed however indicated an increase (e.g., Individual #96) or no change (e.g., Individual #215, Individual #38) in target behaviors, such as physical aggression, with no modification in the PBSPs prior to the annual review. It is important that when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes are made to the PBSP, and that these changes be documented in the progress notes. A criterion for revision of the plan was not included in the PBSPs. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological	This provision item was rated as being in noncompliance due to the absence of complete assessments for some individuals at SGSSLC, and the lack of comprehensiveness of some of the functional assessments. <u>Psychological Assessments</u>	Noncompliance

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	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.	A spreadsheet documenting intellectual and adaptive assessments indicated that seven individuals at SGSSLC did not have an intellectual assessment, and 123 did not have an adaptive assessment or review, at the time of the onsite review. The director of psychology indicated that the facility has recently begun to include a Reiss screen for all new admissions and individuals who were not followed by psychiatry. Each individual's record should contain a psychological evaluation that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. <u>Functional Assessments</u> Twenty-two functional assessments were reviewed to assess compliance with this item of the Settlement Agreement. Reports of psychology staff indicated that not all individuals at SGSSLC with PBSPs had functional assessments. All individuals whose records indicated a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors. Five functional assessments reviewed (Individual #164, Individual #198, Individual #323, Individual #165, and Individual #385) were completed since the baseline review and those were used to evaluate changes in this item of the Settlement Agreement since that review. Review of these functional assessments indicated that the majority of issues identified in the baseline review still existed. As reported in the baseline review, multiple formats (e.g., Individual #164, Individual #385, and Individual #165) were found among the five most recent functional assessments. It is recommended that all functional assessments at the facility use the same format. Additionally, all of the new functional assessments reviewed utilized both direct and indirect methods, identified antecedents and consequences hypothesized to be relevant to the undesired behavior, and attempted to differentiate between learned and biologically based behaviors. All of the functional assessments identified hypothesized reinforcers or functions of undesired behavior, and attempted to identify setting and antecedent events. The quality of some of these components, however, appeared insufficient for the functional assessments to be as effective as they could be. For example, as in the baseline review, the specific measures and results of both indirect (e.g., MAS, FAST, interview forms) and direct observations were absent in all five of the new functional assessments reviewed. As discussed in K4, ABC data collection is an ideal method of direct measurement for functional assessments, however, the functional assessments reviewed simply indicated that direct measures were collected. For example Individual #165's functional assessment stated that, "several direct	

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		observations of Individual #165 (occurred) across different environments and times of the day." All functional assessments should include the measures and results of all indirect and direct assessment measures used. All of the functional assessments reviewed identified potential functions of the undesired behavior. Some of the identified functions, however, were not operationally defined and, therefore, were not useful for understanding the variables maintaining the behavior. For example: • Individual #198's functional assessment concluded that her challenging behavior was, in part, a function of her "… limitation in her ability to control her impulses…" • Individual #323's target behaviors were hypothesized to be, in part, a function of his "…lack of insight into his behaviors." • Individual #165's functional assessment concluded that one of the functions of his undesired behavior was "Release of tension or self modulation of internal states." These descriptions of functions were not based on measurable observable behavior and, therefore, could be interpreted in a variety of ways by different people. All hypothesized functions of the target behavior identified in a functional assessment should be operationally defined. Some of the functional assessments reviewed did not include a section for summarizing the overall results of the functional assessment (e.g., Individual #165 and Individual #385). None of the functional assessments reviewed provided a clear summary of the variables maintaining the target behavior. All functional assessments should contain a summary statement that clearly identifies the variable or variables maintaining the target behaviors. All functional assessments reviewed identified replacement behaviors. As discussed in the baseline report, replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior. Some replacement behaviors reviewed were functional. For example, Individual #323's functional assessment concluded that his undesired behavior often served to escape or avoid unpleasant events or activities. One of his replacement behaviors was to provide him with opportunities and a symbol system to appropriately communicate his desires. Other replacement behaviors were not clearly functional or operationally defined. For example, Individual #385's replacement behavior was defined as "teaching strategies that include coping methods to facilitate appropriate responses to frustrating events in his daily routine…through modeling and relaxation techniques."	

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		Additionally, none of the functional assessments or PBSPs reviewed included specific instructions for how to train replacement behaviors. It is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 of this report). Finally, all the functional assessments reviewed included the identification of setting events relevant to the undesired behavior, however, many appeared to confuse the term. Setting events are the environment, events, or conditions that influence the person's behavior, but typically have a longer duration of influence than the discrete antecedents that occur just before the behavior (DADS Structural and Functional Assessment Report, policy 008). These events can include physical or psychiatric conditions, being with unfamiliar staff, being in the community, and so forth. Setting events also include motivating operations, such as sleep or food deprivation. Several functional assessments, however, included the hypothesized functions of the behavior (e.g., Individual #198, Individual #164), teaching strategies (e.g., Individual #198), and individual characteristics (e.g., Individual #323). There was no evidence that functional assessments at SGSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment. Many of the functional assessments reviewed were two or more years old (e.g. Individual #316, Individual #331, Individual #215, Individual #48, Individual #346). Functional assessments should be reviewed when an individual does not meet treatment expectations, with a maximum of one year between reviews.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	SGSSLC's psychological assessments were not based on complete clinical and behavioral data (see K5 andK7) and, therefore, this provision item was rated as being in noncompliance.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month	Some components of psychological assessments were not completed for every individual at SGSSLC and, therefore, this provision item was rated as being in noncompliance. DADS	Noncompliance

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	from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	and the monitoring teams are determining the conditions for conducting new assessments. Future reviews will evaluate the timeliness of psychological assessments based on those guidelines. Each individual at the facility received an annual psychological assessment update. The content of the psychological assessment updates/summaries at SGSSLC, however, varied widely. Some (e.g., Individual #215) included a review of cognitive and adaptive ability, and a screening or review of psychiatric and behavioral status, and a review of personal history. Other annual assessments/summaries just included a review of psychiatric and behavioral status (e.g., Individual #382, Individual #38), while a few (e.g., Individual #261) included a personal history. The purpose of the annual update is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of the spreadsheet of individuals with psychological assessments provided the monitoring team did not have dates of the most recent psychological summary, however, the monitoring team was provided with a psychological summary for one recently admitted individual (Individual #341). This individual was admitted to the facility and her psychological summary was completed within 30 days. Subsequent onsite reviews will review the most recently admitted individuals to ensure that they have psychological summaries completed within 30 days of admission.	

K8	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.	Psychological services, other than PBSPs were provided at SGSSLC, however, more work is needed to be done before this provision item can be considered to be in substantial compliance.
		
		The psychology department at SGSSLC offered a variety of services in addition to behavior support programs. This component of the psychology department was currently in transition, however, at the time of the onsite review the following services were offered:
		• Individual counseling
		• Group counseling including:
		  ○ anger management therapy groups
		  ○ substance abuse therapy groups
		  ○ abuse survivors therapy groups
		  ○ cognitive behavioral therapy groups
			Noncompliance

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		○ relationship therapy groups • Specialized Teaching and Education for People with Paraphilias (STEPP). • Specialized Treatment and Consultative Services (STACS). This program was designed to work on daily living skills. Daily lists of scheduled groups and individuals participating indicated that over 150 individuals were involved in these activities. For all of these therapy services, it is important that they are goal directed with measurable objectives and treatment expectations. Staff reports indicated that goals and measurable objectives were not consistently present at the time of the onsite review. A meeting with staff indicated that they understood that more work needs to be done to implement processes and outcomes for these services before they can achieve compliance of this item. Subsequent monitoring team onsite reviews will closely review these services to ensure that they contain: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary	This item was rated as being in noncompliance because many of the consequent interventions appeared general and were not clearly based on functional assessment results. All of the PBSPs reviewed had the necessary consents and approvals. Of the 34 PBSPs reviewed, 14 were completed or updated since the baseline review and, therefore, were the focus of this review for evaluating improvements since the baseline report. As noted in the baseline report, a positive characteristic of all of the PBSPs reviewed at SGSSLC was the prescribed use of positive reinforcement. Every PBSP had a section that included reinforcing appropriate behavior. All PBSPS reviewed included opportunities to earn tokens and exchange them for items at the token store. The manager of the token store reported that the store will even stock "custom" items to ensure that all individual's can access potent reinforcers.	Noncompliance

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	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.	A positive aspect of many of the PBSPs reviewed since the baseline review was the use of thorough and potentially effective antecedent procedures. Effective antecedent procedures are related to the hypothesized function of the target behavior, and can often substantially decrease the likelihood of undesired behaviors occurring. For example, Individual #117's functional assessment concluded that her challenging behavior functioned as a means of obtaining desired activities/ items and gaining staff attention. In order to decrease the likelihood of these undesired behaviors occurring, Individual #117's PBSP included providing her with more choices (to decrease the need to engage in target behaviors to obtain desired activities/items), prompting her to her room if she began to get upset (to decrease the probability that she would access desired attention for being upset), and specified the provision of staff attention when she appropriately communicated her desires. There are several important components, in addition to the use of antecedent strategies, which should be included in every PBSP. The monitoring team looked at both functional assessments and PBSPs to determine if the following components were present. As in the baseline review, all PBSPs and/or functional assessments reviewed included: • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Strategies addressing setting event and motivating operation issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. • Interventions for responding to the behavior when it occurs. On the other hand, as noted in the baseline review, few of the PBSPs or functional assessments reviewed contained the following necessary components of a PBSP: • Rationale for selection of the proposed intervention • Plan, or considerations, to reduce intensity of the intervention, if applicable. All of the above components should be included in functional assessments/PBSPs. Although present in all PBSPs/functional assessments reviewed, the quality of many of	

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		the components appeared insufficient for the plans to be as effective as they could be. All of the PBSPs reviewed had insufficient operational definitions of target behaviors, and many plans lacked operationally defined replacement behaviors. The following examples were typical: • Individual #164's target behavior of physical aggression was defined as "Any action intended to cause harm to another…" This definition of aggression requires the reader to infer the intent of the individual. Operational definitions should not require the reader to infer intent; they should consist of objective behaviors that are clear and complete. • Individual #76's replacement behavior was defined as "…will utilize coping skills, such as, listening to music or sitting outside, which will help him overcome situations he finds difficult." Section K5 discusses the problems and recommendations related to operational definitions of replacement behaviors in more detail. All PBSPs should include operational definitions of target and replacement behaviors. Although all PBSPs reviewed included strategies for weakening undesired behaviors, some appeared likely to have the opposite effect. For example: • Individual #38's PBSP indicated that his physical aggression was maintained by avoidance of demands. His PBSPs, however, specified that staff should remove all demands when Individual #38 appeared to be agitated. If his challenging behavior was functioning to avoid demands, then removing demands contingent on becoming agitated would not weaken physical aggression, but rather would increase the likelihood of the target behavior occurring. All strategies for weakening undesired behaviors should be consistent with each individual's functional assessment results. Finally the majority of PBSPs reviewed at SGSSLC utilized very general and imprecise interventions for responding to target behaviors. For example: • Individual #165's PBSP directed staff, following the occurrence of agitation, to "…use a strategy that fits the situation or has been successful in the past." This intervention is too general and imprecise to be useful to many DCPs in decreasing Individual #165's agitation. The consequences of many PBSPs had several common components; that is, say no, redirect, keep everyone safe. The following were typical examples: • Individual #385's PBSP specified that following physical aggression, verbal aggression, property destruction, or unsafe behavior, staff should 1) step in	

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		immediately to prevent harm to Individual #385 or others, 2) attempt to direct Individual #385 to a quieter place, 3) if this is not successful ask the other individual (i.e., the individual, Individual #385 is aggressing toward) to move away. • Individual #215's PBSP specified that following physical aggression staff should 1) tell Individual #215 to stop, 2) alter the situation that started the inappropriate behavior, 3) remove Individual #215 from the area. • Individual #198's PBSP specified that following self-injurious behavior (SIB) staff should 1) intervene to prevent harm, 2) tell Individual #198 to stop, 3) alter the situation that started the SIB, 4) redirect Individual #198 to another area. Maintaining individual and staff safety is important, however, in order to decrease the future probability of dangerous behaviors, interventions for responding to target behaviors should specify precise, clear, and individualized procedures. When the monitoring team asked psychologists at SGSSLC why many PBSPs contained general consequences of target behaviors that appeared to primarily address safety, they responded that they believed that were not allowed to use procedures, such as response costs, level systems, or differential reinforcement. As discussed in the baseline report, the monitoring team believes that the use of positive consequences contingent on desired behavior, and the withdrawal of preferred activities following undesired behaviors is an important component of any effective behavior support plan. It is suggested that the facility develop a list of procedures that can be used, the conditions necessary to implement them (e.g., HRC permission, guardian consent, director of psychology review), and a list of specific procedures that are prohibited by the facility. As discussed in K4, there was no evidence of data-based modifications of PBSPs. PBSPs should be modified when behavior trends in an undesired direction, or continues at an unacceptable level. Four of the PBSPs reviewed did, in the monitor's opinion, contain potentially effective antecedent and consequence procedures that contained the majority of the components identified above (i.e., Individual #117, Individual #170, Individual #243, and Individual #391). None of these PBSPs, however, contained operational definitions of target behaviors, a rationale for the selection of the proposed intervention plan, or considerations to reduce the intensity of the intervention. Additionally, the antecedents and consequences for Individual #170, Individual #243, and Individual #391 were identical. Although all these individuals' target behaviors were determined to have the same function, and therefore interventions would be expected to be similar, the monitoring team believes that PBSPs need to be	

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		individualized to be most effective. Nevertheless, these four PBSPs represented an excellent starting point for SGSSLC to model future PBSPs, and eventually achieve compliance with this provision item.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for meeting the requirements of this provision item. PBSP target behaviors were consistently graphed at SGSSLC, however, there was no evidence, at the time of the onsite review, that replacement behaviors were graphed. Replacement behaviors should be graphed at least monthly, and more often if clinically necessary. As discussed in K4, all PBSP data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). The graphs reviewed contained a horizontal and vertical axis and labels, condition change lines and label, data points, and a data path. Although some graphs (e.g., Individual #382) contained medication changes, the majority of PBSP graphs reviewed did not contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	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.	This provision item was rated as being in noncompliance because, at the time of the onsite review, the facility did not consistently track and use treatment integrity data to improve compliance with PBSP implementation, and many PBSPs were not written so that staff would be likely to implement them with integrity. The most direct way to ensure that PBSPs are implemented as written is to implement a system to systematically monitor treatment integrity. SGSSLC did use a competency assessment tool. The examples of the tool provided the monitoring team involved asking DCPs questions about the PBSP, such as "What are signs of agitation that precede a challenging behavior." The tool also included observing staff, and indicating if they correctly implemented specific components of the PBSP, such as prevention strategies, or responses to target behaviors. There were no data available summarizing each DCP's integrity data or establishment of minimal acceptable integrity scores. It is recommended that a treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established. In the absence of treatment integrity data, the monitoring team attempted to assess if	Noncompliance

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		PBSPs were understood and correctly implemented by asking DCPs how they would respond to various target behaviors and then compared their responses to those instructions written in the PBSPs. Additionally, if the monitoring team observed the occurrence of a target behavior, it compared the DCPs response with that specified in the PBSP. All staff interviewed indicated that they understood each individual's PBSP. An observation of a DCP implementing a PBSP, however, did not allow an accurate evaluation of if the PBSP was implemented with integrity. Individual #331's PBSP specified that following property destruction staff should ignore the behavior if no risk to others is evident, and redirect her if risk of harm is present. The monitoring team observed Individual #331 engaging in property destruction, and a DCP redirected her to another activity. It was not clear to the monitoring team, however, if the behavior (she threw a book against the wall) represented a risk to others. Individual #331's PBSP indicated that positive attention was hypothesized to maintain property destruction. Therefore, ignoring the behavior (since no attention is associated with ignoring unlike redirection which requires interacting with Individual #331) would likely be the most effective intervention. This plan, like many reviewed at SGSSLC (see K9) did not appear to be to clear (e.g., whether someone was at risk or not) and, therefore, it was difficult to determine if the DCP implemented the PBSP with integrity or not.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	As reported in the baseline review, each psychologist at SGSSLC maintained logs documenting DCP training on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. These trainings, however, were not standardized and did not consistently include a competency-based component. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally, there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. In order to meet the requirements of this provision item, it is recommended that staff training procedures include a competency-based component, and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SGSSLC had a census of 251 individuals and employed 12 psychologists responsible for writing PBSPs. Additionally, the facility employed six psychology assistants. None of the psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the	Noncompliance

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	assistant for every two such professionals.	facility must have at least nine psychologists with BCBAs.	

Recommendations:

1. Continue with training and supervision of psychology staff towards obtaining the BCBA certification.
2. The facility should develop a plan to ensure that the remaining psychologists responsible for writing PBSPs attain BCBA certification.
3. Peer review/BSPC meetings should be extended, from primarily annual reviews, to include any case that a psychologist (or his or her supervisor) believes would benefit from the input of other psychologists. Additionally, all psychologists should be encouraged to attend the meeting.
4. The facility should establish external peer review.
5. Operating procedures for both internal and external peer review committees need to be established.
6. It is recommended that DCPs be required to record a zero in each time interval if no target or replacement behaviors occurred.
7. It is recommended that the individual data books follow individuals throughout the day, and that data are recorded as soon as possible after it occurs.
8. The facility should expand its data system to include duration and time sampling measures of behavior.
9. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site.
10. Replacement behaviors should be collected and graphed for each individual with a PBSP.
11. It is recommended that DCP input in data system development be sought and documented.
12. When individuals' data trends in an undesirable direction (or continues with no improvement), hypotheses should be developed, changes made to the PBSP, and these changes should be documented in progress notes.
13. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.

14. Each individual's record should contain a psychological evaluation that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status (or a summary of a full psychiatric assessment, if one had been completed for the individual).

15. All individuals whose records indicate a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors.

16. It is recommended that all functional assessments at the facility use the same format.

17. All functional assessments should include the measure and results of indirect measures and a direct assessment that includes direct observations of target behaviors and relevant environmental variables.

18. All hypothesized functions of the target behavior identified in a functional assessment should be operationally defined.

19. All functional assessments should contain a summary statement that clearly identifies the variable or variables maintaining the target behaviors.

20. All replacement behaviors should include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility.

21. Functional assessments should be revised when new information is learned concerning the variables affecting an individual's target behaviors with a maximum of one year between reviews.

22. The annual psychological assessment update should comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year.

23. All psychological therapies should contain:
    - A treatment plan that includes an initial analysis of problem or intervention target
    - Services that are goal directed with measurable objectives and treatment expectations
    - Services that reflect evidence-based practices
    - Services that include documentation and review of progress
    - A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

24. All PBSPs should contain a rationale for selection of the proposed intervention, and plan, or considerations, to reduce the intensity of the intervention, if applicable.

25. All PBSPs should contain operational definitions of target and replacement behaviors.

26. All strategies for weakening undesired behaviors should be consistent with each individual's functional assessment results.

27. Interventions for responding to target behaviors should specify precise, clear, and individualized procedures.

28. PBSPs should be modified when behavior trends in an undesired direction, or continues at an unacceptable level.

29. Replacement behaviors should be graphed at least monthly, and more often if clinically necessary.

30. Graphs should consistently contain clear demarcation of changes in medication, health status, or other relevant events.

31. It is recommended that a treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established.

32. Staff training procedures should include a competency-based component and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.

The following are offered as additional suggestions to the facility:

33. In addition to the long-term POI goals, it may be useful for the psychology department to establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

34. It is suggested that external peer review be extended to other Texas DADS, BCBAs and supervisors (perhaps by teleconference).

35. It is suggested that the facility consider a simpler alternative to the ABC data system for routine frequency recording.

36. It is suggested that the facility develop a list of procedures that can be used, the conditions necessary to implement them (e.g., HRC permission, guardian consent, director of psychology review, etc.), and a list of specific procedures that are prohibited by the facility.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 7/20/10 o DADS Policy#006: At Risk Individuals, 10/5/09 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o SGSSLC Policy #5.2.05: Emergency Response Procedure, 9/17/09 o SGSSLC Policy #5.2.34: Automated External Defibrillator, 6/15/07 o SGSSLC Policy #1.1.02: Clinical Death Review Committee,5/8/09 o SGSSLC Policy #1.1.13: Administrative Death Review Committee, 5/8/09 o SGSSLC Policy#5.2.03: Communication with Neurologist, 10/25/10 o SGSSLC Policy#5.2.10: Routine Laboratory Test and Screenings, 10/10/10 o Mortality Reviews for individuals who died in 3/10 – 9/10 o Listing, Individuals with seizure disorder o Listing, Individuals diagnosed with pneumonia o Listing, Individuals with diabetes mellitus o Listing, Individuals hospitalized and sent to emergency department 1/10 - 9/10 o Records of the following individuals: • Individual #60, Individual #251, Individual #222, Individual #385, Individual #185, Individual #170, Individual #75, Individual #288, Individual #344, Individual #173, Individual #389, Individual #206, Individual #346, Individual #90, Individual #109, Individual #203, Individual #104, Individual #217, Individual #69, Individual #248, Individual #667 Interviews and Meetings Held: o Rebecca McKown, MD, Medical Director o David Bessman, MD, Primary Care Physician o John Burnside, MD, Primary Care Physician o James Sikes, MD, Psychiatrist o Pam Tanner, Advanced Practice Nurse, Psychiatry o Lisa Busbee, RN, Nurse Operations Officer o Lisa Owen, RN, Quality Enhancement Nurse o Maria DeLuna, RN, Nurse Educator o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator Observations Conducted: o Health Risk Screening Meeting

	○ Cottages and dorms ○ Day services areas
	Facility Self-Assessment: The facility rated itself noncompliant in all areas of this provision of the Settlement Agreement. Observations, interviews, attendance at facility meetings, review of policies, procedures, and multiple documents, including the active records of individuals, have resulted in the monitoring team's finding being congruent with the facility's self-assessment ratings of noncompliance with all provision items.
	Summary of Monitor's Assessment: Progress from the baseline visit was seen in several areas. Efforts in developing a quality improvement process were evident based on the various tools that had been piloted. In other areas, such as the mortality review process, no substantial improvement was noted. The facility had been unable to secure the services of an external physician reviewer to participate in the process. Observations in several homes indicated a lack of physician presence in these areas. The monitoring team observed the primary care physicians spending significant time in the medical complex office areas engaged in casual and informal meetings. There were significant problems related to the failure to complete annual medical summaries in a timely manner. This resulted in annual PSP meetings sometimes using old information during the planning process. Requirements for completion of quarterly medical summaries were also not met. The most concerning issue was inadequate follow-up of problems as evidenced by a lack of physician documentation. Individuals who returned from the hospital frequently did not have any documentation by the SGSSLC physician of the hospital event. Labs, consults, and other abnormal findings were rarely documented in the progress notes. A lack of summary notes, annual medical assessments, and quarterly summaries resulted in the user of the integrated record being unable to obtain a quick snapshot of the status of the individual. Individuals with complex medical problems and frequent hospitalizations did not appear to receive additional follow-up or planning. Overall, there appeared to be a lack of integration of medical into the team process. There were no daily meetings with other disciplines and the medical staff did not usually participate in the personal support planning meetings or addendums.

#	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.	The medical staff was comprised of two primary care physicians, a medical director, and one newly hired advanced practice nurse. One primary care physician was a full time employee and the other was a locum tenens employee who worked every other week. The facility also had psychiatric services provided by one full-time psychiatrist and one full time advanced practice nurse. Primary providers did not maintain caseloads. Each provider was assigned a responsibility, such as rounding, checking lab results, or completing annual medical assessments. The failure to maintain assigned caseloads introduced a lack of continuity and accountability. The fact that individuals did not have an assigned provider made it difficult to know who was responsible for annual assessments and follow-up on issues. The medical director reported that there was no formal rounding. Primary providers conducted rounds every other day twice per week in the homes in which individuals who were less medically fragile lived. The medical director completed rounds daily in the infirmary area in the McKnight building. The monitoring team requested to join the medical staff for rounds during the onsite review, but was told that no formal rounds were available for the monitoring team to attend. There were no daily medical staff meetings with the other disciplines, however, medical staff attended the facility's daily incident management review meeting. Labs were drawn and processed at the facility and sent out to Shannon Hospital. X-rays were done by a mobile unit and interpretations were provided by a local radiology group. Individuals who were in need of acute and emergency care were referred to Shannon Hospital. Neurology and other specialty appointments were secured with community providers. This appeared to be an adequate way of obtaining these services that was working well for SGSSLC. **General Medical Care and Documentation** A sample of records, listed above in the Steps Taken section of this report was reviewed. <u>Annual Medical Assessments</u> Annual assessments (medical evaluations) were completed based on a standardized format. The primary issue with this process was a failure to complete the assessments in a timely manner. In the record sample reviewed, approximately: • 60% of the records reviewed did not have timely annual medical assessments • 40% of the records had no current assessments	Noncompliance

#	Provision	Assessment of Status	Compliance
		Overall, the documents contained useful information and included brief summaries of the health management plans for the active medical problems. There were instances in which relevant information related to active problems was omitted. Delinquent assessments were found for Individual #146, Individual #325, and Individual #203. Additional specific examples are found under medical management below. <u>Active Problem List</u> Active problem lists were inconsistently present in the records reviewed. When present, they were frequently not updated as problems changed (e.g., Individual #173, Individual #185). <u>Integrated Progress Notes</u> Documentation in the integrated progress notes by primary care providers was poor. In cases where multiple complicated medical problems existed, there was inadequate and infrequent documentation. This finding was discussed with the primary care providers during meetings with the monitoring team and is discussed below in this section of the report. **Routine and Preventive Care** The medical department did not maintain a database containing preventive care screenings. A request was made on the first day of the onsite review for data on individuals who had completed colonoscopies, breast cancer screening, cervical cancer screening, and screening for osteoporosis. That request was sent to individual case managers and data were provided the following week. Findings related to these preventive services are based on results documented in the record sample reviewed. There was evidence that some elements of preventive care were consistently being provided. Preventive Care Flow Sheets were included in the records reviewed, but did not appear to be consistently updated. There were several documents that had comments such as "Due," but items remained outstanding. <u>Screenings</u> • Vision and hearing screenings were being provided according to written guidelines. • Screenings for cervical, breast, prostate and colon cancer were being completed in most cases. In many instances where the screenings were deferred, an explanation was written on the flow sheet or included in the annual assessment.	

#	Provision	Assessment of Status	Compliance
		Immunizations • There was evidence of compliance with guidelines for administration of Influenza, H1N1, and pneumococcal vaccinations. • There was evidence of compliance with guidelines for administration of vaccination against Hepatitis B. Non-responders were not always clearly identified in the records. **Medical Management** Individual #173 • Individual #173 was found in bed unable to be aroused at 8:20 am on 8/16/10. Vital signs were BP 78/46, P 72, T 96.6, RR 16, and O2 sat on room air (RA) 92%. The nursing staff attempted to arouse the individual and the individual vomited. The individual was noted to have a weak radial pulse. The physician was notified of the individual's status including vital signs. The nurse was instructed to sit individual up, retake vital signs, and call the physician back. Repeat vital signs were BP 96/63, P 68, RR 16, and T 96.4. The nursing notes documented that the right pupil was unreactive and that distal pulses were weak. "Unable to fully arouse. Placed in WC with staff assist." Physician notified. Received orders to send to ER." The individual was transported to the ER where he was assessed and admitted. The admitting diagnosis was pneumonia. The individual was discharged back to SGSSLC on 8/19/10. There was no physician assessment or documentation in the IPN following return to the facility. • It was unclear why a physician would not have assessed this individual at 8:30 am on a Monday morning particularly given the episode of hypotension and lethargy. Transporting by state vehicle was not the most appropriate method of transportation given the condition of the individual at the time of transfer. Upon return to the facility, the physician responsible for the care of this individual should have evaluated the individual and provided appropriate documentation in the record. • The annual medical summary was dated 9/14/09. The PSP date was 5/6/09. The assessment was, therefore, out of compliance. The health care guidelines state that "All hospitalizations will be briefly summarized in a primary care provider's active treatment note within 72 hours of return." Individual #288 • Individual #288 was reported by staff to be acting weird on 7/19/10 at 6:15 am. Vital signs were BP 162/58, P 54, RR 30, T97, and O2 sat on RA 93%. "Respirations are shallow and quick but unlabored." At 10:11 am, the home	

#	Provision	Assessment of Status	Compliance
		nurse documented that this would be referred to the case manager. At 8:30 am vital signs were T 100.6, BP 89/50, HR 120, RR 22, and O2 sat 98% on RA. PO Tylenol was given by the LVN for increased temperature. Referred to case manager. • On 7/21/10, the individual was reported to have loose stools. Vital signs were BP 93/54, HR 63, T 97.9, and O2 sat 96%. On 7/22/10, the individual was reported to have coughing and gagging. Vital signs were BP 88/51, HR 88, and RR 28. The abdomen was documented as distended since 7/19/10. The physician was notified. The individual was transported to the hospital for evaluation and admitted with a diagnosis of left lower lobe pneumonia. Upon return to the facility on 7/27/10, there was no evaluation of a physician assessment documented in the records. On 7/29/10, the individual was reported to be agitated and yelling. Without any documented physician assessment, the individual was given Ativan 2 mg. The first physician note is dated 8/17/10. It addressed the need for a return neurology clinic appointment. • An ophthalmology consult was requested on 6/5/09 for chronic conjunctivitis. The consult dated 6/12/09 noted chronic iritis of left eye which "is essentially dead eye." An exam on 12/18/08 noted chronic iritis that "has smoldered for years." There was no additional information in the active record regarding eye evaluations prior to 2008, or if the iritis had been inadvertently treated as chronic conjunctivitis prior to 2008. • The individual also had a history of a colectomy in 2008 and was hospitalized in October/November of 2009 with a diagnosis of vomiting, dehydration, and constipation. Progress notes related to that event were not included in the records provided. Although this hospitalization was significant and related to an active medical problem, it was not addressed in the annual medical assessment completed in October 2010. • The individual still had outstanding issues that required evaluation, such as persistent elevations of alkaline phosphatase, as noted in the most recent annual medical assessment. • Drug Regimen Reviews were not completed in a timely manner. One review dated 11/15/09 was received 5/24/10. Another dated 8/26/09 was received 5/3/10. It was not clear if these were completed due to deficiencies discovered through audits or perhaps misplaced. There is little value in completing a drug review nine months after the due date and it is never acceptable to put inaccurate dates on documents. • This individual had multiple medical problems that impacted every aspect of his life, and his ability to transition and achieve his goals. There was no physician participation in the annual support planning meeting. Moreover, the PST did not have a current annual medical assessment to utilize as part of the support	

#	Provision	Assessment of Status	Compliance
		planning process in 6/10. The annual assessment was dated 10/18/10. The PSP date was 6/24/10. This individual showed evidence of a deterioration in health status on 7/19/10. There was no documentation in the records that a physician was notified of these findings. The individual was admitted to the hospital with pneumonia. There was an opportunity to have a medical evaluation and potential for treatment three days prior to the individual being admitted to the hospital. Early intervention and treatment is associated with decreased hospitalization rates. <u>Individual #75</u> • The individual was seen by the neurologist on 5/7/10 and a recommendation was made to start Zonegran, obtain EEG and return to clinic in three months. The EEG obtained on 7/12/10 was mildly abnormal. Upon return to neurology clinic on 8/6/10, the neurologist noted that the Zonegran was not started. There was no note in the record to explain this decision. The Zonegran was started following the 8/6/10 neurology clinic appointment. <u>Individual #60</u> • The records requested for this individual were incomplete and did not include records for the two hospitalizations in April 2010 and June 2010. Both admissions were due to abdominal distention and ileus. The individual had a history of a subtotal colectomy due to celiac disease. Medication records and nursing assessments were reviewed. There did not appear to be any change in any care plans in response to the hospitalizations. • The individual's PSP was conducted on 9/20/10. There was no physician participation in the process and there was no recent medical data supplied by the physician. The last medical summary was dated 8/18/09. <u>Individual #389</u> • Individual #389 had evidence of biochemical hypothyroidism on lab reports dated 5/2010 with an elevated TSH that was confirmed with a follow-up study. The individual was seen by an endocrinologist on 6/24/10 and the recommendation was to start Synthroid. The medication was started 7/2/10. There was adequate information in May 2010 to initiate treatment without endocrine consultation. • The individual was also treated with quetiapine. Laboratory monitoring for this drug was not completed. The active records did not contain any results from lipid studies, complete blood count, or a metabolic panel. The requirement for such monitoring was codified in the state's medical policy.	

#	Provision	Assessment of Status	Compliance
		• The annual medical assessment was dated 10/18/10. The previous assessment was 2/27/09. The PSP date was 2/11/10. • The quarterly medical review completed 6/4/10 noted the abnormal thyroid studies, but did not comment on the significance of the abnormal findings. There was also no mention of the need for laboratory monitoring based on the use of a new generation anti-psychotic. The review did note the need to monitor lipid studies. **Emergency Medical Care** The Nurse Operations Officer provided information on the facility's emergency system. The facility was designated as a BLS facility. There was also an ACLS trained response team. AEDs were maintained in every home, the education building and the gym. The AEDs were maintained by a biomed company. In the case of a Code Blue, the operator notified the code team. There was no overhead paging done. The team responded with crash bags and medications. The crash bags were checked monthly and medications were checked every shift. The facility maintained a system for conducting drills for emergencies. These emergency procedures at SGSSLC appeared to be adequate and acceptable. **Seizure Management** In response to document requests related to seizure disorder, several sets of information were provided. A list of individuals and all diagnoses were provided for the list of individuals being treated for seizure disorder. The majority of individuals on the list included the diagnosis of "other convulsions," resulting in a lack of clarity of the seizure classification. The complete medication regimens were provided for the same set of individuals. The indications for the medications were not provided. It was not possible to determine the indications for several individuals with seizure disorder and a psychiatric diagnosis. The records of 13 individuals with seizure disorder were reviewed. The individuals were receiving care by the neurologist on a regular basis. The clinic notes were relatively detailed and addressed issues related to quality of life and medication polypharmacy. There was also evidence that consideration was given to behavioral diagnoses when medications required adjustments. Overall, the SGSSLC primary providers responded to the recommendations for seizure management and frequently made notations of many of the clinic visits. There were some instances in which medication changes appeared not to occur. Additional reviews of seizure management will need to occur on subsequent visits. The	

#	Provision	Assessment of Status	Compliance
		medical department should pursue development of a database that allows a report to be generated that contains individuals with seizure disorder, medications used to treat seizure disorder as well as relevant laboratory studies.	
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.	A locum tenens physician served as the external reviewer for the purpose of completing quarterly medical reviews and medical care audits. The medical director reported that the external reviewer was a board certified clinical pathologist who conducted quarterly medical reviews of every individual living in the facility. In recent months, the external reviewer had collaborated with the QA Department in completing medical care audits. The quarterly medical reviews evaluated the care provided for active medical problems through chart audits. Recommendations for further care were sometimes provided. Quarterly medical reviews were found in the progress notes, but were not signed by the primary care providers or acknowledged in the progress notes. These reviews did not appear to be completed every quarter in the record sample reviewed. There was no written procedure in place to guide these processes by indicating the frequency of the audits, sample size, and metrics, or how the information was used. The medical care audits were a review of medical care based on the checklist utilized by the monitoring team. Further discussion of this system is contained in provision L3. Case reviews, including mortality reviews, conducted for the purpose of evaluating clinical care, should be completed by persons with expertise in the area being assessed. The preference would be to have a primary care assessed by a trained primary care physician. The following examples highlight the importance of having the appropriate reviewer: <u>Individual #75</u> • A review of Individual #75, dated 9/7/10 summarized several problems including HIV status and Hepatitis B status. The summary noted that the individual was being referred to an infectious disease (ID) specialist as ordered on 9/2/10. The same reviewer signed the annual medical assessment in 10/09 and noted the HIV status. No recommendation was made for ID referral at that time. • The quarterly medical review noted that this individual had chronic Hepatitis B. The recommendation was to monitor liver function tests. The standard of care for this chronic condition is to monitor alpha-fetoprotein levels and liver ultrasounds on a regular basis as surveillance for hepatocellular carcinoma. An adequate case review should have indicated the standard of care for treatment in this condition. There is no evidence that this occurred during the review and appropriate surveillance had not been completed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #288 • A review dated 9/24/10 documented a diagnosis of pneumonia in 7/10. The review failed to point out that the individual had a decline in health status three days prior to hospitalization that was not reported to the physician. Early intervention could have potentially resulted in avoidance of hospitalization. • The review documents left eye chronic iritis as a past medical problem. It is an active problem with the potential for a similar event in the functional right eye and demands close monitoring to preserve visual acuity. Mortality Reviews were another type of case review completed by the facility. The system involved three action steps per policy: 1. Within five working days of notification of death, the physician completes a death summary for the record. 2. Within 14 working days of notification of death (45 with autopsy) the clinical death review committee meets. 3. Within 21 calendar days of completion of review by the clinical death committee (52 with autopsy) the clinical death review committee will forward a report to the administrative death review committee. The goal of the mortality review, as stated in DADS policy, was to provide a comprehensive review of clinical care and operational procedures that may have affected the overall care of the individual. Recommendations for correction actions were to be made when appropriate. Each review committee required the participation of an external representative. There were 11 deaths recorded from July 2009 to April 2010. This represents a mortality rate of approximately 3%. Seven of the recorded deaths occurred in 2010, with the average age at death being 74 years. The causes of the deaths in 2010 were listed as: • Adult failure to thrive (4) • Unspecified cardiovascular disease (2) • Respiratory arrest (1) Mortality reviews were conducted for each death. Documents related to all deaths occurring in 2010 were provided to the monitoring team for review and included the physician death summaries, abuse and neglect investigations, clinical and administrative death reviews, and death certificates. The nursing summaries were not provided. The medical director completed death summaries and these included pertinent clinical information.	

#	Provision	Assessment of Status	Compliance
		The mortality process did not include participation by an external reviewer although the clinical death reviews documented attempts to have such participation. During an interview with the medical director related to the mortality review process, she indicated that the facility staff most appropriate conducted mortality reviews because they had the most intimate knowledge of the individual and the circumstances surrounding the death. The clinical death review documents contained few recommendations and nearly all pertained to end of life issues, such as pain management, hospice, and counseling for grief and bereavement. There was also one recommendation related to nursing plans. The seven mortality reviews for 2010 included no recommendations related to medical care provided to the individuals other than the use of narcotics for pain management. A review of the active records of Individual #257 was completed: • This individual was considered to have adult failure to thrive based on refusal of oral intake and weight loss. The individual also had a diagnosis of dementia. A note from the medical director indicated that a DNR status was being pursued based upon the failure to thrive diagnosis. The case was referred to the psychiatrist for a second medical opinion. The psychiatry note was not available in the record. Additional information on the process of this individual having a change to DNR status was not recorded in the record. Based on the medical director's note, it appeared that the PSP and psychiatrist could jointly decide to change the code status of the individual. • This individual met several criteria for a diagnosis of failure to thrive based on the active record reviewed. The care provided appeared appropriate. • The active record contained documents less than one year prior to death. A detailed mortality review would require, at a minimum, a review of the two years prior to death to ensure that care leading up to the determination of the diagnosis of adult failure to thrive was appropriate. • The state's current policy directs reviewers to focus on events that occurred during the days prior to death.	
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;	The facility did not have a formal procedure in place to comply with this requirement. There were, however, several audits of medical services being conducted: • Quarterly reviews by the external reviewer • Medical care audits by the external reviewer • Medical audits completed by the QA Department The tool being used for the medical care audit was the monitoring team's checklist that was based on the four items of provision L. While this tool was shared with the facility, it was not intended to be used by the facility as a measure of medical quality. The use of	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>identifies and initiates corrective action; and monitors to ensure that remedies are achieved.</td><td>the checklist was an obvious attempt to tie the quality process to the requirements set forth in the Settlement Agreement. Additional work is needed in the development of monitoring tools that are based on the Settlement Agreement and that provide useful data to the facility and clinicians. The fact that the medical and quality departments were piloting various methodologies and tools for measuring quality was showed progress from the baseline visit.

Summaries of the medical care audits were provided to the monitoring team for review. The external physician audit was conducted on four records. A second audit of one record was completed by the QA Department. The findings are summarized in the tables below. Also see discussion in section E of this report.

<table>
<tr><th>M.D. Audit
November 2010</th><th>Compliance%
n=4</th><th>Comments</th></tr>
<tr><td>Annual Medical Assessment</td><td>25%</td><td>• Physical exam was expired
• No complete history and physical in chart
• Last exam 11/30/09</td></tr>
<tr><td>Audiology Exam</td><td>75%</td><td>• Last exam 1/3/08</td></tr>
<tr><td>Vision Exam</td><td>75%</td><td>• Last exam 9/25/09</td></tr>
<tr><td>Immunizations</td><td>75%</td><td>• Needs influenza</td></tr>
<tr><td>Screenings and Labs</td><td>100%</td><td></td></tr>
<tr><td>Communication With Physician</td><td>100%</td><td></td></tr>
<tr><td>Communication With Nurse</td><td>100%</td><td></td></tr>
<tr><td>Instructions Provided</td><td>100%</td><td></td></tr>
</table>

<table>
<tr><th>QA Audit</th><th>Compliance %
n=1</th><th>Comments</th></tr>
<tr><td>Annual Medical Assessment</td><td>100%</td><td></td></tr>
<tr><td>Audiology Exam</td><td>100%</td><td></td></tr>
<tr><td>Vision Exam</td><td>100%</td><td></td></tr>
<tr><td>Immunizations</td><td>0%</td><td>• Consult with MD and ICN to determine if Hepatitis A vaccine is warranted.
• Not documented on preventive care flow sheet</td></tr>
<tr><td>Screenings and Labs</td><td>0%</td><td>• GU exam was deferred on annual PE. Should be conducted annually.
• Consult with MD to determine if 24 hr urine is warranted.</td></tr>
<tr><td>Communication With Physician</td><td>0%</td><td>• There was a two day delay of notifying the MD of complaints of pain relating to arthritis for change in dose of Celebrex without any documented plan.</td></tr>
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#	Provision	Assessment of Status	Compliance

Communication With Nurse	100%	
Instructions Provided	100%	

An additional medical care audit done on 10/18/10 by the QA Department on Individual #127 (one of the four individuals reviewed by the external MD) resulted in the following comments:

- The last physical exam was conducted 2/3/09.
- The last DRR present in chart was completed 7/26/10.
- Quarterly medical summaries were not being completed.
- Although labs had been signed by MDs, not all were dated and many ordered labs were not present in the chart. Those missing were noted from 9/18/10 to present date.
- Individual saw the physician on a routine basis and received care accordingly.
- Individual received emergency care as needed.

The audits produced valuable feedback at the individual-specific level. There was also evidence that systemic issues existed related to completion of drug regimen reviews, annual medical assessments, and quarterly medical summaries. The QA nurse reported that she forwarded deficiencies to the medical director, but acknowledged that follow-up on deficiencies was incomplete. The medical director acknowledged the presence of continued deficiencies when meeting with the monitoring team. An overall strategy for how this information was to be utilized was lacking. There was no system in place to track corrective actions to completion.

The facility collected data on hospitalizations, ED visits, and pneumonia. During interviews with the medical director and QA nurse, there was no clear explanation for how these data were used. There was also no process in place for tracking and trending key quality measures, such as incidence rates for UTI, bowel obstructions, pneumonia, pressure ulcers, seizure medication polypharmacy, and hospital admission rates/preventable hospitalizations. The hospital data collected had the potential to provide valuable information related to the quality of medical care provided. For example, in those cases where an individual was hospitalized more than once in a 30-day period, a review might serve useful in determining if gaps in care attributed to the re-admission. Gaps in care could include issues with medication management as a result of transitioning from one facility to another or failure to have adequate post-hospitalization follow-up. The QA nurse indicated that she would be receiving additional training in this area.

Development of a medical quality program will require that the desirable outcomes be defined. The medical staff will need guidelines to assist in achieving the desired outcomes. Once this is accomplished, a process for assessing compliance with the

#	Provision	Assessment of Status	Compliance
		standards can be developed and implemented. Valid and reliable metrics that measure both process and outcome measures need to be established. A system for data management that ensures data integrity will also need to be developed. Moreover, the facility will need to focus on: • the conversion of data to information that is useful, • implementation of appropriate corrective actions, • the measurement of response to the corrective actions and • re-evaluation of problems when there is a failure to detect improvement.	
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.	This provision item referred to the Health Care Guidelines that provided the framework for the standards of medical care to be provided by the facility. DADS Policy #009: Medical Care was issued in July 2010. The medical department had not issued any local policies or procedures based on the DADS Policy #009 and the Health Care Guidelines. The members of the medical staff reported during various discussions that they were familiar with the Health Care Guidelines. During a meeting with members of the monitoring team and the medical staff, the staff openly acknowledged that they did not document or summarize the findings of consults and labs in the integrated progress notes and they were not aware that this was a requirement of the current guidelines. The majority of the medical staff agreed to adopt this process and appreciated the value of including such information in the integrated progress notes (also see section G2 above).	Noncompliance

Recommendations:

1. The facility must address medical staffing. There should be at least two full time primary care physicians, in addition to the newly hired advanced practice nurse. Each provider should be assigned a caseload to increase continuity of care and accountability. Primary care providers should not have caseloads of more than 100. The medical director should not have primary direct care responsibilities.

2. Policies and procedures are needed to guide the provision of medical care. These should address the provision of clinical care as well as the overall structure of the medical department. Physician duties and responsibilities and requirements for medical care should be clearly defined:
    a. Clinical guidelines are needed to aid physicians in the provision of medical care. These guidelines should be consistent with those adopted by the state. Guidelines are needed for common medical conditions, as well as for conditions that are common in individuals with developmental disabilities. Immediate needs include guidelines for pneumonia, bowel management, management of dysphagia, and osteoporosis.
    b. The organization of the medical department must be better defined. An operational procedure specifically detailing the duties and responsibilities of primary care providers is needed. The duties and responsibilities should be consistent with the health care guidelines and include :

- Assignment of caseloads
- Conducting daily clinical rounds
- Cross coverage in the absence of a primary provider
- Requirements for documentation, review of labs and consults
- Completion of annual medical assessments and the medical director's responsibility related to this task
- Physician response to acute illness
- Physician requirements related to transfers from the facility and requirements once an individual returns to the facility
- Participation in support planning meetings
- Participation in committees and other meetings

3. Physicians should assess all individuals following return from the hospital or emergency department. Documentation from the hospital should be reviewed and orders written as appropriate. A summary note should be written in the IPN that reflects the events, change in status and requirements for a change in care plans.

4. Quarterly medical summaries should be completed as required in the health care guidelines. The quarterly medical review cannot serve as a substitute for the quarterly medical summaries. The summaries are intended to be completed by the primary provider and serve as an update to the PST, hospitals and consultants who must have current information.

5. Efforts should be made to improve integration of neurology and psychiatry. This is best achieved by conducting a neurology–psychiatry clinic on campus for individuals with seizure disorder who also have a psychiatric diagnosis. If this is not possible, telemedicine and other newer technologies should be explored in order to achieve a simultaneous neurology-psychiatry consultation.

6. A qualified external physician reviewer is needed to comply with the Settlement Agreement. Case reviews should preferably be completed by providers who are board certified in family or internal medicine.

7. Efforts should continue to locate external physicians to participate in the mortality review process. This is necessary in order to provide a truly objective review. Until that is accomplished, consideration should be given to altering the current process to include a death summary by the treating physician as well as a review by the medical director. The reviews should be comprehensive and at a minimum include a review of the last two years of life. Efforts should be made to look for opportunities for improvements in all areas that impacted the care of the individual. Such efforts have the potential to improve the quality of care for many individuals.

8. A comprehensive medical quality program is needed. This program should be a collaborative effort between medical, nursing, the QA Department, and the external reviewer. Much of the data needed for such a program will be collected by nursing services and/or the QA Department. Collaboration is necessary in order to prevent duplication of efforts and conflicting data sets. The facility will need to define outcomes, develop measures to reflect achievement of outcomes, and design tools for data collection. In order to achieve a robust QA program, relevant staff will need to be trained on the quality improvement process, data management, and analysis.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Organizational Chart o Map of SGSSLC o DADS State Supported Living Center Policy: Nursing Services (1/31/10) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o A list of all individuals served by residence/home, including for each home an alphabetized list of individuals served, their age (or date of birth), date of admission, and legal status o A list of individuals admitted within the last six months and dates of admission o The agenda for new staff orientation o The curricula for new staff orientation, including training materials used o The schedule for ongoing in-service staff training o The curricula for ongoing in-service staff training, including training materials used o For nursing, the number of budgeted positions; the number of staff; the number of contractors; the number of unfilled positions, including the number of unfilled positions for which contractors currently provide services; and the current FTE o Lists identifying each individual who is identified to be "at risk" utilizing the State's risk categories o Since 1/1/10, individuals who have been seen in the ER, including date seen and reason for visit o Since 1/1/10, individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o Since 1/1/10, individuals admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to home unit o Since 1/1/10, individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial); and/or have had a swallowing incident, including the date of incident, item that caused the swallowing incident, and the interventions following the incident o For the past three months, Health Status Team Meeting minutes o Nursing staffing reports/analysis generated in the last six months o Minutes of the Infection Control Committee for the last six months o Minutes of the Environmental/Safety Committee for the last six months o Minutes of the Department of Nursing meetings for the last six months o Minutes of the Nutrition Management Committee for the last six months o Minutes of the Pharmacy and Therapeutics Committee meetings for the last six months o Minutes of the Medication Performance Improvement Team meetings for the last six months o All SGSSLC policies and procedures addressing emergency/code blue drills o SGSSLC training curriculum for the implementation of emergency procedures including training

	materials o All emergency/code blue drills, medical emergency reports, including tracking logs, recommendations, and/or corrective actions based on these reports/analyses for the last six months o List of SGSSLC staff who are certified in first aid, CPR, or ACLS with expired certification o Documentation of annual consideration or resuming oral intake for each SGSSLC individual receiving enteral nutrition o All SGSSLC training curricula on infection control, including training materials o SGSSLC infection control surveillance and monitoring reports for the last six months o SGSSLC nursing audits, data, analysis reports for the last six months o SGSSLC medication administration audits and reports for the last six months o Since 1/1/10, list of individual who died at SGSSLC or after being transferred to a hospital or other care setting o SGSSLC Self-Assessment: POIs October 2010 and Supplemental POI October 2010 o SGSSLC Meeting Schedule updated 11/13/10, updated o Records and MARs of: • Individual #206, Individual #60, Individual #134, Individual #344, Individual #318, Individual #388, Individual #385, Individual #153, Individual #373, Individual #316, Individual #186, Individual #346, Individual #116, Individual #334, Individual #25, Individual #137, Individual #164, Individual #75, Individual #170, Individual #114, Individual #194, Individual #127, Individual #38, Individual #325, and Individual #203 <u>Interviews and Meetings Held</u>: o Opening meeting on SGSSLC progress since baseline review o Nurse Operations Officer, Lisa Busbee, RN o Quality Enhancement Nurse, Lisa Owen o Nurse Hospital Liaison, Chey McCray o Infection Control Nurse, David Ann McKnight o Nurse Educator, Maria DeLuna o Assistant Director of Programs, Charles Njemanze o Medication Performance Improvement Team Meeting o Skin Integrity Meeting o Informal interviews with 15 nurses (included RN case managers, RNs, and LVNs) o Meeting with Pharmacist, Medical Director, Acting Chief Nurse Executive, Nurse Educator, and Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator <u>Observations Conducted</u>: o Visited individuals residing in buildings 501, 502, 505, 508, 509, 510, and 516 o Medication administration (501A, 502A, 508A, 508B, 510A, 510B, 516E, and 516W) o Nebulizing treatment (516W, 502a) o Dressing change (510A) o Enteral nutrition (508A, 516W)

	Facility Self-Assessment: The facility's self-assessment for section M indicated that many initiatives were in the early or initial stages of development and/or awaiting further direction through policy and procedure development and revision at the state level before proceeding. Thus, the facility self-rated noncompliance for all items, except for these three items: 1) competency based training regarding infection control was included in new employee orientation (NEO), 2) all staff were trained in hand-washing according to CDC guidelines, and 3) all staff were trained in standard precautions. The monitoring team concurred with these self-ratings. These ratings were for three of the many components of the entire provisions. Because all components of the provision were not in compliance, the entire provision was rated as being in noncompliance.
	Summary of Monitor's Assessment: During the conduct of this onsite monitoring review, all homes were visited, 20 nurses were interviewed, and 25 individuals' records were reviewed. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in recordkeeping practices. It should also be recognized for progress made toward compliance with other provisions of the Settlement Agreement and Health Care Guidelines. For example, monitoring tools had been selected, reviews had occurred, and the establishment of inter-rater reliability was underway. Various other performance improvement activities were developed in response the facility's identification of problems and areas of deficiencies in performance. During the conduct of the review, the monitoring team met nurses who were proud to show the results of their efforts to improve the timeliness, content, and quality of individuals' nursing assessments and plans of care. The conduct and competence of the Hospital Liaison was a good example of the facility's progress toward achieving compliance with nursing assessment and reporting protocols. Although the Hospital Liaison was hired only one month prior to the review, her depth of knowledge and understanding of her role to promote individuals' health and wellness through consistent communication with clinical professionals and external health care providers was tremendous. Notwithstanding these positive findings, as noted in the baseline review, SGSSLC continued to operate under the situation of a nursing shortage. Indeed, the nursing shortage had intensified since the baseline review and, despite the hard work of many nurses, it had taken its toll on the delivery of nursing supports and services to individuals. For example, there were frequent and regular absences of complete nursing assessment and follow-up to individuals' emergent health care problems and needs and a pattern of failure to develop adequate, appropriate, individualized plans to address/resolve individuals' health problems, needs, and risks through the implementation of planned, individualized interventions. In 21 of the 25 records reviewed (84%), nursing assessments failed to provide a complete, comprehensive

	review of the individuals' past and present health status and needs and their response to interventions, including, but not limited to medications and treatment, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. The administration of medication and the management of the medication administration system at SGSSLC had also not improved since the baseline monitoring review. As indicated in more detail below, much work still needed to be done to ensure that medications were administered and accounted for in accordance with standards of practice and the Health Care Guidelines.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	As noted in the baseline review, SGSSLC continued to operate under the situation of a nursing shortage. The findings of the baseline review raised concerns that the willingness of the Nurse Managers and RN Case Managers to provide direct nursing coverage to make up for the loss of use of agency/contract nurses would (a) take a toll on the nurses' ability to carry out their own responsibilities, which included assessment, planning, and evaluating outcomes of care, (b) put individuals' health and safety at risk for neglect, and (c) decrease the Nursing Department's ability to meet the provisions of the Settlement Agreement and Health Care Guidelines. Nonetheless, since the baseline review, the situation of nursing shortage had not been adequately addressed. Rather, the nursing shortage had intensified since the baseline review and, indeed, it had taken a toll on the delivery of nursing supports and services to individuals. (see Section M4 for more information and findings specific to the nursing shortage.) During the conduct of this onsite monitoring review, all homes were visited, 20 nurses were interviewed, and 25 individuals' records were reviewed. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in record-keeping practices. During the monitoring team's visits to the individuals' homes, however, it was common for the individuals' records to be "off the home" and not available or accessible to the nurses, who needed the records to ensure that accurate, pertinent health and medical information was available to the clinical professionals who needed the information in order to provide safe and necessary care/treatment to the individuals. Many nurses' notes were not documented in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. Also, the content as well as signature/credentials appearing in some nurses' notes were not legible and/or properly documented with the specific	Noncompliance

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		time, versus shift, of the entry. Also, some nurses' notes were brief, uninformative, cryptic phrases that provided little, if any, specific, objective and/or subjective information to guide and direct planned interventions and/or caregivers' activities, such as, "He is doing a small amount better," "She has not had a major jump in weight," "His behaviors are down," "Medications seem to be effective," and "Implement [diet] and tighten it up." A rating of noncompliance was made for this provision item because of the frequent and regular absence of complete nursing assessment and follow-up to individuals' emergent health care problems and needs and a pattern of failure to develop adequate, appropriate, individualized plans to address/resolve individuals' health problems, needs, and risks through the implementation of planned, individualized interventions. There was evidence across the 25 individuals' reviewed that the individuals' direct care staff members usually notified the individuals' nurses in a timely manner of significant changes in the individuals' health status and needs. Once the nurses were notified, however, there was a significant pattern of failure by the nurses to ensure and/or conduct complete nursing assessments and provide timely and appropriate follow-up nursing care to all 25 of the sample individuals reviewed. Numerous examples from this sample indicated the seriousness of this problem at SGSSLC and extended to all phases of the nursing process from assessment to evaluation of plan effectiveness. • On 8/11/10, Individual #316 reported to her nurse that a male peer pulled her pants down and forced her into a corner. She said that she told him that she "didn't want to do this (sic)." Individual #316's nurse documented that, upon examination, she had "no injury," but there was "drainage resembling semen on and about her vaginal area." Notwithstanding Individual #316's report and her nurse's initial finding, Individual #316's nurse failed to document a complete assessment, failed to ensure appropriate and timely follow-up to suspected sexual abuse, and failed to conduct timely and appropriate follow-up care and treatment. It was not until four weeks later, after an episode of nausea/vomiting and Individual #316's persistent claim that, "she's pregnant (sic)," that she received follow-up evaluation, which included a pregnancy test. • On 8/31/10, Individual #316 fell off her bicycle and sustained a laceration to her right knee and abrasions to her right elbow and left knee. Individual #316's nurse cleansed the injuries and applied antibiotic ointment. There was, however, no evidence of a complete of assessment of Individual #316's extremities, including range of motion, and no evidence that Individual #316 was instructed in bicycle safety, including, but not limited to, encouraging her to wear a helmet.	

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		• On 10/9/10, Individual #316, who is prescribed a special "kidney diet" as part of the treatment of her chronic kidney disease, reported to her nurse that she had not eaten for four days and that she was hungry. Individual #316's nurse failed to conduct an assessment of her and failed to gather information pertinent to her current health status, other than "Gait – normal, no complaints." In addition, there was no follow-up by Individual #316's nurse to ensure that she received appropriate nutrition, in accordance with her special diet. • On 10/26/10, Individual #316's nurse noted that she was "stabbed in the right side and back of her neck with a fork" by a peer. Although Individual #316 sustained four stab wounds to her neck, there was no complete assessment of her wounds documented by her nurse and no evidence of follow-up to these injuries to ensure that they were healing without infection. • During the two-week period of 8/30/10 – 9/15/10, on eight occasions, Individual #194 complained of chest pain, indigestion, and/or "hot liquid" in her throat. On several of these occasions, her direct care staff member reported that she had also vomited. There was no evidence on any of these occasions that Individual #194's nurse conducted a complete assessment or ensured timely and appropriate follow-up to administrations of PRN medications. In addition, there was no evidence that Individual #194's nurse reported her complaints to her physician for medical follow-up. • On 7/29/10 and 8/3/10, Individual #194 complained of foot pain and was observed limping by her direct care staff member. Individual #194's nurse noted that she had "no redness, bleeding, bruising, or swelling," however, her nurse failed to conduct a complete assessment of her feet, toes, toenails, shoes for fit, impingement, and/or pressure, nature of ambulation, etc. Over a month later, Individual #194's nurse finally informed her physician of her repeated complaints of foot pain and dry soles of her feet with thick yellow toenails. Individual #194's physician prescribed a topical antifungal cream to treat a fungal infection of her feet. • On 8/26/10, Individual #186's direct care staff member reported to her nurse that Individual #186 had fainted, did not respond to verbal stimuli for two minutes, and, when she got up, stated she "feels bad." Individual #186's nurse obtained her vital signs, noted that her color was "good," and her skin was "w/d (sic)." Individual #186's nurse failed to conduct a complete assessment, including, but not limited to an assessment of her neurological status. Rather, Individual #186's nurse administered a PRN of Tylenol 650 mg for her complaints of cramps, which were reportedly alleviated in 35 minutes. There was no further follow-up of Individual #186's altered level of consciousness until 9/12/10, when her nurse noted that she fell out of bed and "gashed open her right eyebrow."	

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		• On 10/19/10, just one month after Individual #186 suffered a broken neck and 12-inch laceration to her head after she jumped from the second floor stairwell of her home, her nurse noted that a peer attacked her at 1:45 pm, 2:00 pm, and 2:45 pm. During these attacks, Individual #186 sustained injuries to her face and eyes/eyelids. Individual #186's nurse noted that he/she "told [Individual #186] to wash her face with soap and water." There was no evidence of an assessment of Individual #186's injuries and no evidence of follow-up to ensure her health and safety risks were adequately/appropriately addressed or that her wounds healed without infection. • On 8/4/10, Individual #127 was noted to be agitated, irritable, and excreting dark amber urine with mucus and occasional streaks/clots of blood. His nurse's check of his urine revealed positive findings of blood, protein, leukocytes, etc. This significant change in Individual #127's health status was not reported to his physician. During the period of 8/5/10-8/9/10, Individual #127's nurses noted that he continued to be agitated, irritable, and talked "non-stop," yet, there was no evidence that his nurses identified these signs/symptoms as significant changes and/or reported them to Individual #127's physician. On 8/10/10, Individual #127 was noted to be "hard to awaken," and, once awake, "agitated" and "refusing his medications." Again, these significant changes in his health status were not reported to his physician. It was not until 8/11/10, when Individual #127's penis was draining purulent drainage that his nurse notified his physician and treatment was prescribed. • On 10/4/10, at 10:00am, Individual #127 was noted to have chest congestion. Individual #127's nurse failed to conduct a complete assessment, including, but not limited to, a complete set of vital signs and assessment of Individual #127's respiratory system/lung sounds. From 10/5/10-10/11/10, there were no follow-up assessments of Individual #127's respiratory status. In addition, on 10/11/10, although Individual #127's temperature measured 100.1, this finding was not identified as a significant change, not addressed, and not reported to his physician. It was not until 10/13/10, when Individual #127 was coughing and expectorating "beige-colored" secretions and noted to be "hyperthermic" (his temperature measured 100.2) that he was given Tylenol 650 mg and his on-coming LVN was asked to "recheck his temperature." When Individual #127's temperature was re-checked it measured 101.3. At this time, Individual #127's nurse noted that he/she solicited information from his direct care staff members who reported that he had not urinated, and he had refused his meals and snacks for the past three days. Finally, at this time, Individual #127's physician was notified of his condition. His physician ordered blood tests, urinalysis, urine culture/sensitivity, IV fluids, and antibiotic. Unfortunately, during the period of 10/13-10/16/10, Individual #127's condition worsened. He developed bilateral	

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		lung infiltrates and required additional antibiotics to treat his infection. • On 9/9/10, Individual #38's direct care staff member reported to his nurse that he had not eaten in three days. Individual #38's nurse noted that he/she "notified his RN case manager," but failed to conduct an assessment, review his health status data/information, or ensure follow-up to this significant change in his health status. • On 10/9/10, Individual #38's nurse noted that he had an 8.5 cm area of impaired skin integrity on his back that was "blistered and weeping." Over the next three days, there was no evidence of follow-up to this significant change in his skin integrity and no evidence that his skin was adequately and appropriately treated. • On 11/3/10, Individual #38's nurse noted that he had pain from a tear at the tip of his penis. At this time, he/she noted that the Skin Integrity Team (SIT) would be consulted and he/she would "have doctor review the situation." There was no evidence of an assessment of Individual #38's penile tear and no follow-up to this significant change in his health status. Ten days later, Individual #38 again complained of "hurting." At this time, his nurse asked where he was hurting, and he replied "penis." At this time, Individual #38's physician was notified of his complaint and he/she ordered PRN application of viscous lidocaine to the tip of his penis. Notably, throughout this 10-day period, there was no evidence of a complete assessment of Individual #38's penis, including the nature and severity of the alteration in his skin integrity, which was purportedly from tension applied to his urinary catheter. • On 9/9/10, Individual #385's direct care staff member reported to his nurse that he had a possible seizure and fell off the toilet. Individual #385's nurse obtained his vital signs and noted that he was calm, alert, and responded appropriately. Although Individual #385's nurse failed to conduct a complete assessment of Individual #385, he/she concluded that Individual #385 "had no injuries." In addition, there was no evidence of follow-up to this significant change in Individual #385's health status until 9/14/10 when his direct care staff member again reported to his nurse that he had another possible seizure in the bathroom, fell against the wall, and slid to the floor. • On 11/12/10, Individual #385's direct care staff member brought him to the treatment room and stated to his nurse that he/she found bruises on his back. According to Individual #385's nurse, he had an area of bruising on his back that measured seven inches long by five inches wide. Individual #385's nurse failed to conduct a complete assessment of the nature and severity of his injury. Notwithstanding the lack of assessment, Individual #385's nurse concluded that he had no complaints and needed no treatment. • On 9/4/10, Individual #325's direct care staff member reported to her nurse	

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		that she choked when she was eating/drinking. Although Individual #325 was at risk of choking and aspiration, her nurse failed to conduct an assessment of her. Also, although Individual #325's nurse noted that he/she "Will report [her choking] to oncoming shift and any changes to CM and doctor," there was no evidence of follow-up to this significant incident. • On 10/21/10, Individual #325's direct care staff member asked her nurse to assess her buttocks. According to Individual #325's nurse's note, the skin on her buttocks was "fragile" and "at risk for impaired skin integrity." Although her nurse noted that he/she would inform the Skin Integrity Team (SIT) and "monitor [her] closely," there was no evidence of follow-up to this significant change in her health status. Notably, on 10/27/10, Individual #325's nurse noted that her alteration in skin integrity was a "chronic issue." • On 11/5/10, Individual #373's direct care staff member reported to her nurse that she complained of a sore in her mouth. Individual #373's nurse noted that he/she was unable to visualize anything in her mouth, but that he/she "will request that the nurse follow-up in the morning when she is up (sic)." There was no evidence of follow-up to this report, which was especially significant for Individual #373 who chews tobacco and has a history of buccal mass. • On 8/10/10, Individual #318 fell over, was diaphoretic, and unsteady on his feet when assisted to a chair. Individual #318's nurse suspected that he was "overheated" due to "being outside all day and provided him with two large cups of water. There was no evidence of a complete assessment of Individual #318 to evaluate possible dehydration and/or heat exhaustion. In addition, there was no evidence of or follow-up to this significant change in Individual #318's health status other than the nurse's note, "Color good," and "Said he's going to bed." • On 10/4/10, Individual #318 lost his balance, fell, and hurt his right foot. Individual #318's nurse noted, "Assessment completed. IBU 400mg po per PRN MAR. No redness, swelling at this time. No bruising noted. Foot elevated. Ice pack applied. RN notified. Dr. Bessman notified. Ordered x-ray right foot due to pain after fall…Awaiting x-ray results prior to plan of action. Keep individual pain free. Good ROM." Notwithstanding this significant change in Individual #318's health status and possible fracture, there was no evidence of follow-up by his nurses until seven days later when he sustained yet another fall. • During the period of 8/8/10-10/15/10, Individual #25's nurses noted seven episodes of constipation where there were periods of three to eight days with no recorded bowel movements. On these occasions, Individual #25's nurses administered Dulcolax suppositories, but failed to conduct complete assessments of her health status and failed to note whether or not positive results were achieved as a result of the suppositories. • On 10/27/10, Individual #25's direct care staff member reported to her nurse	

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		that she had vomited several times. Individual #25's nurse noted that he/she administered Pepto-Bismol and instructed his staff member to "let nursing know if she had anymore episodes. Individual #25's nurse failed to conduct an assessment and failed to ensure timely and appropriate follow-up to the administration of PRN medication. • On 8/20/10, Individual #164's direct care staff reported to her nurse that there was blood in the toilet and on the washcloth during her toileting and bathing. Individual #164's nurse noted that her bleeding was "from passing hard, rock-like stool (sic), blood is bright and fresh." There was no evidence of an assessment or of implementation of any intervention to address this significant change in Individual #164's health status, save for the phrase, "Will notify RN Case Manager. Pt is on 0 routine medication for constipation." • On 9/6/10, Individual #164's direct care staff member asked her nurse to assess her "bruising." Individual #164's nurse noted several bruises on her left upper thigh, left inner calf, and left foot. He/she also noted that the tips of Individual #164's right great toe and right second toe were ulcerated. Although Individual #164's nurse noted that he/she completed an incident report, there was no evidence that treatment was rendered and follow-up occurred. • On 9/13/10, Individual #164's nurse noted that she called her physician to see her due to the presence of two- to three-plus, bilateral pedal edema. Individual #164's nurse instructed her staff to "Sit individual in recliner and elevate bilateral lower extremities until MD sees her." There was no evidence that Individual #164's nurse conducted a complete assessment of her circulatory status and no evidence of follow-up to ensure that this significant change in her health status was adequately and appropriately addressed. • On 10/15/10, Individual #164's direct care staff member reported that he/she found Individual #164 on the floor next to her bed with her head/neck still on the bedrails. Individual #164 was lifted into bed and examined by her nurse, who noted: "Skin w/d, pale pink. F/c intact to BSDB, amber urine in bag, leg strap on. Right jaw line red, 1 inch by 3 inches, right upper inner arm light red bruising 1 cm by 6cm, right upper arm posterior 1 cm by 1 cm dark purple bruise (does not look new), left upper arm red area 3 cm by 6 cm with very light bruising in center 1 cm by 3 cm. V/s 98.0, 74, 18, 108/71, 99% O2 sat RA. Feet with 3+ edema bilateral. Slid out of bed. Short, low bedrails NOT effective. Refer for full length bedrails. Staff monitor and report concerns to nurse." Despite Individual #164's nurse's identification of a serious health and safety risk, that is, Individual #164's risk of strangulation or other serious bedrail injury/incident, there was no evidence that any interventions were put forward	

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		to reduce Individual #164's risk of injury and protect her from additional harm. In addition, there was no evidence that follow-up assessments of Individual #164's injuries were conducted to ensure timely identification of actual or potential complications from her injuries. • During the three-month period of 8/1/10-10/31/10, Individual #334 suffered 15 falls and was struck, pushed to the floor, and slapped by peers on eight occasions. There was no evidence on any of these occasions that Individual #334's nurse conducted a complete nursing assessment of her injuries and/or provided follow-up care to ensure her health and safety.	
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.	In October 2010, a revised comprehensive nursing assessment form and state policy and procedure on nursing assessment were initiated at SGSSLC. Quarterly nursing assessments were present in each of the 25 sample individuals' records reviewed. The first step of the nursing process that one would expect to find in a facility such as SGSSLC is the nursing assessment. The nursing assessment is an ongoing and continuous process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, regardless of the reason for the nursing encounter. Generally accepted professional standards of care indicate that nursing assessments must be complete, accurate, documented, and accessible to all members of the healthcare team. It is from the nurses' assessment that actual problems, high-risk potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. Moreover, the assessment records and summarizes pertinent health data against which change can be measured and goal achievement determined. Properly completed, the standardized nursing assessment forms in use at SGSSLC since October 2010 referenced the collection, recording, and analysis of a comprehensive set of health information that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. For example, Individual #164 was a 55-year-old woman who was diagnosed with major depression, severe mental retardation, hypothyroidism, seizure disorder, osteopenia, intermittent hyperglycemia, and hypertension. In addition, she had very unsteady gait and suffered frequent falls. Individual #164's nursing assessments provided a comprehensive review of her health status indicators, evaluated the effectiveness of her treatment with anticonvulsant, antihypertensive, psychotropic, gastrointestinal, and hyperglycemic medications, and generated nursing diagnoses that provided an adequate basis for selection of interventions to achieve her desired health outcomes. A rating of noncompliance was made for this provision because, although the revised nursing assessment forms were in use at the facility, in 21 of the 25 records reviewed	Noncompliance

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		(84%), nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatment, to achieve desired health outcomes. In addition, despite the occurrences of significant changes in individuals' health status that occurred between quarterly assessments (e.g., hospitalizations, serious illnesses, and injuries affecting health status, functioning, and overall health and well-being), the assessments were not updated in accordance with the provisions of the Settlement Agreement and Health Care Guidelines. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Examples of these findings are presented below. • Individual #206 was a 73-year-old woman diagnosed with GERD, history of GI bleed, osteopenia, history of kidney stone and placement of ureteral stent, moderate-severe gingivitis, constipation, incontinence, history of basal call carcinoma, hemiparesis, degenerative joint disease, and hearing deficit. Individual #206's quarterly nursing assessment failed to reference her hearing deficit, periodontal disease, and history of basal cell carcinoma. In addition, Individual #206's physical assessment erroneously indicated that she did not have constipation and failed to include a review of her bowel management plan. Individual #206's physical assessment also erroneously indicated that she had "no abnormal findings" related to her upper and lower extremities and failed to provide an assessment of the nature and impact of her hemiparesis and degenerative joint disease (DJD) on her ability to ambulate. Notably, Individual #206 required the use of a brace on her left lower extremity and a walker to ambulate. • Individual #316's quarterly nursing assessment failed to provide a review of the effectiveness of her medications and treatments. Her nursing assessment also erroneously indicated that she received the birth control medication Yasmin, which is known to increase the chances of heart problems and strokes and is not recommended for individuals with heart, liver, or kidney disease. Several months ago, Individual #316, who was diagnosed with chronic kidney disease, stage II, was prescribed Yasmin, but currently she was prescribed Depo-Provera, which has less serious side effects and is less likely to cause DVT, stroke, etc. The section of Individual #316's nursing assessment entitled, "Nutrition Risks," failed to reference her prescribed "kidney diet" or evaluate the impact of her	

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		adherence/non-adherence to her diet on her progress/lack of progress toward her goal/desired health outcome. The section of Individual #316's nursing assessment, entitled "Endocrine," failed to reference her hypoparathyroidism and its impact on her health status. Although Individual #316's nursing assessment mentioned her diagnosis of chronic kidney disease, stage II, it failed to include a review of the impact of her disease on her actual/potential risks to her health and safety or the barriers to her health. • Individual #194's quarterly nursing assessment did not include a review of the outcomes of her specialty consultations, and it failed to provide an analysis of the health data/information relevant to her hypothyroidism. In addition, Individual #194's nursing assessment failed to portray the significant impact of her recurrent urinary tract infections and cystitis, her frequent complaints of indigestion, and her episodes of constipation on her health. • Individual #186 was a 30-year-old woman diagnosed with bipolar disorder with aggression, seizure disorder, neurogenic bladder, intermittent enuresis, blindness (left eye), iron deficiency anemia, and obesity. In addition, she was designated as a high risk for behavior and injury. Notably, on 10/15/10, Individual #186 sustained a serious injury, that is, she suffered a broken neck and 12-inch laceration to her head after she jumped from a second story stairwell. Despite the tremendous impact of this injury on Individual #186's health status and functioning, her 9/30/10 quarterly nursing assessment was not updated. In addition, it should be noted that Individual #186's nursing assessment failed to completely and adequately analyze and review the frequency, nature, and severity of her many behavior episodes and related injuries. • Another individual was a young woman diagnosed with schizophrenia, HIV, hepatitis B, seizure disorder, hypothyroidism, hyperlipidemia, asthma, frequent urinary tract infections, and onychomycosis. Her quarterly nursing assessment failed to evaluate the effectiveness of her medications and treatment. This lapse was especially significant for this individual who was prescribed Atripla, the first and only entire HIV regimen in one pill a day with long term effects that are still not known. Also, this individual's nursing assessment failed to adequately portray the frequency and significance of her recurrent urinary tract infections, which was, again, very significant and relevant to this individual who was at risk of infections, or other conditions, that happen with HIV infection. • The quarterly nursing assessment for Individual #127, who had undergone extensive excision of ulcerating undifferentiated cancer of his left hand, which included amputation of his fingers, failed to reference his history of cancer and erroneously indicated no abnormalities of his upper extremities. In addition, Individual #127's nurse's review of the effectiveness of his medications and	

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		treatments was incomplete, uninformative, and limited to one word – "Effective." Also, Individual #127's nursing assessment failed to adequately portray his health problems and risks related to his genitourinary system. His nursing assessment did not indicate the nature and frequency of his urinary tract infections or the presence of his indwelling catheter and the associated risks of infection. • Several of Individual #385's nurse's reports of his/her analysis of the data, information, and knowledge relevant to his health status and outcomes were unclear and uninformative. For example, Individual #385's nurse's review of the effectiveness of his medications and treatment was limited to one word – "Good." Also, the following phrases were put forward as explanations of the variances and patterns in Individual #385's health data, but failed to reveal the actual/potential risks to his health and safety or the barriers to health – "Behaviors are down from previous quarters," "Increasing his Seroquel has helped," and "Implement ketogenic diet and tighten it up." • During Individual #38's quarterly review period, he suffered recurrent urinary tract infections, including one urinary tract infection that resulted in metabolic encephalopathy. Individual #38's quarterly nursing assessment section entitled "Infection History," failed to capture this critically important information. • Individual #318 was a 40-year-old man diagnosed with disruptive behavior disorder, hypertension, hyperlipidemia, osteoporosis, marked hemiparesis (left side), foot drop, and left wrist contracture. Individual #318's quarterly nursing assessment erroneously indicated "no abnormalities" of his musculoskeletal system. Also, although Individual #318's nursing assessment noted his risks of injury due to frequent falls and unsafe scooter driving practices, there was no evidence of a thoughtful analysis of the risks of ambulation with unsteady gait and frequent falls versus the actual/potential benefits of structured, formal interventions to address his unsafe scooter driving practices and assist him to adjust to his disability and appropriately use his equipment. • Individual #25's quarterly nursing assessment's sections for the review of consultations and labs were blank. According to the directions noted on the assessment form, the date of the last consultation, date of lab, and date due of standing lab orders were the missing, yet required, data elements. Also, Individual #25's physician ordered monthly bilateral hip x-rays to monitor the status of her healing/non-healing hip fracture(s). According to Individual #25's physician, she was not a candidate for surgery due to "noncompliance." Individual #25's nursing assessment listed the dates and results of her hip x-rays, but failed to explain the nature, scope, and severity of her noncompliance and/or the impact of her untreated, non-healing hip fracture(s), and monthly x-rays on her health and safety and barriers to health. Also, Individual #25's	

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		nursing assessment failed to portray the frequency and severity of her constipation. • Individual #334's quarterly nursing assessment noted that, during the review period, Individual #334 suffered a 19-pound, unplanned, undesirable weight loss. Her nursing assessment failed to include a comprehensive analysis of her weight data, intake information, or other knowledge relevant to her weight loss to identify relevant patterns/variances. In addition, Individual #334's nursing assessment failed to identify her risk of injury due to assaults by peers and frequent falls. • Individual #116 was a 34-year-old woman diagnosed with schizophrenia, seizure disorder, hypothyroidism, hyperlipidemia, non-insulin dependent diabetes mellitus, GERD, venous stasis of lower legs with leg ulcer, syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH), degenerative joint disease of right ankle, and obesity. Individual #116's quarterly nursing assessment's section entitled, "Gastrointestinal" failed to reference her persistent episodes of nausea, vomiting, and diarrhea. In addition, Individual #116's nursing assessment failed to reference her vision impairment and degenerative joint disease.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Health management plans (HMPs) and acute care plans (ACPs) existed at SGSSLC. During the Summer of 2010, the nursing staff members at SGSSLC received the new health management plan, process, and form/format that was prepared and distributed by the state. According to the SGSSLC QA nurse and members of the nursing leadership team, the HMPs and ACPs needed improvement, especially with respect to the review/revision of plans in response to clinical indicators. The monitoring team agreed with the facility's assessment of their status toward compliance with this provision of the Settlement Agreement. Consequently, this provision was rated as noncompliance. In a facility, such as SGSSLC, health management plans and acute care plans are designed to promote health and/or prevent, reduce, or resolve the problems and risks that are identified via the nurses' assessment and nursing and medical diagnoses. In total, the nursing care plans should reference all of the individual's acute health issues, including injuries, actual and potential health risks, restorative and habilitative needs, and chronic/long term health needs. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of the interventions. The individuals' status, and the effectiveness of the plans, must be consistently implemented and continuously evaluated and modified as needed.	Noncompliance

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		All 25 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Acute Care Plans (ACPs). These plans were developed by their RN Case Manager in response to identified health needs, identified risks, and/or significant changes in health status. Part of the problems noted in the HMPs and ACPs were due to the problems noted above in nurses' response to individuals emergent health needs and risk and nursing assessments and diagnoses (sections M1 and M2 of this report). Some general comments are presented below. • Across the 25 individuals reviewed, HMPs and ACPs varied in form/format. • In 21 of the 25 individuals reviewed (84%), the HMPs did not consistently address all of the health care needs of the individuals; and ACPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care needs and risks. • Many of the 25 individuals reviewed had "mini" medical disorder, also known as "stock," care plans added to their HMPs. Although the medical disorder care plans appeared to be added to the individuals' HMPs to provide additional direction and guidance to caregivers, these plans were not specific enough for caregivers to be able to pick it up and effectively continue the care. The medical disorder care plans had not been adequately customized and/or personalized to address individuals' specific health problems and risks. Rather, they referenced generic interventions mostly related to monitoring and reporting activities and usually instructed the reader to follow other "plans," such as, "See HMP," "Per "Follow BMP," "Maintain per PNMP," and "See physician's orders." • Also, for at least four of the 25 individuals reviewed, their HMPs/stock care plans had not been adequately reviewed and revised prior to their implementation. As a result, they referenced the name of the wrong individual(s) in their plans. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. • There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and current ACPs to ensure that the plans continued to be appropriate and relevant to the individuals' health status, and if they did not, the plans were changed. • The objectives and expected outcomes referenced in the HMPs and ACPs were not individualized, and they did not reflect the individuals' participation in their development or the formulation of their desired health outcomes. • The Nursing Assessment portion of the individuals' PSPs was not informative	

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		and did not provide even a brief recapitulation of the individuals' health status over the past year. In addition, usually only two to three of the individuals' health objectives or goals were mentioned. In several instances, no nursing input was provided during the formulation of the PSP. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #116's HMP failed to include a plan to address her frequent episodes of nausea, vomiting, and diarrhea. This may have been due to the fact that her nurses' have dismissed this health need as a true problem, since they noted, "[Individual #116] has emesis on demand." Also, there was no evidence that several of the interventions to address Individual #116's obesity had been implemented. For example, there was no evidence that she was encouraged or assisted to join a support group and no evidence that she had been offered appropriate and relevant information and education regarding healthy weight and lifestyle for someone with her health challenges – diabetes, venous stasis, degenerative joint disease, etc. • Individual #25's HMPs had not been revised after significant changes in her health status. For example, Individual #25's HMPs related to her constipation, skin integrity, and mobility were not revised subsequent to her hip fractures. Individual #25's HMP for constipation had not been revised to reflect the intractable nature of her constipation and changes in her bowel regimen. In addition, there was no ACP developed to address Individual #25's short-term insomnia. • Individual #127's HMPs lacked sufficient information, detail, and individualized interventions to adequately address his health and safety risks related to GERD, constipation, and osteoporosis. For example, Individual #127's HMP for GERD was a stock care plan that called for an "upright position for meals and after (sic)." There were no specific, individualized interventions related to proper positioning to ensure his safety at mealtime and promote gastric emptying, length of time in upright position, etc. Individual #127's HMP for osteoporosis did not reference individualized, specific interventions related to his ability to bear weight, participate in a plan/program of range of motion exercises, etc. Individual #127's HMP for chronic constipation was also a stock care plan that addressed the typical chronic constipation with the usual nursing interventions. It did not, however, spell out the nature of Individual #127's chronic, severe constipation due to partial persistent ileus and/or the specific daily interventions that were required to prevent the development of fecal impaction/intestinal obstruction. The HMP also did not reference Individual #127's prescribed use of four laxatives and the requisite monitoring required ensure his health and safety and reduce the likelihood that he will experience	

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		untoward outcomes. • There was no evidence of implementation of many of the nursing interventions put forward in Individual #75's HMP to address her weight. For example, there was no evidence that she had been encouraged or assisted to develop a diary of her intake, no evidence of an established physical activity program, and no evidence that rewards for the achievement of weight loss were implemented. There was no evidence of an HMP to address Individual #75's nicotine addiction and provide support for her during the time she was prescribed a nicotine patch. This lapse was significant since it represented a lost opportunity to help increase the likelihood that Individual #75's would successfully complete her smoking cessation program. • Individual #194 was a 30-year-old woman diagnosed with disruptive behavior disorder, hypothyroidism, speech disorder, GERD, obesity, chronic cystitis, and tinea pedis. Also, over the past several months, Individual #194 gained eight pounds and weighed 274 pounds. According to Individual #194's nursing assessment, her constipation and hypothyroidism HMPs were discontinued on 11/18/10 because she failed to suffer complications related to these disorders (emphasis added). The rationale to discontinue Individual #194's HMPs did not comport with meeting the goals/desired outcomes of her HMPs. In addition, although Individual #194's chronic conditions may have been stable for a period of time, there was potential for these conditions to become unstable. • Individual #186 was a 30-year-old woman diagnosed with bipolar disorder with aggression, seizure disorder, blindness left eye, neurogenic bladder with intermittent enuresis, hyperprolactinemia, status post MRSA infection right elbow, status post fractured cervical (C-7) and thoracic (T-1) vertebrae, and hyperammonemia. Although Individual #186 had many health needs and risks, the only HMP developed and filed in her record was a 9/30/09 HMP to address her obesity. • Over the past several months, Individual #334 has suffered a 19-pound, undesirable, unplanned weight loss. On 10/18/10, her PST recommended that an ACP be developed and implemented to address her weight loss, but there was no evidence that an ACP was developed and filed in her record. • Since 4/1/10, Individual #385 had an HMP to address his obesity and ketogenic diet for seizures. Over the past six months, Individual #385 gained 12 pounds. Despite Individual #385's lack of progress toward the achievement of his goal, there were no revisions to his HMP. The only reference to a review of the HMP was his nurse's cryptic note that his diet needed to be "tightened up."	
M4	Within twelve months of the Effective Date hereof, the Facility	At SGSSLC, nursing assessment and reporting protocols were in place, however, the presence of protocols was not sufficient to ensure that the health needs and risks of the	Noncompliance

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	shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	individuals at SGSSLC was consistently identified and addressed. As noted above, the facility's implementation of its nursing assessment and reporting protocols was in the early stage of implementation, and there were numerous problems, described above in sections M1, M2, and M3. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not yet evident in the 25 records reviewed. At SGSSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Quality Enhancement Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all had a role and responsibility to ensure the implementation of nursing assessment and reporting protocols to address the health status of the individuals. The facility's Department of Nursing met on a monthly basis. During these meetings, the nursing management team reviewed the role and responsibilities of nurses across various processes and protocols (e.g., CPR drills, Initial Dose Response Forms), discussed revised policies and procedures, and made recommendations to improve the delivery of nursing supports and services across the facility. There was no job too big or too small for the Nursing Operations Officer (NOO), who was also the acting Chief Nursing Executive. On numerous occasions, she was called upon to assist, advise, and, sometimes, directly deliver nursing care. Many times, these calls took her away from her own duties to develop, lead, and guide facility-wide improvement efforts, which was especially significant since she was designated as the "facility lead" for all nursing areas of the facility's POI. During one of many informal interviews with the NOO, she clearly spoke of the commitment shared by nursing leadership to do whatever was needed to deliver the best care possible to individuals. This commitment was reflected in the NOO's conduct at every level, from her rapport with individuals, to her interactions with direct care staff, to her support of nurses and quality nursing care. The NOO reported that steps had been taken to improve nursing assessment and reporting protocols. For example, nurse case managers had begun using a new form/format for their assessments, and expectations for improvement in the timeliness and quality of the assessments were communicated and regularly reinforced. The Nurse Educator echoed the NOO's commitment to improvement in nursing assessment and reporting protocols. She had several presentation books, which confirmed her reported passion for education and training for all employees and, where appropriate, the individuals. A review of the presentation books revealed the progress made toward staff training in	

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		hand-washing (100%) and standard precautions (100%). There were also very well-developed curricula for training in seizure disorders, safety, management, and Vagus Nerve Stimulation (VNS), HIV/AIDS, and CPR. It was also not uncommon for the Nurse Educator to be called upon to provide re-education and training in areas where performance improvement was needed. For example, recently, the Nurse Educator was called upon to re-train an LVN on proper documentation of a seizure log. The Nurse Educator was also the member of health care committees and teams and most recently, in August 2010, she was asked to chair the Medication Variance Committee. At this meeting, she reported on medication errors and assisted in the formulation of recommendations to reduce medication errors and address problems related to medication variance. The conduct and competence of the Hospital Liaison was a good example of the facility's progress toward achieving compliance with nursing assessment and reporting protocols. Although the Hospital Liaison was hired only one month prior to the review, her depth of knowledge and understanding of her role to promote individuals' health and wellness through consistent communication with clinical professionals and external health care providers was tremendous. During an interview with the Hospital Liaison, she reported that she conducted daily visits to individuals who were in the hospital. She made observations, reviewed records, and received reports from the members of the external health care facility. She documented the findings and outcomes of her visits and sent them electronically to the individuals' physician and members of their PST. The Hospital Liaison had been asked to duplicate her electronic report vis a vis handwritten copy of her report on the Integrated Progress Note form to ensure that her findings are effectively communicated. The Hospital Liaison summed up her role/responsibility and stated that her job was "Taking [the individuals] from here to there." Part of that "trip," however, required that she communicate individuals' preferences and needs to those who did not know them well, provide individuals' pertinent, relevant health information/histories to external health care providers to help inform treatment interventions and recommendations, and educate others about the facility and its mission to serve the individuals. The only areas of the facility's self-assessment (POI) that affirmed compliance were three items that pertained to infection control. At the time of this review, the Infection Control (IC) Nurse had been in the job for only one week. Fortunately, she worked at the facility in other capacities prior to her newly-appointed IC Nurse position, and, fortunately, the	

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		former IC Nurse continued her employment at the facility in another capacity and was available to answer questions and provide information pertaining to the facility's infection control monitoring, assessment, and reporting protocols. Unfortunately, there was no evidence that a proper transition of duties from the former IC Nurse to current IC Nurse had occurred, and no evidence that important infection control information and data had been shared/exchanged. For example, at the time of this review, the current IC Nurse had no access to important infection control information (e.g., database of immunizations/infections), she had not received any training/information from the former IC Nurse, she had not been apprised of her role/responsibilities with regard to monitoring/surveillance of infections, and she had not been provided keys to the building or her office. To her credit, the current IC Nurse attended an Infection Control meeting in Austin, scheduled a training session with the individual who maintains the immunization database, and sought help and guidance from another facility's IC Nurse. An interview with the former IC Nurse revealed that when she held the IC Nurse position, she facilitated quarterly Infection Control Committee meetings. At these meetings, she presented information pertaining to the frequency of various types of infections that during the prior quarter. Although data were presented and discussion ensued, there was no evidence that problematic patterns and trends were consistently identified, corrective actions were developed, and action steps were carried out. In addition, there was no evidence that the Infection Control Department, in conjunction, with the Pharmacy monitored the use of antibiotic prescribing practices and responded, where appropriate, with addition training and/or other interventions to achieve positive outcomes for individuals. At the time of the review, it was unclear whether or not the progress achieved by the facility toward its compliance with the infection control-related provisions of the Settlement Agreement would be sustained. During an interview with the Quality Assurance (QA) Nurse, she stated that there had been "leaps and bounds" of improvement in the facility's nursing assessment and reporting protocols. She reported that there had always been "monitoring" conducted by the Quality Enhancement Department, however, as of October 2010, specific monitoring tools had been selected, reviews of several individuals had occurred, and the establishment of inter-rater reliability was underway. The QA Nurse also reported on the various performance improvement team activities, that were underway at the facility. The "PITs," which stood for Performance Improvement Teams, were the facility's designated oversight and monitoring teams	

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		developed in response to problems and performance issues identified vis a vis the monitoring reviews and other reports (also see section E of this report). For example, a Med PIT was developed to address the problems and performance issues that were revealed through an analysis of the Medication Error Reports and the observations and first-hand knowledge of the members of nursing leadership. According to the QA Nurse, prior to October 2010, the Quality Enhancement Department was the only department responsible for monitoring. Since October 2010, the Nursing Department has joined forces with the QA Department to implement the "new" monitoring of the delivery of health care supports and services to the individuals. In order to "monitor" the new "monitoring" protocols, the QA department, in conjunction with the Information Technology Department, created a master tracking system, which was a database that tracked the compliance and inter-rater reliability scores across 10 monitoring tools. During the interview with the QA Nurse, she referred to herself as a "Jack of all trades," who "gets into a little of everything." It was duly noted by the monitoring team that the QA nurse indeed applied her years of training and experience and many learned skills to bring disciplines together in a practical manner. Truly a valuable quality displayed by the facility's QA nurse. At the time of the review, the position of Nurse Recruiter was vacant. The vacancy of this position was notable since the facility was in the midst of a nursing shortage and would have most assuredly benefitted from the skills and expertise of a qualified, experienced Nurse Recruiter. At the time of the review, the Nursing Department had 19 unfilled positions plus three nurses who were newly hired on or about 11/16/10. The nursing shortage, which was noted during the facility's baseline, has undermined many of the efforts that were underway to meet the provisions of the Settlement Agreement's section M. Curiously, nursing leadership, during the monitoring team's interviews, did not raise the subject of nursing shortage, and it was absent on most nursing meeting agendas. On the one hand, this may be perceived as a testament to the willingness and dedication of the nurses to work together to stretch themselves thin to cover meetings, trainings, reviews, and units. On the other hand, this may be perceived as a sign of frustration and resignation. Whatever the reason, the nursing shortage was a matter of great importance and a constant source of stress and strain on all nurses across the facility. A review of the Health Management Department's database revealed the following findings:	

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		• Evening shift LVNs accounted for the significant majority of vacant nurse positions. • All vacant RN positions were on evening and night shift. • The two buildings that shared the highest nurse vacancy rates were buildings 508 and 511. These two buildings served some of the facility's most challenging individuals, who undoubtedly suffered the most from vacancies, turnover, and overtime nurses and/or nurses assigned to "cover" multiple units. A review of a 30-day period (10/19-11/17/10) of nursing staff data revealed the following findings: • Thirty of 30 days (100%) were staffed below the designated minimum staffing levels. • On 30 of 30 days (100%), shifts were "covered" by anywhere from 10% to 60% of nursing staff members who were working "overtime." When nursing "care" becomes "cover," practice declines, untoward outcomes occur, and individuals suffer the consequences. During the monitoring team's visits to all buildings on campus, nurses unanimously reported the negative effect the nursing shortage has had on nursing practice and outcomes for individuals. They also relayed examples of an increasingly difficult and unsafe working environment. The nurses acknowledged the problems inherent in the use of agency/contract nurses, but relayed their frustration with the facility's refusal to consider agency/contract nurses to address, on at least a short-term basis, the nursing shortage. These findings and concerns were shared with the facility's Assistant Director of Programs, who indicated that he would reconsider his refusal to utilize agency/contract nurses and promised to take swift action to address the nursing shortage, including the creation of measures to address the shortage in the short-term as well as on a longer-term basis.	
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	SGSSLC had implemented the state approved health risk assessment rating tool and held regular health status team meetings. The Health Risk Assessment Rating Tool was to assess and identify each individual's level of risk (low, medium, or high) across a number of particular areas: seizures, aspiration, choking, medical, cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, osteoporosis, polypharmacy, respiratory, skin integrity, UTIs, weight, injuries, and their overall risk level. Additional rating tools were completed for risks associated with dental status. The rating tools were completed in conjunction with representative members of the individuals' PST. Health Status Team (HST) meetings were held to review and assign health risk ratings.	Noncompliance

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	status of the individual.	All 25 individuals whose records were reviewed were also reviewed in a timely manner by the HST. All 25 individuals reviewed had multiple risks related to their health and/or behavior, and all had one or more "high" health risks. Several HST reviews that were completed more recently were more comprehensive and ensured more realistic ratings of risk. Planning for and making changes and modifications to the system of identifying and tracking health risks for individuals at SGSSLC, as described in the baseline review, were awaiting revisions to the state policy and procedure that were in process at the time of this review. As noted in the baseline review, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as noncompliance. Examples included the following: • Over the past three months, Individual #164 had several falls. On two occasions, she fell out of bed. On one of these two occasions, she was found with her body on the floor, but her head and neck still on the bed rails. On the other occasion, she was found on the floor in tangled bedding, with her great toenail ripped from her toe. Also, Individual #164's 10/10 nursing assessment stated that she was "at risk of aspiration and choking" due to her "unsafe mealtime behavior." She also had a HMP to address her risk of choking. Nonetheless, this individual's health risk ratings for aspiration remained medium and injury remained low. • Individual #385 was prescribed a strict ketogenic diet to address his obesity, use of Depakote to treat his seizures, and his increased blood-ammonia level. Since his weight risk level was assigned as "low" in July 2010, he gained an additional 12 pounds and his hyperammonemia has not resolved. His assigned risk level, however, remained as low. • According to Individual #134's annual medical evaluation, his seizures were under good control, and he had not had a recorded seizure in two years. During the past six months, however, Individual #134 has experienced recurrent skin breakdown on his feet and was hospitalized for treatment of cellulitis of his lower extremity. Both of his September 2010 risk levels for seizures and impaired skin integrity were categorized as medium risk. • In October 2010, Individual #194's risk of weight gain was decreased from high to low. Her November 2010 nursing assessment noted that over the past quarter, she gained another eight pounds and was more than 140 pounds overweight. The rationale for the reduction of her risk level was unclear and without adequate explanation or justification. • According to Individual #153's integrated progress notes, he reportedly "stuffs large bites into his mouth," "exhibits unsafe eating," considered by his nurse to be "a potential choking risk," and "referred to OT for unsafe eating. His risk level	

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		related to choking/aspiration was categorized as low. • Over the past several months, Individual #325 was diagnosed with hypertension, mitral and aortic valve disease, mild mitral regurgitation, and moderate aortic regurgitation. In September 2010, she suffered a myocardial infarction during her hospitalization for treatment of aspiration pneumonia. Nonetheless, her cardiac risk was rated low.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The administration of medication and the management of the medication administration system at SGSSLC had not improved since the baseline monitoring review. As indicated in more detail below, much work still needed to be done to ensure that medications were administered and accounted for in accordance with standards of practice and the Health Care Guidelines. Therefore, this provision item was rated as noncompliance. During the review, medication administration observations were conducted on 501A, 502A, 508A, 508B, 510A, 510B, 516E, and 516W. As noted in the baseline review, observation of medication passes revealed numerous problems with nurses' compliance with standards of practice and the Health Care Guidelines. • Nurses did not consistently wash and/or sanitize their hands prior to pouring medications and/or between contacts with individuals. • Nurses were observed setting up and, sometimes, documenting the individuals' receipt of medications on the Medication Administration Records (MARs) prior to administration. • As noted in the baseline review, again, one of the staff nurses (516W) misrepresented the facility's policy to the monitoring team and reported, "We (the nurses) are allowed" to set up medications in advance because the medications needed time to dissolve prior to administration, even though the medications were liquid and/or had been crushed. • Pre-poured medications were transported to the individuals' bedrooms without the MAR, and administered by a nurse who was not the nurse who poured the medications. • When the nurses administered medications via enteral tube, at no time did the nurses check for placement of the tube by injecting air into the tube and listening for the air to pass with a stethoscope. • When individuals were "guests" on another unit, their medications, including topical ointments, creams, etc., and MARs were not consistently transferred from their home unit to the guest unit in a timely manner. Thus, it was observed on 510B that a nurse administered medication without the "guest's" MAR and without his/her medications. In this instance, the nurse "borrowed" medication	Noncompliance

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		from another individual on the home and administered it to the "guest" on the unit. • During several medication pass observations, the LVNs who administered medications failed to demonstrate a basic knowledge and/or understanding of the pertinent health conditions of the individuals they treated, save for the LVNs who had worked at the facility for several years. Notably, the LVNs who did not know the individuals reported that they did not need to know the individuals (emphasis added) because they were "just passing medications." All of the 25 individuals reviewed had a SAM (self-administration of medication) assessment and designation filed in their record. During the observations of medication administration, most individuals were treated with respect, however, there were little to no distinctions made between the individuals who had abilities to participate more versus the individuals who had abilities to participate less in the self-administration of medications. According to the Nurse Educator, several months ago, the Chief Nurse Executive recommended quarterly monitoring of the RNs and monthly monitoring of the LVN's medication administration practice to increase oversight and address deficiencies in practice. The results of the medication monitoring reviews were filed in the nurses' personnel files. According to a review of these reports, not one of the monitoring reviews has resulted in a score less than perfect/near-perfect. The review of the 25 sample individuals' November 2010 MARs revealed the following problems: • Individual #134's 11/13/10 8:00 am vitamin D was not signed as given. • Individual #344's 11/10/10 8:00 am chlorhexidine mouthwash, 11/2/10 8:00 pm, 11/7/10 8:00 am and 8:00 pm, and 11/15/10 8:00 pm timolol maleate .5% eye drops were not signed as given. • Individual #60's 11/1-11/17/10 lactaid one tab six times a day and 11/11/10 and 11/16/10 levoxyl were not signed as given. • Individual #385's 11/10/10 8:00 pm valproic acid 1000 mg, 11/10/10 hs clonazepam 4 mg, 11/10/10 8:00 pm lamotrigine 100mg, 11/10/10 8:00 pm propranolol hcl 40 mg, 11/10/10 8:00 pm Metamucil wafer, and 11/10/10 8:00 pm Seroquel 200 mg were not signed as given. • Individual #38's 11/5/10 7:00 am, 11/9/10 5:00 pm Lactaid chew, 11/5/10 8:00 am budesonide, 11/5/10, 11/9/10 8:00 am calcarb 600 mg, 11/5/10 8:00 am Vitamin D, 11/5/10 8:00 am, 12:00 n and 11/9/10 4:00 pm and 8:00 pm Benadryl 100 mg, 11/5/10 8:00 am Calcidol plus, 11/5/10 8:00 am levothroxine sodium 75 mcg, 11/5/10 8:00 am Mag Delay, 11/5/10 8:00 am and 12:00 n	

#	Provision	Assessment of Status	Compliance
		percogesic, 11/5/10 8:00 am multivitamin, 11/5/10 8:00 am Zyprexa, 11/5/10 8:00 am protonix 40 mg, 11/5/10 8:00 am miralax, 11/5/10 8:00 am prednisone 10 mg, 11/5/10 8:00 am lyrica 150 mg, 11/5/10 8:00 am sucralfate 1 gm, 11/5/10 7:00 am and 11:30 am sulfasalazine 1000 mg, 11/5/10 8:00 am and 12:00 n tizanidine hcl 8:00 mg, and 11/5/10 8:00 am and 12:00 n tramadol 50 mg were not signed as given. • Individual #325's 11/5/10 12:00 n lactinex, 11/5/10 12:00 n refresh eye drops, 11/5/10 12:00 n cyproheptadine hcl, 11/5/10 11:30 KCL, 11/5/10 12:00 n simethicone, and 11/4/10 and 11/11/10 7:00 am insulin lispro were not signed as given. • Individual #203's 11/5/10 12:00 n lactinex, 11/12/10 and 11/13/10 guaifenesin, 11/5/10 12:00 n tizanidine, and 11/5/10 12:00 n albuterol were not signed as given. • Individual #127's 11/14/10 8:00 pm Exelon was not signed as given. • Individual #116's 11/3/10 5:00 pm metformin hcl and 11/3/10 8:00 pm oxcarbazepine were not signed as given. • Individual #137's 11/10/10 and 11/14/10 gentamycin eye drops, 11/15/10 7:00 am and 12:00 n omega-3, protonix, and altace were not signed as given. • Individual #206's 11/15/10 8:00 am Depakote 500 mg was not signed as given. • Individual 114's 11/2/10 and 11/7/10 8:00 pm docusate sodium, 11/5/10 8:00 am and 12:00 n Haldol 10 mg, 11/2/10, 11/6/10, 11/7/10, 11/8/10 Necon birth control, 11/2/10 8:00 pm protonix, and 11/5/10, 8:00 am vitamin D were not signed as given. • Individual #116 did not have her blood pressure documented on the MAR as ordered; Individual #325 and #203 did not have their weekly weights documented on the MARs as ordered; and Individual #346 did not have his blood sugar documented on the MAR as ordered. The Nurse Educator maintained a comprehensive database on reported medication errors. The database included the date, time, location, type, severity, cause, and contributing factors related to the medication error. According to her database, in September 2010, there were five medication errors reported, and in October 2010, there were 16 medication errors reported. Almost all of the reported errors were due to "omission," or failure of the individual(s) to receive their prescribed medication(s). During the monitoring team's interview with the Nurse Educator, Medical Director, Pharmacy Director, and acting Chief Nursing Executive, it was clarified that medication errors had not been analyzed over time, and error rates had not been calculated. In fact, according to the Pharmacy Director, the number of medications dispensed per month by the pharmacy had not been calculated.	

#	Provision	Assessment of Status	Compliance
		It was also learned that the overage/shortage medication sheets, which were forms completed by unit nurses to capture the number of each and every medication per individual that was not accounted for at the time medications were dispensed/delivered by the pharmacy, were "piled up" in the pharmacy, and had not been examined or analyzed for patterns/trends. During the review, on 11/16/10, on 508A, the nurse completed medication "over/short forms" for 13 of the 18 individuals who reside on the unit. Each form (100%) referenced anywhere from one to eight medications per individual where there were discrepancies (usually "overages") in the individuals' medications on hand at the time of the pharmacy's delivery of medications. The medications returned to the pharmacy included medications for thyroid, cardiovascular, respiratory, and gastrointestinal disorders and medications to treat diabetes, constipation, anemia hypertension, etc. None of these medications were accounted for or reconciled with the individuals' MARs. According to the Pharmacy Director, on a monthly basis, hundreds, if not thousands, of medications are unaccounted for and returned to the pharmacy. When the Pharmacy Director was asked what he did with the medications that were returned to the pharmacy, he replied that he destroyed them. As noted in Section M4, the Medication PIT was developed during the Summer of 2010 to identify and address problems related to medication administration and accountability. The team members included nursing leadership, an RN case manager, a unit LVN, and a home manager. To date, the team had completed a medication error survey and reviewed/revised the facility's Medication Administration Policy and Procedure. However, for several months, the team had made repeated recommendations for revisions to the Transcription of Orders/MARs Policy, the process of identification of individuals during medication administration, the scheduled time(s) of medication administration, and the performance of a skit for nursing department staff members. The team also repeatedly requested that a representative from the pharmacy department attend the meeting because their recommendations to stagger the medication times and training of pharmacy staff in the WorX program would not go forward until the pharmacy representative attended the team meeting and provided input and consultation to the team. A representative from the pharmacy department attended the 11/16/10 Medication PIT meeting and reported that the pharmacy staff members were unaware of how to change medication times in WorX. According to the pharmacy director, none of the pharmacy	

#	Provision	Assessment of Status	Compliance
		staff members had received training in the pharmacy software program – WorX, and were not aware of how the system could be modified to reduce medication errors.	

Recommendations:

1. The facility should take immediate action to address the nursing shortage. It should also develop a strategic plan to, over time, reduce the nursing shortage and implement recruitment and retention strategies that provide long-term solutions to the nursing shortage.

2. The facility should actively seek to fill the vacant Nurse Recruiter position.

3. The Nursing Department should address the practice deficiencies that have increased over time, both related and unrelated to the nursing shortage. The "short-cuts," "timesavers," and other peculiar habits, which were noted during the review are dangerous practices, and they should stop.

4. Documentation, particularly the SOAP charting as specified in the Health Care Guidelines, needs to be trained and monitored until nurses are implementing the process more systematically. The facility should consider developing a process for unit nurses to review individual records for SOAP charting and provide feedback to one another on the quality of that documentation.

5. The facility's Nurse Educator should conduct a mandatory training for all nurses regarding the facility's expectations for timely identification, reporting, addressing, evaluating, and following-up to resolution significant changes that occur in individuals' health status, as these expectations have been articulated by the facility's policies and Health Care Guidelines.

6. Ensure that nursing assessments are accurate, complete, comprehensive and updated when there are significant changes in the individual's health status and/or functioning.

7. The HMPs stock care plans need to be individualized with interventions, timeframes, goals and desired health outcomes and developed with evidence of the individual's participation.

8. Nurse case managers should ensure complete information to the individual's PST during the PSP process, including, but not limited to, findings of the nursing assessment, individual's response to planned interventions, and progress/lack of progress made toward desired health outcomes.

9. The QA Department should re-evaluate the effectiveness of the Medication Administration monitoring tool, since conducting more of the same has not resulted in correction of and/or improvement in practice deficiencies and medication errors.

10. The Infection Control Nurse needs to be provided with the information and tools to do her job, including, but not limited to, access to immunization database, clarification of expectations regarding infection control monitoring processes, corrective actions, and outcomes to be achieved within specified time frames, and mentorship by an experienced Infection Control Nurse.

11. Nursing Department, Medication PIT, and the Pharmacy and Therapeutics Committee should combine efforts to identify the nature and scope of medication variance at the facility. This may include, processes to better identify, report, and calculate medication errors, calculation of the medication error rate, reconciliation of the monthly overages/shortages of medications, evaluation of the current practice of destroying hundreds, if not thousands, of medications every month, and research and propose to the facility administrator several options for a more current medication administration system that supports medication administration practices, which are safe, accountable, and cost-effective.

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: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o SGSSLC Policy#5.2.35: Quarterly Drug Regimen Reviews, Revised 7/10/09 o SGSSLC Policy #1.1.07: Pharmacy and Therapeutics Committee, Revised 3/10/06 o Pharmacy and Therapeutics Committee Meeting Minutes, 3/16/10, 7/1/2010 o Medication Error Performance Improvement Team Meeting Notes, 8/10/10, 8/17/10, 8/24/10, 9/14/10, 9/21/10, 10/5/10, 11/12/10 o Quarterly Drug Regimen Reviews, MOSES and DISCUS forms for the following individuals: • Individual #60, Individual #251, Individual #222, Individual #385, Individual #185, Individual #170, Individual #75, Individual #288, Individual #344, Individual #173, Individual #389, Individual #206, Individual #346, Individual #90, Individual #109, Individual #203, Individual #104, Individual #217, Individual #69, Individual #248 o Drug Utilization Evaluations for the following drugs: • Reglan • Thorazine Interviews and Meetings Held: o Don Conoly, R.Ph., Pharmacy Director o Rebecca McKown, MD, Medical Director o David Bessman, MD, Primary Care Physician o John Burnside, MD, Primary Care Physician o James Sikes, MD, Psychiatrist o Pam Tanner, Advanced Practice Nurse, Psychiatry o Lisa Busbee, RN, Nurse Operations Officer o Lisa Owen, RN, Quality Enhancement Nurse o Maria DeLuna, RN, Nurse Educator o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator o Medication Error Performance Improvement Team meeting Observations Conducted: o Tour of pharmacy o Informal observations of medication administration
	Facility Self-Assessment: The facility's self-assessment POI for Provision N found all items to be in noncompliance. Observations,

	multiple interviews, and review of many documents resulted in the monitoring team's agreement with the rating of noncompliance.
	Summary of Monitor's Assessment: The pharmacy was staffed with a pharmacy director, pharmacist, and three pharmacy technicians. The pharmacy director reported directly to the medical director and, according to him, there had been many attempts to hire a clinical pharmacist over the past year. The facility was negotiating with a clinical pharmacist at the time of the onsite review and the pharmacy director believed that one would be hired by the end of November 2010. Little progress had been made since the baseline visit. The pharmacy director expressed that he was overwhelmed by his duties and felt that many of the requirements related to the Settlement Agreement were beyond the scope of his practice. He reported that he had little guidance in carrying out these duties and was functioning as best possible. Statewide conference calls involving all pharmacy directors had proven beneficial, but had not occurred in recent months. Significant issues were noted in every section of this provision: • There was no documentary evidence that all medication orders received the appropriate reviews. • Drug regimen reviews were not being completed in a timely manner and many were appearing in the records four to eight months after the due dates. • Primary care providers did not comply with the requirement to agree or disagree with the recommendations of the pharmacists. • The facility had not established a system for detecting, monitoring, and reporting adverse drug reactions. • The drug utilization evaluations completed were rudimentary and the system did not meet the requirements of the Health Care Guidelines. • Two serious medication errors resulting in hospitalization had occurred in the month prior to the onsite review.

#	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	The pharmacy was staffed with a pharmacy director, pharmacist, and three pharmacy technicians. According to the pharmacy director, there had been many attempts to hire a clinical pharmacist over the past year. The facility was negotiating with a clinical pharmacist at the time of the onsite review and the pharmacy director believed that one would be hired by the end of November. The pharmacy director described the following process for filling medication orders: 1. Orders were faxed to the pharmacy and received by the pharmacy technicians. 2. The technician called the nurse to verify the order if there were problems with	Noncompliance

#	Provision	Assessment of Status	Compliance
	health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	the order. Clarification was written on the order sheet maintained in the pharmacy. If there were major problems, the pharmacist called the physician. 3. The technician entered the order into WORx. 4. The pharmacist received the order with the label and verified the order. Alerts generated were printed out and placed with the order for review by the pharmacist. 5. If there were problems with the order, the pharmacist would contact the nurse for clarification. The prescriber would be contacted if there was an issue, such as a drug interaction. The pharmacy director documented clarification on the physician order form. The physician order sheet was the only place that communication with the prescriber was documented. The pharmacy director was not familiar with the Single Patient Intervention Report and its use to document and track communication with practitioners, information provided, and responses. The pharmacy director stated that the department was in need of training on how to utilize the WORx system. He was aware that other facilities were generating reports because he relied on another director at another facility to generate his polypharmacy reports.	
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.	Drug regimen reviews were completed by the pharmacy director. During interviews with the monitoring team, the pharmacy director openly expressed that this function was beyond the scope of his training. Drug Regimen Reviews were found in all of the records reviewed. There were multiple issues related to these reviews. Many of the concerns related to the timeliness of completion based on the dates recorded on the reviews and dates of receipt stamped on the documents. The following findings were noted: • The DRRs were not completed in a timely manner. There were numerous documents that were received many months after the dates of completion based on the time stamp. The reviews did not state the date completed. The form stated "review period" and a specific date was recorded. Several of the reviews contained notations from the psychiatry providers that the review was just being received. The primary care providers made no comments related to date discrepancies. • The primary care providers rarely noted agreement or disagreement with recommendations. • The QA Department completed audits of pharmacy services utilizing the monitoring team's checklist. In five of six (83%) of the records reviewed by the	Noncompliance

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		facility, it was recorded that the DRRs were out of date. The facility audit of Individual #75 documented that DRRs for 11/24/08 and 2/20/09 were in the record. This audit was completed on 6/4/10. The records provided to the monitoring team in November 2010 contained DRRs dated 7/26/10, 2/20/10, and 1/27/10. Clearly, the latter two reviews were not present in the record on 6/24/10. This finding is consistent with observation that DRRs were being received by medical/psychiatric services many months after the date recorded on the reviews. The QA audit provided in section L4 provides information on similar findings in another record.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The quarterly drug regimen reviews included information on the use of polypharmacy and benzodiazepines. The reviews were not completed by a clinical pharmacist and, as a result, very little could be stated relative to the clinical justification for use of these drugs. The drug regimen reviews did not contain information on the anticholinergic burden for the individuals. The Polypharmacy Committee met every Thursday. This meeting had been recently implemented. The meeting was attended by the monitoring team. It appeared that little substantive discussion occurred. A suggestion by a facility staff member to engage in a discussion about polypharmacy justification was abandoned in favor of reading a document that contained the individuals for review and the pre-determined justifications. This information was only available to those who actually attended the meeting and was not recorded in the records of the individuals. The meeting in its current format did little to satisfy the requirements of this provision item. The Pharmacy and Therapeutics Committee meeting notes of 3/16/10 documented that no reports were available due to the lack of a database. This comment was reiterated in subsequent meeting minutes.	Noncompliance
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	The format of the drug regimen reviews required prescribing providers to indicate agreement or disagreement with the recommendations of the pharmacist. If the physician disagreed, an explanation was required on the form. The primary care providers signed the majority of the DRRs reviewed in the records. The boxes indicating agreement or disagreement with the recommendations of the pharmacist were consistently left blank. Very few were appropriately checked. The psychiatry providers indicated agreement or disagreement on a greater number of the forms. Psychiatry was provided the DRRs in several cases where psychotropics were not prescribed.	Noncompliance

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	recommendation is not followed.	The Pharmacy and Therapeutics Committee meeting notes of 3/16/10 documented audits of physician responses as a discussion topic and indicated that audit results would be brought to the meeting. The audit results were not documented in subsequent meeting notes.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The record sample listed in section L was reviewed for the presence of MOSES and DISCUS scales when appropriate. Overall, the documents were being completed. The prescribing providers were signing the documents, but did not check any responses on the majority of the documents. Information from the rating tools did not appear to be utilized in any manner, as there was no reference to this information in the integrated progress notes or annual medical assessments. The Pharmacy and Therapeutics Committee meeting notes of 3/16/10 documented the monitoring of MOSES and DISCUS as a discussion topic. The 3/16/10 notes stated that the audit of DISCUS for AEDs would be presented at the next meeting. The audits were not found in subsequent meeting notes.	Noncompliance
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.	The pharmacy director indicated that no adverse drug reactions had been reported at the facility. There was no process in place for detection, reporting, and monitoring of adverse drug reactions. The facility had recently received an ADR draft policy from the El Paso SSLC. That procedure was being reviewed for use at the facility and should be helpful to SGSSLC. Although the pharmacy director reported that no ADRs were reported, the Pharmacy and Therapeutics Committee meeting minutes documented an adverse drug reaction to morphine. This same reaction was reported in all minutes, but no additional information was available.	Noncompliance
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	The facility's POI indicated that the Pharmacy and Therapeutics Committee approved a process in April 2010 for completion of DUEs. The DUEs were to be completed every six months. The pharmacy director could not provide a calendar for future reviews and the process approved by the P&T Committee had not been codified into policy and procedure. At the time of the on site review, The facility had completed drug utilization evaluations on Thorazine and Reglan: • Reglan – Audit criteria included indication, dose, route, side effects and labs. • Thorazine - Audit criteria included BMI, fasting blood glucose (FBG), HbA1c, lipid	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	panel, EKG, EPS evaluation, tardive dyskinesia evaluation, ocular evaluation, and dose. • No corrective actions were taken if compliance rates were 80% or greater. P&T Committee minutes documented that corrective actions for the Reglan DUE included retraining nurses on the DISCUS requirements. MOSES is to be completed every six months and the DISCUS every three months. No corrective actions were deemed necessary for the Thorazine DUE. The following DUE results were reported: • Reglan, n=4 o Indications listed – GERD (2), GI motility, N/V o Doses listed o Route – PEG (2), PO (2) o Side Effects (MOSES/DISCUS) – Yes 4/4 o Labs (creatinine) – Yes 4/4 • Thorazine, n=5 o 0 of 5 charts showed ocular problems o 1 of 5 charts had no BMI o 1 0f 5 charts had no FBG o 3 0f 5 charts had no HbA1c o 5 of 5 charts had lipid panels o 5 of 5 charts had EKG o 5 of 5 charts had MOSES/DISCUS o 5 of 5 charts had eye evaluation o 5 of 5 charts had dosing according to guidelines Several concerns were identified with the process of completing DUEs: • The methodology was not provided. The rationale and objective for completing the audits were not stated. • Results were presented in a chart that was not accompanied by any narrative or explanation of the findings. • There was also no explanation for the sample sizes. • In cases were there was a deficiency, there was no indication that the primary provider was notified of individual-specific data so that corrective action could be taken. • The dates of the actual reviews were not provided. The Health Care Guidelines state that high risk and high use drugs should be given priority for drug utilization evaluations.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N8</td><td>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.</td><td>The facility had taken several steps in order to address the problem of medication errors.

Copies of two sets of Pharmacy and Therapeutics Committee meeting minutes were provided to the monitoring team. The dates were 7/1/10 and 3/16/10. An additional document, dated 10/26/10, appeared to be an agenda. The content of the documents was identical with the exception of the follow-up meeting dates and documentation of attendance. The medication variance discussion was limited to reporting of the numbers for January 2010 through March 2010. Again, the same information was repeated in all of the documents.

The following numbers were taken from documents provided by the nurse educator:

<table>
<tr><td colspan="10">Total Medication Variances 2010</td></tr>
<tr><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>14</td><td>10</td><td>5</td><td>8</td><td>10</td><td>10</td><td>21</td><td>25</td><td>5</td><td>16</td></tr>
</table>

The medication error performance improvement team met weekly. The monitoring team observed this meeting. Participants included nursing management, direct care nurses, the QA nurse, and direct care professionals. This meeting was organized, thoughtfully conducted, and began with an explanation of the rules and introduction of new participants. The result was a succinct meeting that included engaging discussion related to problems of medication variances. The corrective actions discussed were driven by data analysis. Corrective actions included systems changes related to medication dispensing and administration. The facility had been in contact with DADS state office regarding concerns about the WORx system and how the system could be modified to improve services at the facility.

In spite of these efforts, two serious medication errors had occurred just weeks prior to the onsite review. Both resulted in hospitalizations. One individual experienced aspiration as a result of somnolence after receiving another individual's medication. The individual deteriorated while at the facility and was transferred to the local hospital. Intubation and mechanical ventilation was required. The facility had taken all of the necessary steps related to these events. The nurses involved were removed from duty. As these were critical incidents, they required that root cause analysis be conducted. The state office nursing services coordinator indicated that the investigations were in the final stages at the time of the onsite review. Both individuals appeared to be on the path to full recovery.

Another area of concern related to medication variances was the issue of overages and shortages. The nursing department recognized this as a problem and had prioritized its</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		approach to the issues related to medication variances. Discussion in the meeting indicated that further analysis of this issue would occur in the near future. The facility will need to continue to collect data and perform proper analysis. The problem of overages and shortages must be considered a priority. Until the data on this problematic area is clarified, the extent of the medication variances will remain unknown.	

Recommendations:

1. The Pharmacy Department must implement a system to ensure that all verifications are being completed. There must also be a process to document that this is being completed. The department staff must receive training on the capabilities of the WORx system including the Single Patient Intervention Reports.

2. A clinical pharmacist must be hired to assist with completion of drug regimen reviews and drug utilization evaluations.

3. An ADR reporting and monitoring system should be developed.
    a. This is a comprehensive program that requires reporting by all healthcare practitioners, not just pharmacy staff.
    b. A data collection tool is needed to assist staff in detecting and reporting suspected ADRs. The tool should include a probability scale, a severity scale, and individual outcome thresholds.
    c. The outcome thresholds should be used to conduct intense case analysis.
    d. All data should be reviewed by the P&T Committee and submitted to the facility's quality department.

4. The medication error PIT should continue to analyze data and implement corrective actions. The problem of overages and shortages must be rigorously pursued as this represents a potentially serious problem. This should be considered an urgent problem.

5. The facility will need to thoroughly review the root cause analysis conducted related to the medication variances to ensure that appropriate corrective actions are taken to address any systemic issues that contributed to the variance. There should be follow-up on the corrective actions by nursing services, the QA Department, facility administration, and state office.

6. The Drug Use Evaluation system must be developed to fulfill the requirements of the Health Care Guidelines. The Pharmacy and Therapeutics Committee should provide oversight for the system. The medical director should have an active role in the process including a review of data prior to presentation at the P&T Committee meeting.

7. The agency's Drug Regimen Review system must be evaluated. The reviews, if more substantial in content, could provide valuable resources to clinicians. The revision process should include input from the medical staff. The use of computer software for completion of these reviews should be explored. While a clinical pharmacist is not required to complete a basic drug regimen review, the drug regimens for the individuals supported by the facility are complex and through reviews are required to meet the requirements of the Settlement Agreement. A clinical pharmacist is needed to conduct such reviews.

8. The facility must ensure that there is legitimate oversight related to the use of polypharmacy. The Pharmacy and Therapeutics minutes provided no data related to justification and the polypharmacy meeting attended by the monitoring team did not meet the requirements of the Settlement Agreement. The hiring of a clinical pharmacist will be a critical component in achieving resolution to this problem.

9. The results of the side effect rating tools should be incorporated into the evaluation and treatment decisions for medical, psychiatry, and neurology practices. The medical director should work with the nursing department to ensure that more meaningful reviews are completed. The medical director must also convey to the medical staff the importance of adequate monitoring for side effects when individuals are treated with antipsychotics and AEDS.

10. The facility must examine the current function of the Pharmacy and Therapeutics Committee. Meetings must occur regularly and accurate documentation of the meetings should be disseminated to committee members and the facility administrator. Meeting minutes should be reviewed by the committee chair for content and accuracy prior to signing.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Clinical Staff list and PNMT members o Continuing Education documentation for clinical staff o PNMT initial training outline o PNMT draft policy, draft assessment format and assessment sample o SGSSLC POI and Supplement o POC for Mock Survey related to O, P, and R o QA Audit reports for sections O, P, and R o Presentation Book for Section O o Draft PNM Assessment and monitoring timelines o NMC meeting minutes o HST meeting minutes o PNMP Clinic Report template o NEO Training modules with checklists and competency tests o Dysphagia and Mealtime Training module o PNM training rosters submitted o Quality Improvement Council Agenda o PNM spreadsheets o OT/PT spreadsheets o List of PNM assessments completed in the last quarter o PNMP Clinic Reports submitted o PNMP Clinic Summaries o PNM Maintenance Log o MBSS reports and plans submitted o List of individuals with Orthotics and Braces o Individuals Who Use Ambulation Devices o Individuals Who Use Transport Wheelchairs o Individuals Who Use a Wheelchair as Primary Mobility o Non-Ambulatory - Assisted Ambulation Risk Levels o Individuals Who Require Mealtime Assistance o Falls list (10/8/10) o At Risk Individuals – Injury o At Risk – Impaction/Bowel Obstruction/Constipation o At Risk – Dehydration o At Risk- Choking o At Risk – Aspiration

	○ Deaths since 1/1/10 ○ Poor Dental Status Individual List ○ Individuals with diet downgrade change – 12 months ○ Modified diets and thickened liquids list ○ Pneumonia list ○ Follow-up Documentation for all Choking Events since 1/1/10 ○ Choking event list ○ Fractures 1/1/10 – 10/4/10 ○ Follow-up Documentation for Falls and/or Fractures in last six months for: • Individual #379, Individual #186, Individual #93, Individual #95, Individual #302, Individual #322, Individual #288, Individual #318, Individual #153, Individual #26, Individual #256, Individual #312, Individual #50, and Individual #34 ○ At Risk Individuals HST Risk Levels ○ List of individuals At Risk for Skin Breakdown/Decubitus Ulcer ○ At Risk Individuals – Osteoporosis/Osteopenia ○ Enteral Feedings list ○ Individuals with BMI less than 20 ○ BMI greater than 30 ○ Individuals with Unplanned Weight Loss or greater ○ Infirmary list ○ Emergency Room list ○ Hospitalization list ○ Decubitus Report for Sept 2009 – Sept 2010 ○ Mat evaluation and simulation report for Individual #164 ○ Dining Plans submitted with training sheets ○ PNMPs submitted ○ PNMP Progress Notes Monthly submitted ○ PNMP Monitoring Tools (Mealtime, Lifting/Transferring, Bathing, Off-Home) ○ Mealtime Monitoring Drill forms completed ○ PNMP Monitoring – Therapist Monitoring July 2010 – September 2010 ○ PNMP Monitoring Forms completed 9/10 – 11/10 ○ PNMP Monthly Monitoring Log ○ Lifting/Transferring Log ○ Lifting Monitoring Database ○ Bathing Monitoring Database ○ Bathing Monitoring Report July 2010 ○ PNMP Clinic Documentation for Individual #66 and Individual #128 ○ PNMP Workgroup Committee Summary (5/10/10, 5/24/10, 6/7/10, 6/21/10, 7/5/10, 7/19/10, 8/2/10, 8/16/10, 9/13/10 and 10/25/10) ○ Skin Integrity Team Committee meeting minutes 5/26/10 -11/17/10) ○ OT/PT Assessments and other documentation for the following individuals: • Individual #126, Individual #106, Individual #146, Individual #382, Individual #14,

	Individual #219, Individual #164, Individual #318, Individual #293, Individual #383, Individual #61, Individual #196, Individual #330, Individual #347, Individual #298, Individual #239, Individual #379, Individual #120, Individual #341, Individual #214, Individual #294 and Individual #99 o Personal Records for sample of individuals including: Fall Prevention Risk Assessment, PSP and all Addendums, PNMP Monthly Progress Notes, PSP Quarterly Reviews, History and Management Plan/Physical Examination, Hospitalization Discharge Summaries, Health Risk Assessment Rating Tool, Annual comprehensive Nursing Assessments, Quarterly Nursing Assessments, Habilitation Therapy section of record, Integrated Progress notes for past 12 months, 12 months weight history, PNMPs for last 12 months, Dining Plans for last 12 months as submitted for: • Individual #164, Individual #66, Individual #7, Individual #109, Individual #203, Individual #373, Individual #217, Individual #150, Individual #173, Individual #78, Individual #352, Individual #206, Individual #278, Individual #2, Individual #90, Individual #25, Individual #318, Individual #334, Individual #122, Individual #344, Individual #181, Individual #46, Individual #314, Individual #271 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR Director of Rehabilitation Therapy Services o Charis Worden, OTR o Judy Perkins, PT o Cindy Bolen, PT o Various Supervisors and Direct Support Staff o Meeting with OTs and PTs o Skin Integrity Meeting o Quality Improvement Council meeting (11/15/10) o NMC meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Habilitation Therapies clinic areas o PNMP Clinic
	Facility Self-Assessment: SGSSLC's self-assessment identified noncompliance for all items of this provision with one exception. The facility indicated that all individuals were assessed upon admission to SGSSLC. Systems were in the process of development particularly the new PNMT process. This self-assessment was consistent with the monitoring team's assessment of noncompliance. A new PNMT process was in development.

	Summary of Monitor's Assessment: The process used to establish health risks continued to be inconsistent across the HST and NMT. A new system for risk assessment had been developed, but was not yet in place statewide. There was also a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT). SGSSLC had identified the team members and a meeting was scheduled for 12/15/10. The existing NMC functions were to be integrated into the PSP process within the next month. In addition, the health risk assessment system was also being revised and a trial was being conducted at the time of this onsite review. Review of this process as implemented at SGSSLC will be necessary as the new systems for Health Risk Assessment and PNMT review are established during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team expects that these issues will be resolved as the new systems are implemented in the near future. There were observable improvements at mealtimes and more so related to positioning. There continued to be some inconsistencies as information did not also match across each of the plans. There continued to be room for improvement and a clear need for competency-based staff training and monitoring of compliance. The PNMPCs were not consistently identifying errors noted by the monitoring team that should have been recognized and remedied. Staff training continued to be more focused on information rather than skills necessary to appropriately implement PNMPs. PNMPC training will be a critical element to the overall success relative to PNM supports and services.

#	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	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** By report, SGSSLC had recently begun the process for the development of an integrated Physical Nutritional Management Team (PNMT). The intended function of the team was to address individuals whose identified health status placed them at a high risk of potential or actual injury and/or illness. The initial step in this process was to identify PNMT members. The core members of the newly established Physical Nutritional Management Team (PNMT) included the following: • Cindy Bolen, PT • Susan Holler, MS, CCC/SLP • Dena Johnston, OTR • Judy Perkins, PT • Sally Smith LD, MBA • Charis Worden, OTR Lisa Busbee, RN, NOO was listed as a temporary member as of 9/29/10. It was reported at the time of the onsite review, however, that the hospital liaison had been finalized as	Noncompliance

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	PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	the permanent nursing member of the team. Brandy Schmedecke, PNMPC, was identified as the team scribe. Though not listed, it was reported that Dr. Bessman would serve as the physician member of the team. Additional adjunct members included other physicians, nurse case managers, QMRPs, PNMPCs, and direct support staff as indicated depending on which individual was to be reviewed by the PNMT. Continuing Education in 2010 related to PNM for these team members was identified as the following: Judy Perkins, PT: .67 continuing education credits • PNMP and Wheelchair Clinic Teleconference (1/13, 1/20, 1/25, 1/27, 2/3, 2/8, 2/22, 4/5, 4/26, 5/3, 5/5, 5/10) Cindy Bolen, PT: 7.57 continuing education credits • Fall Prevention (8/17/10) • PNMP and Wheelchair Clinic Teleconference (1/13, 1/25, 1/27, 2/8, 2/22, 2/24, 4/5, 4/26, 5/3, 5/10) • Annual Habilitation Therapy Conference 10/11/10) Dena Johnston, OTR: 15.0 continuing education credits • Laboratory Assessment of Nutritional Status (7/7/10) • PNMP and Wheelchair Clinic Teleconference (1/13, 1/20, 1/25, 1/27, 2/3, 2/22, 2/24, 4/5, 4/14, 4/26, 5/3, 5/5, 5/10) Charis Worden, OTR: 9.7 continuing education units • PNMP and Wheelchair Clinic Teleconference (1/13, 2/8, 2/22, 2/24, 4/14, 5/3, 5/5, 5/10) • PNMT Introduction/wound Investigation (8/13/10) Susan Holler, MS, CCC/SLP: 2.0 contact hours • Issues in Nutritional Management (7/7/10) Sally Smith, LD, MBA: 2.0 contact hours • PNMT Introduction/wound Investigation (8/13/10) Evidence of significant continuing education was submitted for the temporary PNMT nursing member, Lisa Busbee, RN, NOO, but none was submitted for the hospital liaison nurse who had been established as the permanent nursing team member. Current licenses were confirmed for the team members listed.	

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		The PNMT membership had just been recently established, but the process outlined in the draft state policy had not yet been initiated at the time of this onsite review. The next phase as identified by Dena Johnston, OTR, Habilitation Therapy Director, was to obtain specialized training for the team members to demonstrate competence in working with individuals with complex PNM needs. At the time of this review, it was reported that most of the existing team members had participated in this training and they planned to continue this phase until all training for each member was complete. This also included training as to team member roles on the PNMT. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** Nutritional Management Committee (NMC) meetings had been held routinely (38 meetings held since 1/1/10 through 10/25/10). Approximately 180 individuals had been reviewed by the NMC since the previous onsite visit by the monitoring team. There had been no action by the newly established PNMT to date. By report, the team was to conduct its first meeting on 12/15/10. The previous functions of specialized review teams such as the NMC and Skin Integrity Team would become a function of the PST. Many of the members of these specialized teams also served as PST members for individuals living at SGSSLC. There were two physical therapists providing services at SGSSLC and both were to serve on the PNMT as well as serve as clinical staff PTs. There were two OTRs, one serving as clinical staff and the other served as Director of Rehabilitation Therapies. Both were to serve on the PNMT and continue their current duties. There were three part-time contract SLPs. Two of these worked only one day a week. The third SLP, Susan Holler, MS, CCC/SLP, provided 32-35 hours weekly and per her admission had limited experience in the area of PNM. She was to serve on the PNMT as well as continue in her role related to communication services during her limited contract time. There was one dietitian, Sally Smith, LD, MBA who in addition to providing all nutrition services to every individual at SGSSLC, was to serve as the dietitian for the PNMT. The nurse assigned to the team also served as hospital liaison. There were approximately 161 (65%) of individuals identified with PNM needs per the spreadsheet submitted. The number of those with high PNM risk concerns was not clearly established as described above. It was of concern how these clinicians would be able to meet all of the roles and responsibilities outlined for them and adequately meet the PNM needs of the individuals at SGSSLC.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify	**Standard: A process is in place that identifies individuals with PNM concerns.** The process used to establish health risks was inconsistent across the HST and NMT. A new system for risk assessment had been developed and a trial had been set up at another	Noncompliance

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	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.	SSLC in the state. There was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT) with an implementation date of 9/1/10. The newly established PNMT process had not yet been initiated at SGSSLC at the time of this review. Further review of this system will occur during subsequent onsite monitoring visits. The existing system used at SGSSLC to identify risk was described as the following per documentation submitted: • High Risk: "If the individual has a diagnosis that requires frequent medication adjustments or change of medications, requires close monitoring of condition (labs, frequent v/s, etc.), is medically fragile and still having exacerbations or breakthrough episodes within the past 1 year should be assigned as a high risk." • Medium/Moderate Risk: "If the individual has a diagnosis that is being controlled and maintained (with or without Medications) and has an occasional or infrequent exacerbation or breakthrough episode &/or Medication Adjustments within the past 1 year then a moderate/medium risk should be assigned." • Low Risk: "If the individual has a diagnosis that is being controlled and maintained (with or without Medications) and has no exacerbations or breakthrough episodes and has not had any for 1 year then a low risk should be assigned." An additional document that was submitted with the At Risk lists stated that: • Individuals with a High Risk rating always had a care plan. • Individuals with a Medium Risk rating would most often have a care plan, but not always. • Individuals with a Low Risk rating would most often not have a care plan, but it was possible if circumstances warranted. Review of this process will be necessary as the new systems for Health Risk Assessment and PNMT review are implemented during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team expects that these issues will be resolved as the new systems are implemented in the near future. The existing risk identification process continued to be a concern. Some examples include: Choking: Per a list submitted, there were three individuals who experienced one or more choking events in the past 12 months. Individual #271 had experienced two such events during that period. Documentation of follow-up for each choking case since 1/1/10 was	

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		submitted as requested. Follow-up was not conducted for Individual #46 because it was determined that she had seizure-like behavior resulting in choking on food. It was of concern that no referral had been made to OT/PT for follow-up and to ensure that the existing plan was appropriate and met her needs. In the other two cases, Individual #314 and Individual #271, follow-up including a mealtime observation by OT occurred on the same date as the incident for Individual #314. There was no evidence of a mealtime observation for Individual #271. There was no evidence of a similar follow-up involving mealtime observation by OT or SLP after the event on 9/29/10. Further there was an NMC progress note dated 8/13/10 identifying a choking event on 2/12/10 that was not listed on the choking event list submitted. This event would make a total number of three choking events for Individual #271 in the last 12 months. His Rehabilitation Therapy Assessment Update on 9/14/10 stated that he had three choking events, two of which occurred in three months' time. This update further stated that there had been three choking events in the past two years. The dates of these events were not specified in the update. This update also identified that Individual #271 was considered at low risk for GI concerns though he had continued to lose weight (20 pound unplanned weight loss this past year), low hemoglobin and hematocrit, history of H-pylori, diagnosis of GERD, and esophageal dysphagia. An NMC progress note, dated 10/25/10, listed a choking event and referred to an EGD completed on 10/18/10 that identified multiple esophageal strictures and pending dilation. There was no evidence of PST follow-up meetings for any of these individuals submitted with the documentation requested. <u>Osteoporosis/Osteopenia</u>: There were only two individuals considered at high risk for osteoporosis or osteopenia (Individual #318 and Individual #25). Individual #25 had experienced a fracture of her left femur in February 2010. Individual #318 sustained a left ulna/radius fracture following a fall in April 2009. Another eight were considered at medium risk. There were 27 individuals who used a wheelchair for their primary means of mobility and, as such, would be considered non-ambulatory, and another 15 who used a wheelchair for transport or partially ambulatory and as such were potentially at greater risk of these conditions. Only four individuals were listed with care plans in place to address osteoporosis/osteopenia. <u>Falls</u>: There were only seven individuals who were considered at high risk for injury and another 33 who were considered to be at medium risk. There were at least 21 individuals who had been listed with five or more falls in the past year, most of who were identified with non-serious injuries, though five individuals had experienced serious fall-related injuries (Individual #186, Individual #288, Individual #382, Individual #258 and Individual #229).	

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		The accuracy of these data was in question and there may have been numerous additional falls that were not included on the list submitted. For example, there were approximately 35 or more entries related to falls in the integrated progress notes for Individual #7 from 11/3/09 to 11/15/10. A PST meeting had been held on 9/3 after she had fallen three times on 9/2/10, none of which were included on this list. She was listed at medium risk for injury. While it was understood that risk of injury may be related to a variety of factors, frequent falls should be considered one of those. The number of falls listed for the 21 individuals referenced above ranged from five to 21 (Individual #98). She, however, was listed at only medium risk of injury. Individual #302 (7 falls), Individual #294 (6), Individual #104 (6), and Individual #229 (7) had each experienced more than five falls, but were also listed at medium risk for injury. A number of others had five or more falls and were identified only at low risk for injury. This included the following individuals: Individual #194 (5), Individual #95 (5), Individual #271 (5), Individual #391 (9), Individual #18 (5), Individual #277 (7) and Individual #258 (7). <u>Aspiration Pneumonia</u>: There were 10 individuals who had experienced one or more incidents of pneumonia in the last 12 months per the list submitted, dated 10/5/10. None were identified as aspiration pneumonia. Three of these incidents were listed as either bacterial or viral pneumonia, two were listed as "community acquired," and the other seven were listed as "other." Three of the seven were nourished enterally and the others received a modified diet orally. Individual #109, Individual #203, Individual #373, Individual #217, Individual #150 and Individual #173 had non-specified pneumonia since 1/2/10 through 10/5/10. Individual #90 was hospitalized from 4/3/10 to 4/9/10 for pneumonia, but was not included on the Pneumonia Tracking list, dated 10/5/10. She was considered at high risk for aspiration. Individual #352 was admitted to the Infirmary on 1/25/10 and 3/16/10 with a diagnosis of pneumonia, but he was not included on the list of pneumonia incidents submitted. Individual #89 had been admitted to the hospital with a diagnosis of pneumonia on 2/22/10, but was not included on the list of pneumonia incidents submitted. Individual #150 was hospitalized from 5/29/10 -6/2/10 with "pneumonia, acquired" per the hospitalization list, but the Pneumonia Tracking list indicated that the type of pneumonia was not specified. There were 10 individuals listed as at high risk for aspiration and included Individual #78, Individual #373, Individual #38, Individual #90, and Individual #203. Two others identified with pneumonia since 1/2/10 were identified at medium risk (Individual #109 and Individual #217) and one was identified at low risk (Individual #150). Though Individual #238 was listed with pneumonia, it was categorized as bacterial and he may not have been at ongoing risk of aspiration and was listed at low risk. Individual #173 was listed at low risk for aspiration. Individual #90 as listed also at high risk for chronic respiratory infections. <u>Weight Loss/Gain</u>:	

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		There were six individuals identified at high risk for weight loss or gain and included Individual #170, Individual #137, Individual #301, Individual #158, Individual #344, and Individual #254, yet five other individuals had experienced an unplanned weight loss of 10% of greater. Two of these were considered to be well below their ideal body weight range and were considered at only medium risk. Individual #264's significant loss occurred in January 2010 with minimal but steady weight loss since that time. The weight loss in January 2010 may have been an error as his subsequent weight was consistent with that obtained the previous month, however, he remained well below his ideal body weight range. Individual #328 had been above his ideal body weight and was now in the middle of that range. It appeared that his weight loss had stabilized since July 2010. Individual #337 had also been above his ideal body weight range and experienced a significant loss in February 2010 though this appeared to have stabilized over the last several months. Individual #151's weight loss was potentially of greater concern as it had steadily decreased since January 2010 and he remained well below his ideal body weight range. There were five individuals with a BMI of less than 18.5 which was considered to be underweight. Four of these were considered at medium risk for weight loss (Individual #27, Individual #151, Individual #247 and Individual #278) and one (Individual #334) was considered at low risk. While only Individual #151 had experienced a significant weight loss, further weight loss for any of these individuals had the potential to be serious as each was well below their established ideal body weight range. Individual #271 was identified with a 20 pound weight loss over a year's time per the Rehabilitation Therapy Assessment Update on 9/14/10. This was not identified in the risk documentation submitted and he was identified only at low risk for weight loss. There were 45 individuals listed with BMI calculated as greater than 30 in the obese category, with 11 considered morbidly obese with a BMI greater than 40. Three individuals were seriously obese with a BMI listed as above 50 and included Individual #274 (66.12), Individual #232 (54.08), and Individual #301 (91.44). Individual #274 and Individual #232 were listed at low risk for weight loss or gain while only Individual #301 was considered to be at high risk for this serious health issue. Three others in the obese range were also considered to be at low risk. <u>Pressure Ulcers</u>: There were at least 15 individuals with one or more incidents of decubitus or pressure ulcers in the last year for a total of 28 incidents during that time. Only two of these individuals were considered at high risk, including Individual #122 and Individual #116, with six and one incident, respectively. There were 19 individuals identified at medium risk for skin integrity concerns, six of whom had experienced one or more incidents in the last year. All others were considered to be at low risk, four of whom had experienced one incident in the last year. Two of these individuals were now deceased and there was no risk level available for them at the time of this review (Individual #89 and Individual	

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		#390). There were seven individuals who used wheelchairs as a primary means of mobility who were listed with decubitus/pressure ulcers in the past year. Four of these individuals including Individual #181, Individual #122, Individual #325, and Individual #38 had multiple incidents. <u>Medical Concerns</u>: There were 10 individuals who were considered to be at high risk for medical concerns and included a number of the individuals discussed above and throughout this report as they presented with multiple PNM-related health concerns. At least nine individuals were hospitalized two or more times in the last year for PNM-related issues. Others had emergency room visits or admissions to the infirmary as well. Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were generally discipline-specific assessments, with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk. The PNM Clinic included participation of the OTs, PTs, SLP, audiologist, dietitian as possible, direct support staff and nursing or physician, as available. As described above, there was a new draft policy developed by the state to provide for a Physical Nutritional Management Team (PNMT). This was to include a comprehensive assessment by the team that included the OT, PT, dietitian, SLP, and nurse. Further review of this area will occur as this system evolves.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 161 or 65% of individuals identified with PNM needs and PNMPs. The facility-wide system, HST, of risk assessment and designation did not appear to consider actual incidence of a concern. These risk designations also did not drive review by the NMC and there was little integration of that team with the HST. The NMC used a different method to designate risk and it did not necessarily correlate with those used by the HST. It was understood that the HST system was under current revision to address these issues and further review of integration of these two systems will be indicated in the future. All assessments were discipline specific and comprehensive PNM assessments were not completed at this time. The new PNMT assessments were intended to be focused on those at high risk and will be reviewed during the next onsite visit by the monitoring team.	Noncompliance

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	difficulties.	The PNMP contained information related to the focus, specialized equipment, communication, mobility, transfers, movement instructions, and positioning, as well as mealtime instructions. The plans provided a revision date and a box before a statement in the plan was an indication that a change had been made in that particular area. The majority of the plans reviewed were current within the last 12 months, with the exception of the following: • Individual #162 (12/12/08) • Individual #265 (10/13/09) • Individual #75 (10/26/09) • Individual #392 (3/5/09) • Individual #165 (9/8/10) Criteria considered to develop a comprehensive individual record sample of 24 individuals at risk included some or all of the following: • Emergency Room visits • Hospitalizations • NMT Committee meeting documentation • Individuals with active pressure ulcer within the last six months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last six months • Individuals with unexplained weight loss or BMI ≤ 20 • Individuals ≥ BMI of 30 • Individuals who experienced a choking incident which required abdominal thrust within the last six months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or ambulation • Individuals with chronic respiratory infections • Individuals with chronic dehydration • Individuals with a diagnosis of osteoporosis and/or osteopenia • Individuals who experienced a fracture • Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care and functional communication The individuals selected included Individual #164, Individual #66, Individual #7, Individual #109, Individual #203, Individual #373, Individual #217, Individual #150, Individual #173, Individual #78, Individual #352, Individual #206, Individual #278, Individual #2, Individual #90, Individual #25, Individual #318, Individual #334,	

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		Individual #122, Individual #344, Individual #181, Individual #46, Individual #314, and Individual #271. The PNMPs submitted for each of these individuals was reviewed with findings as follows: • PNMPs were submitted for 22 of 24 individuals included in the sample. PNMPs were not submitted for Individual #314 or Individual #206. Per his PSP, Individual #314 did not have a PNMP and did not appear to require one. Individual #206 did have a PNMP per her PSP, but it was not available for review by the monitoring team. The sample size for PNMPs was considered to be 22 for the purposes of this review. • PNMPs for 22 of 22 individuals in the sample (100%) were current within the last 12 months. • In 22 of 22 of PNMPs (100%) reviewed, mobility was addressed. • In nine of the 11 PNMPs reviewed (82%) for individuals who used a wheelchair, general positioning instructions for wheelchair and/or alternate positions instructions were included. In several cases staff were referred to a positioning card for instructions. (Individual #66, Individual #278, and Individual #109, for example). • In 22 of 22 PNMPs reviewed (100%), the type of transfer was included or there was a statement indicating that the individual was able to transfer without assistance. • In five of 22 PNMPs reviewed (23%), the PNMP listed bathing instructions. Bathing equipment was not listed under specialized equipment for three individuals who required bathing equipment (Individual #25, Individual #318, and Individual #122). • In 22 of 22 PNMPs reviewed (100%), handling precautions or instructions were included. • In 20 of 22 PNMPs reviewed (91%), instructions related to mealtime, assistive equipment and mealtime positioning were included. Seven of the 22 individuals (32%) received all of their nutrition via gastrostomy tube, so oral intake instructions were not indicated. It was noted, however, that Individual #2 and Individual #217 were offered oral intake for pleasure offered by medical staff only. Amounts and food texture or liquid consistency was specified but adaptive equipment or assistance techniques were not. • In 22 of 22 PNMPs reviewed (100%), diet orders for food texture was included, including those who received only non-oral intake. • There were 16 individuals who received liquids orally. Of those, the liquid consistency was not specified for eight individuals. It may have been in those cases that they received regular thin liquids but this was not specified. • In 15 of 17 PNMPs (89%) reviewed for individuals who received oral intake,	

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		mealtime equipment was specified. In one case it was clearly stated that Individual #352 did use any adaptive mealtime equipment. In the case of the two individuals who were enterally nourished with oral intake for pleasure offered by medical staff only, no mealtime equipment was specified. • In 0 of 22 PNMPs reviewed (0%), strategies for medication administration were included. • In 0 of 22 PNMPs reviewed (0%), strategies for oral hygiene were included. • In 20 of 22 PNMPs reviewed (91%), individual dining positioning was very clearly addressed in the plan. There were no instructions offered for Individual #66 or Individual #109, each of whom received enteral nutrition. • 22 of 22 PNMPs (100%) reviewed included a heading related to communication, though information included was very limited and the plans did not address strategies for staff to use to communicate with the individual for 17 of 22 plans (78%). **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Information from discipline specific assessments was included in the assessment portion of the PSP, including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. Findings and recommendations were generally listed there. In most of the PSPs reviewed, there was also a section under the General Discussion Record that addressed review of the PNMP and, in most cases, there was only a statement that indicated that the PNMP was reviewed and approved by the PST rather than a clear outline of the strategies indicated in the PNMP. In addition there was no evidence that these strategies were incorporated into other aspects of the PSP. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Individuals who had received PNM supports were reviewed prior to the annual PSP meeting to complete assessments/updates and to address changes needed in the PNMP. These findings were documented in the OT/PT and SLP assessment reports and PNM Clinic documentation. Recommendations were generally listed in the assessment sections of the PSP. Annual PSP meetings were attended by Rehabilitation Therapy staff for only two of 24 individuals in the sample (Individual #122 and Individual #90). Bathing, oral hygiene, and medication administration were not addressed in the PNMPs. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.**	

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		There were 23 of 24 PSPs submitted for the individuals included in the sample. Two of the PSPs submitted were not current within the last 12 months (Individual #164 and Individual #373). One was not dated (Individual #78). No current PSP was submitted for Individual #203, rather only PSP Addendums. In 13 of the PSPs reviewed there was a section in the General Discussion Record of the PSP that included a PNMP heading. Each of these reflected that the PST had reviewed the plan and whether changes were indicated though in the case of Individual #314 this section stated that he did not have a plan. In six plans there was no documentation that the PST had reviewed the PNMPs.	
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.	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** PNMPs and Dining Plans were developed by the therapy clinicians and pictures were taken by the PNMPCs and incorporated into the PNMP upon approval by the therapists. Wheelchair positioning instructions were not always specific in the PNMPs. Limited instructions identified that individuals should remain upright, described the angle of recline, and the type of transfer to be used. General practice guidelines with regard to transfers, seatbelt use, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation but not specified in the PNMPs. There was a noted improvement in the implementation of positioning plans for individuals observed during this onsite review by the monitoring team. Based on findings from the previous monitoring report, a number of action plans were implemented to address issues related to staff knowledge, diet texture issues, dining room furniture and environmental layout as well as engagement during meals. There were four work groups established to address each of these concerns. Training modules, design plans, and modifications to the mealtime process were identified as needs. Implementation of these action plans was to occur in the homes with higher risk individuals first with a monitoring system to assess the success of the improvements. Mealtime Drills were initiated in addition to the mealtime monitoring conducted by the PNMPCs. The Mealtime Drills included questions to staff regarding the rationale for strategies outlined in the Dining Plans. These included the following questions: • What diet texture is this person on and why? • Why does this person use adaptive equipment? • Why does this person require monitoring? • What type of monitoring is required?	Noncompliance

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		• What would you do if this individual begins to cough? Begins to choke? • Who is at risk for Aspiration? For choking? • How do you know if individual is in optimal positioning for eating? • What do you do if the incorrect diet texture is delivered? In addition, PNMPCs participated in mealtimes as well to ensure that the Dining Plans were implemented as prescribed. In some cases, the PNMPCs were observed providing excellent oversight and support during meals, though this was inconsistent. For example, in one home there were a number of inconsistencies in the dining plans and diet cards that had not been recognized by the PNMPC during mealtime monitoring. Based on observations of individuals during meals across a variety of homes, there was also improvement in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP, though there continued to be some concerns noted. Some examples are presented below: • Some individuals were seated at the dining table with no food or beverage well ahead of mealtime service, in some cases more than 30 minutes prior to food service (Individual #202, Individual #248, and Individual #313). Individual #202 began to cry and when her food was served she threw her plate on the floor. In home 508A, 12 ladies had been sitting at the table at least 15 minutes prior to food delivery for a dinner meal. At that time, they continued to wait for an extended time while staff plated the food. • In the case of Individual #248, her Dining Plan stated she was to receive ground food and diced bread. Her diet card stated all ground foods. • Individual #313 was observed to place two- to three-inch pieces of broccoli in her mouth without staff intervention. Staff were directed to intervene. Individual #313 was also noted to begin coughing as a result of eating these large pieces of food. • Individual #17 was observed to have rice from a previous meal on her shirt front when she came in to the dining area for dinner. This was reported to staff to address. • A number of individuals were noted to be in inappropriate position and alignment during a meal (Individual #17, Individual #78, Individual #130, Individual #383, and Individual #7). • Individual #7 was supposed to be seated in a dining chair per her Dining Plan. The PNMPC indicated that there had been an order for her to be in a wheelchair in crowded areas such as the dining room. There had been no changes to her Dining Plan or PNMP. • Staff were observed to complete tasks for individuals who had the potential to participate in serving themselves or cutting up their food. • Individual #294 was observed taking very large bites without staff intervention.	

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		There were nine men eating, with one staff serving and two staff supervising individuals his home as well as transporting individuals to and from the dining room. Supervision was not consistent and every individual in the home required some level of supervision, prompts, or assistance to safely eat and drink. • Individual #288 was sitting at the table at least 15 minutes prior to being served his meal. • Individual #281 was supposed to take two teaspoons of lemon ice before his meal and after completing half of his meal. Staff were to ensure that he took a drink after each bite of food. Staff were not present to ensure that these strategies were implemented as prescribed in his Dining Plan. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Dining plans were generally out on the tables during the meals. A few staff were able to verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident and, as described above, there were errors in implementation suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served.	
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.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** By report, the mealtime and dysphagia portions of New Employee Orientation training included a written test requiring that staff score 100%, but here were no skills-based competencies required. The lifting and transfer sections continued to have skills-based competencies and there was a requirement for re-training every two years. **Standard: Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable.** Competency-based training was in development and further review of progress in this area will occur in subsequent onsite reviews by the monitoring team. **Standard: All foundational trainings are updated annually**. Only lifting training was updated after initial NEO training, but only on an every two year basis at this time. Additional staff training modules were in development.	Noncompliance

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		Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel. Initial staff training was conducted by Habilitation Therapies for available staff and PNMPCs. Cascade training was conducted by PNMPCs and, in some cases, the home managers. There were efforts to better outline specific skills or a performance criterion for individual-specific training though this was not consistent at this time. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. **Standard: 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.** Staff training was not currently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was a policy that staff had to be trained prior to working with an individual at mealtime, but there was no clear mechanism to ensure that this was occurring consistently.	
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.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no policy that related to the process of monitoring. The current monitoring tools were being reviewed and revised to increase their functionality and to eliminate any nonessential tools or indicators. As these tools were refined, SGSSLC planned to establish a competency checklist to guide the monitor and to detail the process. There will be a monitoring tool to be used by therapy clinicians to evaluate the effectiveness of the PNMP components on a routine basis. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).**	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring was conducted to address mealtimes, as well as communication, specialized equipment use and condition, transfers, and positioning in the homes. Bathing had been monitored in four homes during the month of July 2010. No monitoring was completed related to medication administration or oral hygiene. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. There had been a significant number of monitoring sheets completed in the last three months, predominately by the PNMP coordinators and a few by professional staff. The PNMPCs included the monitoring completed in a log that could be used to track the actual frequency of monitoring conducted. There were no specific guidelines to provide increased frequency of monitoring for those at highest risk however as each individual was supposed to be monitored one time per month. There was no established review to verify that this was done. **Standard: All members of the PNM team conduct monitoring.** Evidence of formal monitoring by the clinical staff was limited. Only a few sheets were submitted by professional staff. By report, informal monitoring occurred on an ongoing basis, but documentation was inconsistent and related most often to a specific problem identified by the PST or PNMPC. The PNMT was not yet implemented at the time of this review. **Standard: Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.** There was no mechanism to track data for system analysis in order to focus training and coaching. The NMC did not utilize PNMP or mealtime monitoring information in their reviews consistently. The NMC did not specifically review aggregated findings across homes for trend analysis to drive system change and training in most areas. Analysis of bathing monitoring was conducted in July 2010 only and will serve as a model for analysis in additional areas. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review overall incidence of health concerns, such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.**	

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		There was an expectation of immediate intervention when an individual was determined to be at risk of harm. When present during observations by the monitoring team, the Habilitation Therapies Director was observed to intervene when the PNMP, particularly the dining plans, were not properly implemented by direct support staff. Home supervisors or PNMPCs were generally not observed to intervene unless prompted to do so. There was no mechanism to track training related to, communication of, or follow-up to concerns noted during monitoring.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** The NMC assigned risk levels for each individual reviewed. The team did not appear to complete a specific screening tool for this, but it appeared to be driven by the identified need for follow-up intervals as described above. The HST screening was completed every six months. The PST was to meet monthly on those deemed to be at highest risk. The HST screening system also reviewed a variety of health risk concerns. These two systems were not integrated and were inconsistent. By report, both systems were being revised by the state and further review will be necessary during subsequent reviews by the monitoring team. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Individuals with PNMPs were reviewed on a prescribed interval, loosely based on risk level with follow-up every quarter, six months, or annually only. In the case that an individual participated in direct therapy, a monthly progress note was written but was greatly inconsistent (see section P below), but functional and measurable goals were not identified in most cases and very few individuals received this. Currently there was no other system of monitoring of PNMP effectiveness for those at highest risk.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were eight individuals listed as receiving nutrition and hydration enterally. Six of these were placed in 2010, Individual #203's tube was placed in February 2010 and the other five since July 2010 (Individual #2, Individual #66, Individual #278, Individual #90, and Individual #109) per the list submitted. Both Individual #217 and Individual #2 also	Noncompliance

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	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.	received oral intake or "pleasure feedings." There was no evidence that there was a specific PST or NMC review of those who received enteral nutrition on an annual basis to address medical necessity, particularly since 63% of the all individuals with enteral tubes have had placement in the last four months. It was noted that at least in the case of Individual #2, he actually had tube placement months prior to the date listed on the documentation submitted with regard to individuals who received enteral nutrition and the date of tube placement. In Individual #2's case it was listed as 8/3/10. Documentation as far back as March 2010 made reference to non-oral intake. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake had been provided a PNMP that included the same elements described above. **The need for continued enteral nutrition is integrated into the PSP.** Based on a review of 24 PSPs in the individual record sample, there were seven who received enteral nutrition and nothing by mouth. These individual's PSPs did not document the rationale for the continued need for enteral nutrition. There also was no evidence that the PST reviewed the need for tube placement prior to or immediately after tube placement. **Standard: When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used.** This was noted for Individual #2 and Individual #217 only. Each received some level of oral intake. Each individual had a PNMP which specified amount of oral intake offered only by medical staff. Each had a dining plan with instructions related to position, equipment and assistance strategies. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** There were no facility policies that defined the frequency and depth of evaluations related to an individual who received enteral nutrition. **Standard: Individuals who are at an increased PNM risk are provided with**	

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		interventions to promote continued oral intake. The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking.	

Recommendations:

1. Continue to refine the development of staff training competencies in the area of PNM. The recently developed checklists were a good start for the mealtime aspect but competencies in other aspects of the PNMP will also be needed.

2. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor.

3. The focus of competency-based training for the PNMPCs should be on skill performance relative to monitoring and training rather than only clinical knowledge. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy.

4. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. Consider review of trends as a role for the PST and PNMT.

5. PNMT assessment and review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. The PNMT should continue to monitor until the individual attains and maintains at the goal level. This may become more easily integrated with the new process.

6. Ensure that annual review of those who receive enteral nutrition is outlined clearly for the PSTs as this will likely become a function that they will be responsible for this process.

7. Integrate instructions for staff related to bathing, medication administration and oral hygiene in the PNMP.

8. The entire facility must make a commitment to the environmental modifications that will be necessary to streamline the system of serving meals as well as to ensure that staff assignments consider the need for many individuals who require prompts and cues throughout the meal for their safety and independence.

The following are offered as additional suggestions to the facility:

9. Consider use of a color printer for greater clarity and detail for printing PNMPs dining plans and other instruction plans.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: ○ Clinical Staff list ○ Continuing Education documentation for OTs and PTs ○ Section P POI and Supplemental POI ○ POC for Mock Survey related to O, P, and R ○ QA Audit reports for sections O, P, and R ○ Presentation Book for Section P ○ OT/PT Assessment template ○ PNMP Clinic Report template ○ NEO Training modules with checklists and competency tests ○ OT/PT spreadsheets ○ PNMP Clinic Reports submitted ○ PNMP Clinic Summaries ○ PNM Maintenance Log ○ List of individuals with Orthotics and Braces ○ Individuals Who Use Ambulation Devices ○ Individuals Who Use Transport Wheelchairs ○ Individuals Who Use a Wheelchair as Primary Mobility ○ Non-Ambulatory - Assisted Ambulation Risk Levels ○ Falls list (10/8/10) ○ At Risk Individuals – Injury ○ Fractures 1/1 – 10/4/10 ○ Follow-up Documentation for Falls and/or Fractures in last six months for: • Individual #379, Individual #186, Individual #93, Individual #95, Individual #302, Individual #322, Individual #288, Individual #318, Individual #153, Individual #26, Individual #256, Individual #312, Individual #50, and Individual #34 ○ List of individuals At Risk for Skin Breakdown/Decubitus Ulcer ○ At Risk Individuals – Osteoporosis/Osteopenia ○ Decubitus Report for Sept 2009 – Sept 2010 ○ Mat evaluation and simulation report for Individual #164 ○ PNMPs submitted ○ PNMP Progress Notes Monthly submitted ○ PNMP Monitoring Tools (Lifting/Transferring, Bathing, Off-Home) ○ PNMP Monitoring – Therapist Monitoring July 2010 – September 2010 ○ PNMP Monitoring Forms completed 9/10 – 11/10

	○ PNMP Monthly Monitoring Log ○ Lifting/Transferring Log ○ Lifting Monitoring Database ○ Bathing Monitoring Database ○ Bathing Monitoring Report July 2010 ○ PNMP Clinic Documentation for Individual #66 and Individual #128 ○ PNMP Workgroup Committee Summary (5/10, 5/24, 6/7, 6/21, 7/5, 7/19, 8/2, 8/16, 9/13 and 10/25/10) ○ Skin Integrity Team Committee meeting minutes 5/26 -11/17/10) ○ OT/PT Direct Services list ○ OT/PT Assessments and other documentation for the following individuals: • Individual #126, Individual #106, Individual #146, Individual #382, Individual #14, Individual #219, Individual #164, Individual #318, Individual #293, Individual #383, Individual #61, Individual #196, Individual #330, Individual #347, Individual #298, Individual #239, Individual #379, Individual #120, Individual #341, Individual #214, Individual #294 and Individual #99 ○ Personal Records for sample of individuals including: Fall Prevention Risk Assessment, PSP and all Addendums, PNMP Monthly Progress Notes, PSP Quarterly Reviews, History and Management Plan/Physical Examination, Hospitalization Discharge Summaries, Health Risk Assessment Rating Tool, Annual comprehensive Nursing Assessments, Quarterly Nursing Assessments, Habilitation Therapy section of record, Integrated Progress notes for past 12 months, 12 months weight history, PNMPs for last 12 months, Dining Plans for last 12 months: • Individual #164, Individual #66, Individual #7, Individual #109, Individual #203, Individual #373, Individual #217, Individual #150, Individual #173, Individual #78, Individual #352, Individual #206, Individual #278, Individual #2, Individual #90, Individual #25, Individual #318, Individual #334, Individual #122, Individual #344, Individual #181, Individual #46, Individual #314, Individual #271 <u>Interviews and Meetings Held</u>: ○ Dena Johnston, OTR Director of Rehabilitation Therapy Services ○ Charis Worden, OTR ○ Judy Perkins, PT ○ Cindy Bolen, PT ○ Various Supervisors and Direct Support Staff ○ Meeting with OTs and PTs ○ Skin Integrity Meeting <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Day Programs ○ Habilitation Therapies clinic areas

	○ PNMP Clinic
	Facility Self-Assessment: SGSSLC's self-assessment identified noncompliance for all items in this provision. In many areas, the department was working towards implementation. They modified the comprehensive assessment format to improve the content of the OT/PT assessments to include analysis and risk assessment as a foundation for recommendations and interventions. This self-assessment of noncompliance was consistent with the monitoring team's assessment of noncompliance with this provision. It is understood that the self-assessment tools were being revised and should be in place at the time of the next review.
	Summary of Monitor's Assessment: Since the baseline onsite review, the focus for OT/PT had been related to improving the assessment process and the provision of staff training. By report, the assessment format was revised to include medications, medical history, comparing changes across time, and other modifications to the content of the reports. In addition, a Living Options section was added and currently, the risk levels identified through the HST process were also addressed. Increased evidence of comparative analysis relative progress or regression was noted in a number of recently completed assessments. There was no data system used to track completion of assessments submitted. There was great inconsistency in the types of assessments used across individual. For example, updates were used for annual assessments as well as a progress note-type of documentation related to a problem or for documentation of interventions provided. In other cases, a consult report was used. Subsequent to the onsite review, the facility told the monitoring team that some changes had been recently put into place. Annual assessment updates were to be completed using a standard format, and a referral/consultation form was to be used that included a SOAP note style of documentation. There was less frequent documentation by therapists in the integrated progress notes and as a result the information was not well integrated into the process of service delivery as a member of the PST. The process observed during the PNMP Clinic was interactive, interdisciplinary, and generally thorough. There was evidence that the clinicians were very active in the provision of indirect supports to address identified issues as they came up, however, the documentation did not accurately reflect this activity In general, however, it appeared that staff were attending better to the details of proper positioning and compliance with the PNMPs and implementation was improved since the previous onsite review by the monitoring team. In general, the clinical staff worked well together and presented with a strong knowledge base relative to therapy clinical information. There was a need to tighten up their systems and documentation.

	Staffing levels remained unchanged since the previous review and continued to pose a challenge to effective implementation of the elements of the Settlement Agreement. There were eight PNMPCs who provided monitoring and staff training. The training programs for these staff were ongoing to identify specific competencies for PNM-related areas such as mealtime, alignment and positioning.

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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.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** The Habilitation Therapies Director was Dena Johnston, OTR. Though credentials were not submitted, current licenses were verified online for each of the clinicians. OT services were provided by one full-time occupational therapist, Charis Worden, OTR. There were two vacancies for OT. There were no OT assistants. PT services were provided by two full time therapists: Cindy Bolen, PT, and Judy Perkins, PT. There was one PT vacancy. There were no PT assistants. There were eight Physical Nutritional Management Plan Coordinators (PNMPCs); four worked the 6:00 am to 2:00 pm shift and the other four worked the 2:00 pm to 10:00 pm shift. These staff were supervised under residential services. Two PNMPCs were employed under Therapy Services and one other was identified as the Rehab Therapy Coordinator. There was one vacancy for a PNMPC under Therapy Services per the documentation submitted. OT/PT staffing levels remained the same as during the previous review. Fabrication of seating systems occurred onsite. The fabricator was responsible for collaborating with therapy clinicians to design seating systems for individuals living at SGSSLC, fabricating custom components, and completing repairs and modifications. The PNMP Coordinators were supervised under residential services and had been assigned to specific homes. Habilitation therapies had initiated person-specific training with competencies identified in the areas of mealtimes, AAC, and OT/PT related programming. The training was continuing at the time of this review. Evidence of participation in continuing education for therapy clinicians was submitted as follows: PNMP and Wheelchair Clinic Teleconferences (DADS): • Charis Worden, OTR (7.7 hours since 1/1/10) • Judy Perkins, PT (1.17 Continuing Education Credits since 1/1/10) • Cindy Bolen, PT (.97 Continuing Education Credits since 1/1/10)	Noncompliance

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		• Dena Johnston, OTR (12.70 hours since 1/1/10) PNMP Webinars (DADS): • Charis Worden, OTR (4.0 hours since 5/24/10) • Judy Perkins, PT (.50 Continuing Education Credits since 5/24/10) • Dena Johnston, OTR (3.00 hours since 5/24/10) PNMT (DADS) on 8/13/10 (2.00 contact hours) • Charis Worden, OTR Fall Prevention on 8/17/10 (six contact hours) • Cindy Bolen, PT **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** OT/PT assessments were completed as a more discrete measure of status rather than screenings. Initial assessments were noted for Individual #347, Individual #298, Individual #239, and Individual #341 as part of the Presentation Book prepared by Dena Johnston, OTR, Director. Each of these had been completed within 30 days of admission (4/4 or 100%). **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period, by report. There was no system to track specific referrals generated by the PST or via PNMP monitoring through to resolution. In response to the request for a list of all OT/PT referrals for the last six months, PNMP Workgroup Committee summaries were submitted. This group appeared to meet at least monthly, but specific referral dates, identification of issues triggering a referral, and date of assessment and disposition through resolution of the issue were not consistently maintained. Actions taken related to these concerns were not outlined in these summaries. It did not appear, however, that comprehensive assessments were completed but rather issue specific consults. For example: • Individual #181: left hip pressure and wound investigation and skin tears (7/5/10, 8/2/10 and 10/25/10) • Individual #7: mobility evaluation (9/13/10 and 10/1/10) • Individual #122: post-operative fracture evaluation and skin breakdown (5/10/10,	

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		5/24/10, 6/7/10, 7/5/10, 7/19/109/13/10 and 10/25/10) In many cases, documentation of actions taken was not well documented by the clinicians. Most were written in separate consult or update documents not included in the integrated progress notes. These were sporadic, inconsistent, and a clear progression to resolution was not evident. Measurable outcomes were not clearly stated in any case. • There were integrated progress notes for Individual #122 that documented issues with pressure ulcers on her buttocks and coccyx as far back as 10/7/09 (progress notes submitted began on this date). There were nursing notations and Skin Integrity Team (SIT) notes throughout her record. On 2/3/10, SIT notes indicated that PT was to pressure map her mattress as soon as possible. There was no documentation in the record by PT that this occurred. An SIT note on 3/3/03 reported that pressure mapping of Individual #122's mattress and wheelchair was completed, but no issues were noted. On 4/28/10, a SIT note indicated that PT was to conduct pressure mapping in a tilted position in her wheelchair, and a subsequent SIT note, dated 5/5/10, reported that this was completed. PT was to consider an alternate seat cushion covering material. There was no documentation by PT related to either of these issues in the integrated progress notes. There was a consult note written on 5/14/10 for the review completed by PT on 5/5/10. It was reported that she was to get a new seating system in the very near future. The PNM Clinic summary on 5/11/10 during her annual review did not indicate that a new system was being considered and there was no subsequent documentation related to this as well. On 6/26/10, a nursing note identified a pressure ulcer attributed to her wheelchair and that alternate positioning in sidelying was indicated. There was no evidence that OT or PT assisted with this. Individual #122 was admitted to the infirmary secondary to a non-healing Stage II pressure ulcer on her buttocks. There was no evidence of assessment by OT/PT. On 9/15/10 there was a nursing note that indicated Individual #122 was referred to OT/PT for evaluation and treatment. There was no evidence of assessment by either. On 9/29/10, Individual #122 experienced a fall during a transfer in bed by staff and she reported pain in her left lower extremity. On that same date, the nurse reported that PT was assessing her transfer, but there was no documentation by the PT in the integrated progress notes. A brief update was completed that highlighted the incident and the PT changed her transfer to a mechanical lift rather than the Sara lift transfer that staff training was conducted at that time. X-rays indicated a distal spiral femur fracture requiring hospitalization and ORIF surgery. PROM was ordered upon discharge back to SGSSLC on 10/18/10. The PT completed a consult on that date with recommendations for daily PROM exercises on a daily basis for two to four weeks then discharge to PNMPC for	

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		home program. There were no measurable goals established and no treatment plan. The only subsequent documentation by the PT was on 11/4/10 when it was reported that she received daily PROM and that the doctor had ordered ROM also to the right lower extremity due to edema. Individual #122 continued to present with skin integrity issues and had been diagnosed with aspiration pneumonia as a complication of hospitalization related to the fracture. There was no comprehensive assessment by OT or PT during this period of significant change in health status. • SIT notation on 3/24/10 for Individual #181 indicated that PT should conduct a wound investigation related to the open area on her buttock. There was a wound investigation report dated 3/25/10. On 7/1/10, a Stage II pressure ulcer on her right ischium was reported by nursing. There was a wound care evaluation by PT dated 6/26/10. On 7/28/10, a progress note by PT indicated that she would be providing dressing changes and debridement as indicated. The order was written on 7/28/10 and PT responded on that same date. There were subsequent dressing change notes by PT on 7/30/10, 8/2/10, 8/4/10, 8/11/10, 8/13/10, 8/18/10, 9/1/10, and 10/22/10. There were no measurable goals for this intervention and there was no documentation to indicate that the problem had been resolved. There just were no more notes written by the PT related to this after 10/22/10. **Standard: If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.** Since the baseline onsite review, the focus for OT/PT had been related to improving the assessment process and the provision of staff training. By report, the assessment format was revised to include medications, medical history, comparing changes across time, and other modifications to the content of the reports. In addition a Living Options section was added and currently the risk levels identified through the HST process were also addressed. In general, a baseline evaluation was completed for each individual upon admission. Then assessments were conducted one time a year for those who received OT/PT services, with additional quarterly, semi-annual, or annual reviews depending on individual need. The assessments and reviews were conducted during the PNMP clinics when the therapists generally worked collaboratively to gather data about each individual and to problem solve issues and concerns as identified, however, by report only one clinician actually wrote up the assessment report and signed it. There was a signature sheet and minutes that were taken during each clinic serving as additional documentation. The monitoring team requested that the five most current assessments completed by	

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		each therapist with the associated PSPs to be submitted. No assessments were submitted, rather only PSPs for the following individuals: Individual #116 (9/1/10), Individual #194 (9/22/10), Individual #85 (8/24/10), Individual #163 (9/16/10), Individual #46 (8/2/10), Individual #281 (9/9/09), Individual #271 (9/23/09), Individual #60 (9/20/10), Individual #71 (8/26/10), Individual #264 (9/29/09), Individual #217 (8/10/10), Individual #15 8/17/10), Individual #1 (8/24/10), Individual #64 (8/26/10), Individual #344 (7/22/10), and Individual #158 (9/13/10). There was no evidence in the PSP that an OT/PT assessment was even completed for some individuals including: Individual #64, Individual #158, and Individual #163. It was unclear as to why these PSPs were selected for submission. OT/PT assessments were also requested for the following individuals who were listed as receiving direct OT or PT (dates of the assessment submitted are indicated in parentheses) and included: Individual #293 (7/19/04), Individual #14 (1/11/05), Individual #219 (1/3/03), Individual #383 (4/27/10) , and Individual #382 (12/14/06). Each of these were referred to as assessments. Additional Annual Review documents were submitted as follows: Individual #382 (12/18/09), Individual #293 (6/16/10), Individual #219 (11/24/09 and 4/1/10) and Individual #14 (12/18/09). Each of these was signed by Dena Johnston, OTR, Director. Initial assessments for individuals newly admitted to SGSSLC were also requested and received for Individual #61 (6/24/10), Individual #106 6/24/10), Individual #196 (8/6/10), Individual #330 (7/15/10), Individual #347 (9/17/10) , and Individual #99 (8/6/10). Additional assessments were noted as aspects of the Presentation Book prepared by Dena Johnston, OTR, Therapy Services Director, and submitted for review, as requested. This included assessments for the following individuals: Individual #341 (9/29/10), Individual #239 (10/8/10), Individual #46 (8/2/10), Individual #379 (9/7/10) , Individual #298 (9/10/10), Individual #347 (9/17/10), Individual #271 (9/14/10), Individual #120 10/1/10), Individual #294 7/1/10), Individual #214 (10/12/10), and Individual #203 (8/10/10). Assessments for Individual #347, Individual #298, Individual #341, and Individual #239 were initial assessments for admission to SGSSLC. Each was completed within 30 days. Each was described with functional gross and fine motor skill abilities. Only Individual #347 presented with an issue requiring review by OT/PT as she had a leg length discrepancy. All others, with the exception of Individual #294, had Assessment Updates. He had a Rehabilitation Therapy Assessment, though it was of the same format as the Updates. With the exception of Individual #120 and Individual #214, each of these	

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		individuals presented with some level of motor skill concern. Additional OT/PT assessments and PSPs were requested for the active record samples for 24 individuals including: • Individual #164, Individual #66, Individual #7, Individual #109,Individual #203, Individual #373, Individual #217, Individual #150, Individual #173, Individual #78, Individual #352, Individual #206, Individual #278, Individual #2, Individual #90, Individual #25, Individual #318, Individual #334, Individual #122, Individual #344, Individual #181, Individual #46, Individual #314, and Individual #271 Evaluation Updates were submitted with Annual Reviews and Physical Nutritional Management Clinic Review documentation for some of these individuals. In some cases, consultant reports and other updates were also submitted from the personal records. Evaluations/Assessments were submitted for: Individual #352 (11/13/07), Individual #344 (5/6/10), Individual #373 (7/18/07), Individual #271 (9/7/07), Individual #206 (3/14/07), Individual #394 (5/28/02, though likely misfiled as he was not included in the sample), Individual #217 (6/8/10), Individual #122 (5/11/10), and Individual #173 (8/2/99). Clearly six of these were not current, but remained in the personal records. These were of a similar format, but differed from the current format identified as in use by the clinicians at this time. The format for Individual #344's assessment was consistent with the other Evaluation Updates submitted. He had a previous update also on 6/4/09. More current updates were not submitted for either of the other two individuals, however, Annual Reviews were submitted. The Annual Review for Individual #352 was dated 11/9/09 and referenced his full evaluation described above dated 11/13/07 as his admission assessment. According to this review, he also had a review on 11/3/08. An Annual Review for Individual #173 was dated 5/5/10 though only the first page was submitted (the signature page was missing). This review referenced a full evaluation dated 8/2/99 as noted above. He had also received a previous review on 5/5/09. It was not clear why some individuals received an Annual Review report: Individual #173 (5/5/10), Individual #352 (11/9/09), Individual #373 (7/27/10), Individual #206 (3/11/10), Individual #271 (9/14/09), Individual #150 (6/16/10), Individual #314 (4/2/10), Individual #164 (11/2/09), Individual #46 (7/30/09 and 7/11/08) and Individual #7 (2/26/10), while others received an Evaluation Update report: Individual #181 (3/19/09 and 2/2/10), Individual #334 (12/10/09), Individual #203 (8/10/10), Individual #271 (9/14/10), Individual #66 (2/9/10), Individual #278 (3/16/10), Individual #90 (1/5/10), Individual #109 (12/3/08 and 11/17/09), Individual #78 (4/8/10), Individual #25 (4/8/10), Individual #150 (7/3/09), Individual #318	

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		(1/11/10), Individual #46 (8/2/10), and Individual #344 (6/4/09). Individual #217, Individual #122, and Individual #394 had only the assessments sited above. Individual #164 had also received an Addendum dated 10/28/09 and Individual #334 had received a CLDP Summary dated 10/12/10. It was not clear what the purpose was from reviewing these two documents. There was no clearly established system for assessments completed. The content was generally consistent. Annual Reviews each had the same headings and general content and were typically signed by the Director, Dena Johnston, OTR. The current Evaluation Updates each were of a similar format with general similarities in content. The oldest of these was dated 7/18/07 and it differed in format from those completed in 2008 and 2009. Those completed in 2008 and 2009 differed also from those completed in 2010. Updates completed in August 2010, September 2010, and October 2010 submitted differed slightly from those completed in April 2010 with changes including a living options section and Rehabilitation Therapy Goals. The documents submitted for PNM Clinic included one for each clinic review that also summarized previous reviews for up to one year in most cases. These documents described PNM equipment prescribed for the individual and reviewed the status related to condition, fit and function. When the individual had an annual review in the clinic there was generally either a PNMP Clinic Annual Review or PNMP Clinic Annual Assessment document, a PNM Equipment Evaluation report and an Assessment Update report, all dated the same. This appeared to be significant redundancy and did not seem to yield different information. Given the limited staffing numbers reducing or eliminating this redundant documentation should be considered. Each of the assessments submitted for individuals included in the sample described individuals with movement disorders, and limitations in self-care and/or functional skills. There were: • 161 individuals identified with PNM needs per the spreadsheet submitted. • 45 individuals identified as non-ambulatory or requiring assistance for ambulation • 27 individuals who used a wheelchair as a primary means of mobility • 34 individuals who used assistive equipment for ambulation • 15 individuals who used transport wheelchairs as needed • 80 individuals with upper or lower extremity orthotics, braces and/or orthopedic shoes. • Eight individuals who sustained an injury requiring sutures or dermabond or resulting in a fracture due to a slip, trip or fall • Numerous individuals who had experienced five or more falls in the last year.	

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		It was noted, however, that only one individual received direct occupational therapy treatment (Individual #383) for upper extremity range of motion and strengthening. There were six individuals who received PT services. Four of these were receiving treatment for pain and two others for strengthening. Many others received only indirect supports via annual assessments, PNMPs, or dining plans. There was no data system used to track completion of assessments. Other than the actual assessments submitted, it was not possible to verify reports that all individuals had received a comprehensive baseline assessment. In general, a baseline evaluation was completed for each individual upon admission with updates conducted annually for those who had received some level of services. There was little difference between these, though updates had been revised to include comparative analysis to describe progress or regression over time as indicated. For example in the case of Individual #203, a review of falls described that she had one fall during the year compared to no falls during the previous year. A review of falls for Individual #46 indicated that she had two falls with injury during the year compared to only one the previous year. Similar comparisons were noted in other areas as well. Analysis of findings was added to the content of the reports and was in the process of being better implemented. For example, the clinicians indicated that due to two falls, that staff required retraining related to sighted guide techniques. In addition, they questioned whether this increase could be related to impaired sensation due to her diabetes and recommendations included a referral for ABI to assess lower extremity circulation. Staff were also to check her feet and legs on a daily basis to ensure skin integrity. A noted improvement in this area is acknowledged and will require ongoing effort to refine and fully integrate into the assessment process. At this time, the assessments continued to be more focused on impairments and traditional clinical data rather than function and potential for skill acquisition. The most current assessments highlighted measurable Rehabilitation Therapy Goals, but they typically related to minimizing concerns related only to health risk indicators rather than skill acquisition. Assessment format, detail, and clinical reasoning appeared more consistent. The new format included justification for use of assistive equipment and health risk indicators. The Active Medical Issues section listed current diagnoses and past medical problems, surgeries, and inactive problems. Health and medical concerns occurring during the past year were not clearly outlined and discussed so that this information could be integrated to formulate an analysis of findings and rationale for recommendations. Both a new PSP	

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		process and Health Risk Assessment process were in development and would likely further impact the OT/PT assessments over the next year. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. The updates contained a significant amount of information and did not appear to update the reader as to the individual's current status relative to the previous status at the time of the baseline assessment and, as such, served essentially as another baseline. There was evidence that the clinicians were reporting changes noted from the previous update in most cases as described above. **Per the Health Care Guidelines, the comprehensive assessment should address the following:** • **Movement;** • **Mobility;** • **Range of motion;** • **Independence; and** • **Functional Status across each of these areas (Health Care Guidelines, VIII.B.2)** Range of motion was generally addressed, though specific range of motion measurements were not provided. Overall, posture in a variety of positions was not described adequately. Posture in sitting or dynamic balance was inconsistently described. Movement skills were included, but general skills were merely identified, rather than providing a description of movement quality, particularly for fine motor skills. This provided very little information useful to other team members, such as day program staff, for training or active treatment purposes because there was no context offered through specific examples. **Standard: Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.** This was not apparent in the documentation submitted. Individual #318 was included in the sample for review because he was reported to receive direct PT at the time of this onsite review. No integrated progress notes were submitted in order to track documentation of this service. Typed update notes were submitted from the Rehabilitation Therapy tab in the individual's record (3/31/10, 7/15/10, 8/16/10 and 9/15/10 only). The documentation indicated that the PT class continued to be a need, but specific measurable goals were not outlined. It was not clear	

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		as to why this was referred to as a class rather than intervention or treatment. Documentation separate from the integrated progress note section was not functional for utilizing this information to track and trend his status in a holistic manner, but rather was separate making it difficult for other staff to use the PT findings. Individual #164 was also selected in the sample for review because she was also listed as receiving direct PT at the time of this onsite review. Documentation on 8/3/10 in the integrated progress notes indicated that she had been referred due to a recent decline in function and refusal to walk with home staff. Assessment on that date revealed a decrease in muscle strength from her previous PT assessment. She was placed in a "PT class" three to four times a week for four to six weeks for strengthening and gait training. There were no subsequent progress notes written through 11/18/10 related to this issue. The reason for services was listed as "strengthening due to debility." There was an additional Consult Report also dated 8/3/10 that was a typed version of the same handwritten progress note described above. Individual #164 had been seen by the PT within 24 hours of the initial request. There was an Annual Review dated 11/2/09 and a Rehabilitation Therapy Addendum dated 10/28/09. There was no additional, more current assessment present in her personal record as a result of this change in status. Further assessment of this element will be conducted in subsequent reviews by the monitoring team. Individual #203 had been reviewed in NMC seven times related to hospitalizations for pneumonia, respiratory distress, new PEG tube placement, septicemia, thrombocytopenia and PICC line placement with eventual surgical placement of an Infusaport for better venous access for IV fluids and blood draws as needed. Her status was referenced in the summary section of the OT/PT annual update report. Individuals were generally reviewed in the interim following their annual assessment during the PNMP Clinic according to their risk level, quarterly, semi-annual, or annual. Individual #203 had been seen in Clinic on 9/15/09 for an annual assessment with no schedule of review established. She was subsequently reviewed on 12/22/09, 5/18/10, and 8/10/10 for another annual update. There was no documentation that she had been seen in November 2010 at the time of this onsite review. Though she had been reviewed by the NMC in a meeting on a nearly monthly basis, there was no clearly established interval of hands-on review by OT/PT. Given the complexity of her health issues changes since her previous annual assessment in 2009, more comprehensive assessment and more frequent review were clearly indicated for Individual #203. As identified above, there was limited evidence that appropriate supports had been provided to Individual #181, Individual #7, and Individual #122 as required secondary to changes in their health status.	

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		Individual #206 had been hospitalized for pneumonia and UTI on 2/17/10. She had experienced subsequent falls and was referred for a mobility evaluation. She was seated in a wheelchair at that time. Gait belt assistance when using her rolling walker was recommended and PT was to follow-up in two weeks. There was no further consult report documenting this. **Standard: Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment.** Most of the assessments described the seating system components, with general justification and a statement that it was meeting the individual's needs. In most cases these individuals were seen multiple times throughout the year and issues related to their seating was addressed in PNMP clinic and documented in clinic review notes. As described above, an ankle-brachial index test (ABI) was recommended for Individual #46 to assess circulation in her extremities. It was not clear why this was recommended rather than conducted as an aspect of the assessment. Recommendations for additional assessment were not noted in the assessments submitted for review. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** There was generally a review of health and medical status included in various sections of the OT/PT assessment reports, though merely identifying the issues was not sufficient to ensure that they were addressed appropriately by therapy services. Recommendations were in general terms, such as "reflux positioning" to address aspiration pneumonia risk, or "positioning instructions" in the PNMP to prevent skin breakdown. A rationale for selection of a specific strategy was not consistently noted. General statements that the PNMP was updated throughout the year were also included in the body of the report under the PNMP section, but the specific strategy added or modified was not consistently identified. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** Each of the current Assessment Updates was signed by both the OT and PT. There was a communication section with a brief review of communication status and supports, but otherwise little to no evidence of collaboration with any other PST members. The interim PNMP reviews were conducted by both OT and PT in conjunction with SLPs, dietitian, audiologist, nursing, and direct support staff. The reports from these were	

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		generally written up by either the OT or one of the PTs and signed by that clinician only. There was no clearly documented evidence of the collaboration that occurred during these clinics or during the annual OT/PT assessments, though this was observed by the monitoring team during this onsite review.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.** The only plans developed were the PNMPs and those were generally only revised based on findings from the annual review. In a consult report for Individual #7 dated 9/13/10, she was reported to have had nine falls within the previous month. A stated therapy goal was to have a 75% reduction in falls. The interventions included a right shoe lift and gait belt assistance when using her rolling walker or during transfers "until she can be evaluated in two weeks." It was unclear as to why an assessment was not conducted at that time. A subsequent consult report on 9/30/10 indicated that she was seen for OT/PT "class" three times a week. There was no reference to the goal statement identified in the previous note described above or a PT assessment. Interestingly, there were only four falls identified on 3/23/10, 4/21/10, 9/6/10, and 9/12/10 on the falls list dated 10/4/10. The quarterly review documentation from PNMP Clinic indicated that the falls list data and documentation in her medical chart were inconsistent as well. Review of integrated progress notes revealed approximately 35 notations regarding falls from 11/3/09 to 11/15/10. There was no documentation from a quarterly review subsequent to the one on 7/1/10 other than a brief notation in the integrated progress notes on 10/7/10. There were no findings or recommendations documented at that time. Individual #7's PSP was dated 3/1/10 with subsequent addendums, though only one was related to falls. This PSP was held on 9/3/10 after she had fallen three times on 9/2/10. The addendum stated that the PST was very concerned that while her falls generally did not result in an injury, they required action. The PST did not believe they could prevent her falls and that monitoring and quick action was indicated when falls occurred. There were no changes recommended to her plan and staff were to continue to monitor her falls and medical status. The team agreed that her falls were addressed appropriately in her BSP and no additional interventions were needed. There was no representation from Rehabilitation Therapy at this meeting. **Standard: Within 30 days of development of the plan, it was implemented.** As no intervention plans were developed other than the PNMPs, this element was not in compliance. Generally, however, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30 day period. These did not	Noncompliance

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		typically involve a PSP addendum and as described above documentation by the clinicians was inconsistent and incomplete in many cases. **Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.** There were six individuals who received direct PT (Individual #382, Individual #14, Individual #219, Individual #164, Individual #318, and Individual #293). Only one individual was listed with direct OT services (Individual #383). A number of others had been identified as participating in OT/PT "class" including Individual #318, Individual #181, and Individual #7 for example. It was not clear what this involved and how, or if, it differed from direct OT or PT. There were no functional outcomes identified related to skill acquisition for either intervention. The new assessment format included measurable Rehabilitation Therapy Goals, but these typically addressed health risk concerns only and were addressed through the PNMP rather than an intervention plan for direct intervention. There were no measurable outcomes identified to address skill acquisition. An appropriate objective is a clear description of expectations for the individual. When written in behavioral terms, an objective should include three components: the anticipated behavior, conditions of performance, and performance criteria. Emphasis on progress related to a specific measurable objectives should be clearly and consistently stated. Clear rationale to discharge or to continue therapy should be tied to progress or lack thereof related to established measurable objectives. PNMPs were the primary intervention plan and, while a general focus was identified in the rationale for the plan, the assessment did not consistently provide a clear rationale for the specific selection of interventions for that individual. While not a full comprehensive assessment, there was an extended consultation report completed by OT with regard to Individual #383 on 7/7/10. Individual #383 had previously been recommended for OT intervention, but it had been discontinued due to no shows and refusals to participate. Skilled OT services three times a week to decrease tone, increase passive and active range of motion, and increase strength of both upper extremities was recommended. Baseline information was clearly listed in the report. Goals were not measurable and functional, however, though it was reported on 7/30/10 that the clinician was attempting to involve Individual #383 in the development of functional therapy goals. Subsequent updates on 8/31/10 and 9/30/10 also described specific skills related to her performance and several had also been described in the baseline consult. However, since there were no specific measurable goals it was difficult	

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		to assess efficacy of the interventions. Attendance again became inconsistent and since no further documentation was submitted it was not known if Individual #383 continued in skilled OT and whether the interventions were effecting change in her functional status. Documentation for other individuals who received therapy services was not as thorough as that submitted for Individual #383. Other examples included the following: • As described above a goal related to a 75% reduction in falls had been identified by the PT on 9/13/10 for Individual #7. There was no evidence that this outcome was adequately addressed or tracked by the clinician. • Individual #318's update on 1/11/10 stated that he had been recommended for a "PT class" three times a week for strengthening, balance and coordination exercises following a consult on 9/18/09 due to ataxic gait. There was a consult report on that date. The only documentation related to this intervention was a progress note (not in the integrated progress note section, however) , dated 3/31/10, and brief updates on 3/31/10, 7/15/10, 8/16/10 and 9/15/10. There were no measurable therapy goal(s) identified by the therapist and recommendations shifted from continuing in order to increase safety during walking in March 2010 to maintaining his current level of function in July 2010, August 2010, and September 2010. There was no documentation from PNMP Clinic submitted for Individual #318. • Though Individual #219 was listed as receiving direct PT, there was no evidence of this in the documentation submitted other than a consult report dated 8/23/10 stating that he would be seen two times a week for two weeks until his discharge from the facility on 9/3/10. This intervention was to address left shoulder pain after an injury playing basketball. The stated goal was that Individual #219 would report no pain upon functional use of his left upper extremity. There were no progress notes related to this intervention submitted. • Individual #14 was also listed as receiving direct PT due to lumbar and wrist strain with pain. He was to participate in PT class three times a week for two to four weeks. Stated goals were: 50% reduction in reported back and right wrist pain, compliant with use of back brace and right wrist brace, and demonstrate competency in back stretching exercise. There was no further documentation until 10/1/10 when he was discharged from PT class. He had only attended two sessions. He had been fitted with a lumbar support and right wrist brace on 9/17/10. There was no clear rationale stated for discontinuing direct PT. • Individual #293 was referred to PT for assessment of back pain on 8/24/10. A consult report 21 days later on 9/14/10 indicated that he had been seen by the PT and recommended to participate in PT class three times a week for two to four weeks for modalities to treat back pain. Goals were identified as 50% reduction in back pain symptoms and compliance with stretching exercises.	

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		There were no criteria established as to how these would be measured. There was no further documentation submitted relative to this intervention. • There were brief updates on 11/6/09 and 1/22/10 for Individual #78 that described an ambulation program and lower extremity strengthening program. He participated in a stretching and strengthening program daily though the goal was not clearly stated. General reference to progress was noted but was not quantified in any way. The update on 1/11/10 reported that he was to begin a Rehabilitation program also for stretching and strengthening beginning on 1/25/10. A consult report on 1/26/10 described a PT assessment with recommendations for PT three times a week for strengthening, stretching, and endurance. There was no baseline established for these general outcomes other than his left heel cord measured -12˚ dorsiflexion. Subsequent updates on 3/11 and 4/1/10 referred to a standing program. His tolerance was 30 to 45 minutes and the purpose was to improve his posture. There was no justification for this shift in his program and again there were no measurable goals established. His annual update was on 4/8/10 and the report described that he received skilled PT three times weekly, but indicated that he had been discharged on 4/28/10 with a standing program to be implemented by home staff twice daily, five days a week. The timeframes were unclear as the discharge occurred 20 days after the assessment date. A Discharge Report was dated 4/28/10, indicating that he had participated in a standing program three times week and that he was being discharged. There was no rationale offered for why he was discharged and there had been no criteria for change related to this intervention for Individual #78. The PSP submitted for Individual #78 was not dated, though there were various addendums. On 8/4/10 the PST met to review falls and related injuries reported in June and July (6/10/10, 6/12/10, 6/19/10, 7/2/10, 7/6/10, and 7/31/10). OT/PT did not attend this or other PST meetings. The Addendum on 8/4/10 indicated that there would be a monthly meeting with OT/PT but there was no evidence in the PSP or integrated progress notes that this had occurred. He had been reviewed quarterly in PNM Clinic on 7/1/10 and again on 10/7/10. During the review in October 2010, staff reported that he had not been participating in his standing program and that his lift recliner was broken. PT was to follow-up as well as retrain staff regarding the standing program. There was no evidence that this had been addressed as of 11/15/10, over a month later. It was of concern that there had not been sufficient monitoring to identify that this program was no being implemented prior to the quarterly review. • A consult report by PT on 3/3/10 indicated that home staff were to provide gait belt assistance to Individual #206 due to weakness post hospitalization for pneumonia and that PT would recheck her in two weeks to see if she could resume independent walking with her rolling walker at that time. There was no evidence of this follow-up. A progress note on 4/12/10 was in reference to her	

#	Provision	Assessment of Status	Compliance
		left AFO but no mention was made of her ambulation status. The most current therapy evaluation was dated 3/14/07, though the annual review on 3/10/10 referenced a full evaluation completed on 2/5/09. This was not submitted as present in her personal record. There was no evidence of PNM Clinic review from 1/7/10 until 7/1/10 and no reference to this issue noted at that time. Quarterly reviews were recommended for her due to her risk level. • In the case of Individual #334, there was a consult report dated 3/10/10 that she was evaluated by PT per the request of the PST secondary to six falls in her home from 2/20/10 to 3/3/10, three of which resulted in injury. By report, Individual #334 was supposed to be wearing elbow and knee pads since October 2009 and was not wearing either of these when she came for the PT assessment. By report, staff were not aware of this equipment. She was wearing hip protectors. The consult also referred to a report on 3/26/09 by the PT that recommended that the PST should determine if her vision contributed to her falls. The PT stated, "it would be beneficial for the PST to follow up" on this. Rehabilitation Therapy was to provide a bed cane and the Home Manager was to follow-up regarding the elbow and knee pad as well as a night light for Individual #334. There was no evidence of an annual assessment for her, but rather a "CLPD" Summary dated 10/12/10 (it was assumed that this was actually referring to a Community Living Discharge Plan (CLDP) Summary). Per a PSP Addendum dated 8/31/10, Individual #334 had visited a community home and expressed a desire to go back there. Preparations via discharge planning began at that time. On 10/18/10, the PST recommended that she move to a group home in San Angelo and recommendations from all of the summaries were reviewed at that time. These issues did not appear to be addressed by the PST or therapy services. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the direct intervention discussed above, the primary support provided was via the PNMPs provided. PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. There were a very limited number of intervention plans beyond the PNMP and the focus, while appropriately movement-related, was too general to be functional and meaningful. As described above, goals were not functional or measureable. All of the plans were written in first person language such as "I can move by myself in bed" and the language was very user-friendly for staff. PNMPs included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and positioning.	

#	Provision	Assessment of Status	Compliance
		Neither toileting nor bathing were addressed in the plans and there were no supports outlined related to medication administration or oral hygiene. There were mealtime instructions and adaptive mealtime equipment was listed consistently. There was a very brief communication section, though generally AAC was identified when indicated. A list of assistive equipment was consistently provided in the plan. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments generally provided a brief rationale for the equipment recommended for use. The monitoring team noted that the pictures provided to support the plans and to serve as visual cues for staff were generally excellent. This was noted in a number of cases for positioning and for splints provided as well. Clinical staff were encouraged to use multiple views and to continue to be very particular about the quality of the photographs to ensure adequate detail. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were minimal intervention plans and these were inconsistently documented in a brief update or consult report. Measureable goals were uncommon and, as a result, there was little in the documentation to quantify progress or regression. From discussion with the clinicians, they generally had an appropriate justification and rationale for interventions and supports. This did not, however, get translated to their documentation. As described above, there was little evidence of a clear rationale for establishing a need for OT/PT services, continuing interventions or discharging an individual from direct services. **Standard: On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.** Only in the case that an individual received direct therapy, was progress reviewed routinely, however, this was not done on any consistent basis. Documentation was of a variety of formats and there did not appear to be an established protocol as to when and where and of what format and content that documentation should occur. As stated above, there was no objective or goal with a clear measurement of progress toward	

#	Provision	Assessment of Status	Compliance
		achievement. Individuals were not otherwise reviewed on a monthly basis, but rather on a predetermined schedule via PNMP Clinic reviews on a quarterly, semi-annual or annual basis. PNMPs were reviewed at that time and changed on an as needed basis in addition to the annual assessment.	
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.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP. A few individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. Some examples included the following: • Individual #18: pelvis posteriorly tilted and loose seatbelt • Individual #25: pelvis posteriorly tilted • Individual #78: feet not adequately supported in sitting at table during a meal • Individual #17: observed during a meal with her legs extended off the foot rests, her pelvis was posteriorly tilted, the seatbelt was loose and she had slid down in the chair • Individual #130: her seat cushion was firm, the back cushion was soft. She was leaning to the left with her left arm hanging off to the side unsupported • Individual #118: was observed barefoot in her wheelchair (increased risk of injury) • Individual #7: was seated in a red wheelchair with a large Rojo cushion that was not well centered or stabilized in the seat bottom. She was supposed to be seated in a dining chair according to her Dining Plan • Individual 203**:** was yelling and had slid down in her bed. She was not attended and the monitoring team notified nursing to assist her In general, however, it appeared that staff were attending better to the details of proper positioning and compliance with the PNMPs in that regard was improved since the previous onsite review by the monitoring team. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** Staff training was reported to have been a major focus for OT/PT since the previous review. Transfers and lifting training offered in New Employee Orientation (NEO) was competency-based. Lifting was the only PNM-related area for which re-training was provided at the time of this review and this was conducted by the PNMPCs every three months. Staff were required to take this retraining every two years.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual-specific training was not competency-based. Therapy staff provided inservice to available direct support staff and home managers or supervisors who were then responsible for cascade training for other direct support staff. There was no mechanism to ensure that the subsequent training provided hands on opportunities for practice to demonstrate competent skill performance. There were reported plans to implement a system to monitor the PNMPCs as well as to monitor training conducted by the Coordinators and home managers to ensure consistency of content and performance expectations related to competencies. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff were not consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was consistently included in the PNMP. This is an important aspect of staff training as well as monitoring and coaching.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The current system of PNMP monitoring was conducted by the PNMPCs and therapy clinicians. The PNMPCs were directed to monitor each individual on their caseloads one time each month and enter it on the monthly monitoring chart. It was generally limited to availability and condition of equipment, rather than function and fit. Function and fit were consistently reviewed by the therapists in PNMP clinic on at least an annual basis via evaluation, and quarterly or semi-annually as indicated based on risk level, at the request of the PST, and upon referral when a problem was identified. Additional proactive review of staff performance was reportedly conducted on an informal basis by therapy clinicians and PNMPCs. Tracking and trend analysis were not yet in place, however, bathing and lifting databases had been developed and were reviewed recently. Further analysis of all monitoring data was to be in put place in the near future, by report. Approximately 240 monitoring sheets were submitted as completed by PNMPCs from 9/1/10 through mid-November 2010 at the time of this onsite review. Only 17% of the monitoring sheets documented any concerns with regard to implementation of the PNMPs. In some cases, the PNMPCs documented staff retraining, but this was not consistent. There was no mechanism on the form to track back to resolution of problems identified or remedial actions required. Formal monitoring by the therapy clinicians using the monitoring form was less consistent and was not driven by risk level.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs. As stated above, monitoring typically was primarily limited to availability and condition of equipment by the PNMPCs, rather than efficacy of the interventions. Currently there was no system to ensure that those at greatest risk were monitored consistently and at an appropriate frequency as indicated by their level of risk. There was a monitoring data sheet that was used to provide oversight as to frequency and consistency of monitoring by the PNMPCs. There was no system at the time of this review to monitor the competence of the PNMPCs, though training with specific skills-based competencies was in development. **Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There were no policies or guidelines to address the monitoring process. There had been a tremendous number of monitoring sheets completed in the last three months predominately by the PNMP Coordinators. There was no schedule established for monitoring frequency based on risk levels at this time. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** There was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated. Validation of the PNMP Coordinators had not been completed by the therapy clinicians. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** There were no intervention plans developed. See above. **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff .** This was reported to be true by therapy clinicians, however, because training was not competency-based, there was no assurance that those who were most at risk were assisted by competent and well-trained direct support staff.	

#	Provision	Assessment of Status	Compliance
		Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. There was no documentary evidence that issues identified during monitoring had been remedied or that home supervisors were notified of the findings. There was no tracking system to enable systemic analysis of findings or to track follow-up. **Standard: Data collection method is validated by the program's author(s).** There were no plans implemented, other than the PNMPs, at this time, and no data collection was occurring, so validation was not indicated.	

Recommendations:

1. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports.

2. PNMP Coordinators continue to require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.

3. Clarify the system of reports and other documentation to reduce redundancy for improved time management as well as consistency across clinicians and individuals as to how and where documentation should be completed. Progress notes, updates and consults did not adequately state the issue, report clinical data, state a rationale for interventions and measurable goals with consistent and ongoing analysis of the efficacy of interventions at a regular interval. In the event that the issue as a problem-oriented one. Action by the clinician and the documentation must continue through to resolution of the concern.

4. Include measurable Rehabilitation Therapy Goals related to skill acquisition rather than related only to minimizing health risk concerns.

5. Direct OT and/or PT therapy is not consistently implemented and documentation is inconsistent and likely does not reflect supports and services provided. Specific measureable outcomes must be developed with routine documentation related to changes in status as a result of these interventions.

6. Consider use of therapy techs and assistants to ensure that supports and services are readily available to those who require it. Consider seeking community-based therapy for those who are able and require more typical rehabilitation intervention such as sports injuries.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SGSSLC Policy #5.1.7: Medical Dental Restraint and Sedation, 9/9/0 o SGSSLC Policy #: Desensitization and Intervention Policy for Dental Services, 8/11/10 o SGSSLC Policy: Dental Care – Toothbrushes, 5/18/10 o SGSSLC Oral Care For Individuals With Dysphagia, 1/11/10 o SGSSLC Policy: New Employee Oral Care Training, 2/10/10 o SGSSLC Dental Data (4/10 – 9/10) o Admit/Seen o Refusal o Missed appointments o Extractions o Emergencies o Preventive services o Annual exams o Dental records for the individuals listed in Section L o List of Pre-sedations, Dosages, Route and Plans, TX-SG-1008-VII.2 Interviews and Meetings Held: o Tom Anderson, D.D.S, Dental Director o Belinda Lendermon, RDH o Rebecca McKown, MD, Medical Director o Lisa Owen, RN, Quality Assurance Nurse Observations Conducted: o Dental department o Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated noncompliance in all areas. Observations of clinics, interviews with the staff, and reviews of many documents indicated that much progress has been made in both items of this provision of the Settlement Agreement. Even so, there are some areas, such as actual implementation of desensitization plans, that require work. Other areas, such as proving appropriate precautions for individuals at risk for aspiration during oral hygiene, are being hampered by issues outside of the purview of the dental department. The monitoring team must currently agree with the facility's self-

	assessment of non-compliance.
	Summary of Monitor's Assessment: The Dental Department staff was comprised of the dental director, full-time dental hygienist, part time dental hygienist, dental assistant, and a contract dentist/anesthesiologist. The part time hygienist worked eight hours on Tuesday and Thursday. The full time hygienist did not provide any direct clinical care. There were three operatories, two of which were fully equipped. The facility had made significant progress since the baseline visit by addressing every recommendation contained in the baseline report. Initiatives in data management, quality improvement, documentation, and restraint management were visible. The clinic benefitted from the leadership of a full-time RDH who was responsible for ensuring that the clinic staff was knowledgeable about the provisions of the Settlement Agreement, dental policies, the Health Care Guidelines, and the agency's POI. Record reviews, interviews and observations indicated that individuals were receiving a variety of services in the dental clinic. Problems were identified in the areas of restraint use, oral hygiene in the homes, and missed appointments. It was evident that a great deal of thought and effort had been utilized by the clinic staff in identification and analysis of the problems. Corrective actions were implemented in the problematic areas. In spite of this diligence, the monitoring team was not able to find adequate evidence to support compliance. The dental clinic will need support from disciplines such as psychology, nursing, and residential services in order to meet the requirements set forth in the Settlement Agreement.

#	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.	Interviews were conducted with the medical director, dental director, and the full-time dental hygienist. The monitoring team toured the clinic and had the opportunity to observe individuals receiving treatment. The dental policies and procedures contained in the document request had been revised over the past several months. The policies were consistent with state issued dental policy. Clinic was conducted five days a week. Two operatories were used. The dentist saw approximately eight to 10 individuals per day and the hygienist averaged an additional eight individuals per day. All of the records reviewed contained evidence that individuals were receiving dental treatment on a regular basis. Annual assessments appeared to be completed in a timely manner for most of the individuals in the record reviews. The clinic did not actually collect data on compliance with this requirement. When the annual assessment was missed due to refusal or "no show no call", the	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>appointment was re-scheduled and additional corrective action was taken as needed. Emergency care was available for individuals both during and after normal business hours. A summary of the types of services provided in 2010 is provided in the chart below:

<table>
<tr><td></td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td></tr>
<tr><td>Prophylaxis</td><td>55%</td><td>114</td><td>101</td><td>97</td><td>101</td><td>89</td></tr>
<tr><td>Exams</td><td>11%</td><td>18</td><td>31</td><td>36</td><td>26</td><td>27</td></tr>
<tr><td>Restorative</td><td>7%</td><td>19</td><td>20</td><td>23</td><td>21</td><td>26</td></tr>
<tr><td>Dentures</td><td>4%</td><td>1</td><td>12</td><td>9</td><td>10</td><td>3</td></tr>
<tr><td>Tooth brushing</td><td>NR</td><td>3</td><td>2</td><td>3</td><td>NR</td><td>2</td></tr>
<tr><td>Emergencies</td><td>2%</td><td>4</td><td>1</td><td>2</td><td>NR</td><td>3</td></tr>
<tr><td>EXT</td><td>NR</td><td>3</td><td>1</td><td>0</td><td>NR</td><td>42</td></tr>
<tr><td>Sedations</td><td>NR</td><td>10</td><td>1</td><td>NR</td><td>NR</td><td>5</td></tr>
<tr><td>Desensitization</td><td>NR</td><td>NR</td><td>NR</td><td>0</td><td>NR</td><td>NR</td></tr>
</table>
*NR – not reported

The SGSSLC policy implemented procedures for individuals at risk for aspiration. Positioning plans were documented in the progress notes and PNMPs were placed in the dental charts. The dental hygienist explained that a new procedure for the use of suction toothbrushes was approved and the toothbrushes had been purchased. The actual implementation of use was under the direction of nursing services and this process had not progressed from the baseline visit.</td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to</td><td>The Dental Department maintained a database for tracking the following information:
• Name of individual
• Address of individual
• Appointment time
• Type of appointment (annual, follow-up)
• Name of consultant
• Appointment date
• Attendance of appointment
• Pretreatment sedation
• Desensitization program
• Recommendation for return visit
• Date of return visit

Dental clinic notes were written in the integrated progress notes. Annual exams were</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>also included in the integrated progress notes in addition to being stored electronically in "All About Me."

The hygienist reported that 71% of appointments were successfully completed and 29% were failed. The written reports provided to the monitoring team indicated that there were a substantial number of appointments not fulfilled. These were due to refusals or missed appointments. Data on dental refusals and missed appointments were maintained and the reasons were recorded when available. These data were also stratified by living unit to aid in analysis and trending. Certain homes were identified as having high failure rates. Missed appointments are summarized in table below:

<table>
<tr><th></th><th>April</th><th>May</th><th>June</th><th>July</th><th>August</th><th>Sept</th></tr>
<tr><td>Excused</td><td>8%</td><td>11</td><td>10</td><td>18</td><td>11</td><td>21</td></tr>
<tr><td>NSNC/Refusals</td><td>13%</td><td>29</td><td>36</td><td>39</td><td>56</td><td>15</td></tr>
</table>

In recent months, a new procedure had been implemented to address the issue of missed appointments. The policy, Dental Appointment Attendance, was revised 9/10 to ensure that missed appointments were tracked and outcomes reviewed. A document was created for both dental staff and the QMRPs. The document titled "NS REF EXC Excel List" was e-mailed to the QMRPs monthly. A timeline was placed for documentation of the team meeting to address the issues and forward to dental clinic strategies or plans to increase attendance of dental appointments by the individual.

An email to the dental clinic from psychology, dated 7/31/10, contained examples of the communication to the dental clinic on strategies:
• Individual #274 – Appointments will be made in the morning post medication to ensure that she is comfortable.
• Individual #9 - Preferred staff will escort individual to appointment. The staff will carry the individuals' preferred reinforcers. Upon successful completion, the individual will receive the preferred reinforcers

Restraint data from April 2010 through September 2010 were reviewed. Twenty-one individuals received pretreatment sedation, 11 of which were intravenously or intra-muscularly administered. According to the document, nine individuals had unspecified plans in place, eight had no plans in place, two had desensitization plans and two had strategies in place. Mechanical restraints were not used. A dental anesthesiologist from Austin provided anesthesia at the clinic approximately every three to four months.

Individuals who consistently refused treatment were considered potential candidates for desensitization. The process involved approval by the Human Rights Committee and the</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		PST. When deemed appropriate by the primary provider and dentist, the request was forwarded to the psychologist for completion of functional assessments and development of the plan. The clinic provided the monitoring team with a list of 42 individual who were considered potential candidates for desensitization. Twenty-three individual had no plans in place. The remainder either had strategies, unimplemented desensitization plans or were determined not to be a candidate for a desensitization plan. The RDH reported that some desensitization plans had been developed, but not implemented. This was due to the fact that the functional assessments needed to be completed by a board certified behavior analyst. The dental department did not have a peer review process in place. The hygienist explained that a statewide phone conference was held in July 2010 with Dr. Russell Riddell. Further activity of the Dental Peer Review Committee was pending. The dental department had made progress in the area of monitoring the quality of services provided. Quality audits had been recently implemented. A random sample of 10 charts (4%) was audited on a monthly basis using the checklist of the monitoring team. As reported in the facility's POI and discussed with the RDH, several problems were identified including: • Oral hygiene rating not being documented in the notes • Oral hygiene instructions not being provided to individual or staff • Missed appointments For each deficiency, corrective active plans were created. Summaries of the corrective action plans and status reports were provided for review. The corrective actions included: • In-servicing of the dental clinic staff on documentation by the hygienist • Collaboration with residential services on efforts to decrease missed • Collaboration with psychology and psychiatry on desensitization programs Audits will be ongoing to assess for response to these interventions. The dental clinic did not routinely collect aggregate data on oral hygiene ratings in the facility. The clinic, however, did provide data to the monitoring team upon request during the onsite review. The chart below compares facility reported data to data collected by the monitoring team through review of annual dental assessments.	

#	Provision	Assessment of Status	Compliance

	Facility Reporting n=230 (%)	Monitoring Team Annual Assessments n=33 (%)
Very good		3
Good	51	42/45
Fair	15	6
Poor	34	21/30
Very poor		9
Not rated		3
Edentulous		3

A Health Assessment questionnaire form had recently began being completed at the annual exam. Efforts to improve oral hygiene included the recent use of electric toothbrushes. It was reported that direct care professionals were demonstrating increased cooperation. All staff received competency-based training during new employee orientation. Several months prior to the onsite review, a new competency based training on oral care was implemented.

Recommendations:

1. The facility must ensure that adequate special supports are provided to persons with dysphagia and aspiration risk. Implementation of the use of suctioning toothbrushes is one such special support that needs to occur.

2. The Dental Department should include data in its database that allows for easy recognition of compliance with the annual assessment requirement. This could be achieved by providing the date of the previous annual assessment.

3. The administrative team and QA Department should provide oversight to ensure that all areas and disciplines are implementing corrective action plans developed to decrease failed appointments.

4. The administrative team and QA Department should determine the cause of the failure to implement desensitization plans. The qualifications for the psychology staff required to conduct the functional assessments must be clarified.

5. The Dental Department should track oral hygiene of every individual on a quarterly basis. The data can be collected from clinic visits and assessments in the home areas. Quarterly monitoring will allow the facility to detect issues in a prompt manner so that corrective actions may be implemented.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Clinical Staff list o Continuing Education documentation for SLPs o Section R POI and Supplemental POI o POC for Mock Survey related to O, P, and R o QA Audit reports for sections O, P, and R o Speech Priority Levels o Speech Therapy Master Plan o SGSSLC Presentation Book for Section R o AAC Evaluation and SLP Assessment template o Speech Monitoring log o PNMP Monitoring Form AAC Routine/ Follow-up o Visual Processing training handouts provided by SLPs for Psychology o NEO Training module o Communication Assessments and other documentation for the following individuals: • Individual #61, Individual #106, Individual #196, Individual #330, Individual #347, Individual #126 and Individual #99 o List of individuals with a PBSP o SLP Direct Therapy list o PNMPs submitted o Completed AAC Monitoring forms from August 2010 to November 2010 o Draft Speech Department procedures o Communication Dictionaries submitted for 14 individuals o Communication Assessments for the following individuals: • Individual #294, Individual #146, Individual #341, Individual #239, Individual #219, Individual #180 and Individual #389 o Personal Records for sample of individuals including: Fall Prevention Risk Assessment, PSP and all Addendums, PNMP Monthly Progress Notes, PSP Quarterly Reviews, History and Management Plan/Physical Examination, Hospitalization Discharge Summaries, Health Risk Assessment Rating Tool, Annual comprehensive Nursing Assessments, Quarterly Nursing Assessments, Habilitation Therapy section of record, Integrated Progress notes for past 12 months, 12 months weight history, PNMPs for last 12 months, Dining Plans for last 12 months as submitted: • Individual #164, Individual #66, Individual #7, Individual #109, Individual #203, Individual #373, Individual #217, Individual #150, Individual #173, Individual #78, Individual #352, Individual #206, Individual #278, Individual #2, Individual #90, Individual #25, Individual #318, Individual #334, Individual #122, Individual #344, Individual #181, Individual #46, Individual #314, Individual #271

	Interviews and Meetings Held: o Dena Johnston, OTR, Director of Rehabilitation Therapy o Susan Holler, MS, CCC/SLP o Caitlyn McMahon , Speech Assistant o Discussions with various individuals, supervisors, and direct support staff Observations Conducted: o Mealtimes in many residences o Observations in Day Program and Homes
	Facility Self-Assessment: Per the facility's POI, SGSSLC reported that all elements and actions steps were in noncompliance in section R, Communication, with the exception of A.4. "limit use of professional staff for activities other than those for which they were hired." A number of elements indicated that the speech department was initiating programs and systems. In addition, assessments and monitoring tools were being developed and refined. There were no data offered for any of the elements listed in this section. Implementation of the data analysis aspect of the monitoring system and collaboration with QA to evaluate actual performance will provide a better picture of status and progress with each of the elements in this section. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the POI self-assessment findings of noncompliance in all areas.
	Summary of Monitor's Assessment: Positive progress was evident since the baseline review. Staffing had changed somewhat with the addition of two additional part-time contract staff, however, the fulltime clinician available during the baseline review had since resigned. SGSSLC had not been able to successfully recruit additional SLPs. As reported in the baseline review, clinician caseloads were still very high and it would likely be difficult to meet all the provisions of this section of the Settlement Agreement with the current numbers of staff. By report, revising the communication assessment format, revising the Master Plan to determine priorities for completion of new assessments and increasing communication opportunities for individuals at SGSSLC was a focus since the previous review. Each of the individuals had been prioritized for re-assessment because the previous assessments were inadequate. There were approximately 30 individuals who had received a more current assessment since the previous onsite review by the monitoring team in May 2010. The current assessments were much improved, though clinicians should take care so that there is sufficient exploration of AAC supports for those with serious communication deficits and for those who were non-verbal with communication-based behavior concerns. Recommendations appeared to be based primarily on existing abilities only, rather than also on potential for benefit from structured exposure to and training opportunities related to AAC use.

	In some cases, the assessment addressed expansion of current abilities via very limited recommendations for communication strategies, such as reinforcing the individual's communicative efforts or advising staff to refer to the individual's communication dictionary. There was no evidence that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. In some cases, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. Some very functional and creative community communication systems had been developed, however, extensive use was not reported by the clinicians nor observed by the monitoring team. There had been an outstanding effort in the area of AAC and a sound foundational beginning upon which to build was clearly established.

#	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.	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** At the time of the onsite monitoring review, there were three contract SLPs working at SGSSLC, (Susan Holler, MS, CCC/SLP, Erin Bristo, MS, CCC-SLP, and Susan Reeves, MS, CCC/SLP). Current licenses were verified online for all clinicians. CVs were not submitted for any of these clinicians. Susan Bradley, MS, CCCA, was an Audiologist and there was a fulltime Speech Language Pathology Assistant who was currently on maternity leave. Another speech assistant, Caitlyn McMahon, was contracted to provide services through the end of the year only because she was to move from the area. Evidence of continuing education for the SLPs was limited to the following: Susan Holler, MS, CCC/SLP • Assistive Technology Assessment "Where Do We Begin?" (8/10-8/11/10, 10.5 contact hours) Susan Bradley, MS, CCCA • Annual Habilitation Therapy Conference (10/11-10/12/10, 6.0 contact hours) By report, revising the communication assessment format, revising the Master Plan to determine priorities for completion of new assessments, and increasing communication opportunities for individuals at SGSSLC was a focus since the previous review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The number of speech clinicians continued to be of very significant concern at this time because, as identified in the baseline review, each individual living at SGSSLC (250 individuals) communicated in some manner and participated in mealtimes and, as a result, potentially required the direct and/or indirect supports from a speech-language pathologist. There were three part-time clinicians solely responsible for the communication and mealtime needs of all 250 individuals living at SGSSLC. Essentially, their collective hours were approximately 50 to 60 hours a week. Per the Master List, the assigned therapist was Susan Reeves, MS, CCC/SLP for 30 individuals, Susan Holler, MS, CCC/SLP for 13 individuals, and Erin Bristo for four individuals. Others listed were not assigned a therapist at the time of this onsite review. The full time speech assistant was able to assist with these responsibilities, but required supervision and was not licensed to provide assessment or develop intervention and support plans. In addition, speech assistants were not permitted to provide any services related to mealtimes or dysphagia per the state practice act. Susan Holler, MS, CCC/SLP, had recently been assigned as the SLP member of the newly established PNMT. The extent of her roles and responsibilities had yet to be identified. The continued lack of qualified professional staff available for communication and mealtime supports and services was of serious concern to the monitoring team. Informal procedures had been developed to ensure that the three clinicians were able to communicate effectively, though two of them were generally only available one day a week or so. The system outlined was thorough, and provided a mechanism for each clinician to know what they should accomplish. This was reported to be working well. The three clinicians were responsible for two critical service areas: communication and mealtime supports. Given this ratio, it would be impossible to adequately meet the needs of the individuals at SGSSLC. Minimum basic supports would include re-assessments for all individuals, annual updates for those receiving services, development of communication strategies for use by staff, communication dictionaries, dining plans, and the routine monitoring and revision required. This did not include those who would require direct speech-language services or more intensive supports necessary for developing and using AAC systems, and/or attention to address increased risk for aspiration or choking during meals. There is no possible way that supports and services were provided based on need rather than staff availability at this time. **Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant.**	

#	Provision	Assessment of Status	Compliance
		During the baseline review, it was identified that the communication assessments that had been completed to date were not adequate to meet the intent of the Settlement Agreement Section R. SGSSLC elected to begin re-assessment of all individuals using a revised assessment format. The Master Plan had been developed in order to prioritize the completion of these according to identified need for communication supports and AAC. According to the Master Plan, there were approximately 214 individuals listed. The current census was identified as 250. The reason for a discrepancy of 36 individuals was unclear to the monitoring team because the Master Plan submitted was reported to be the most current and as such would be expected to include all those individuals currently living at SGSSLC. Speech Priority Levels were described as follows: • Priority 1: No effective means of communication. Needs are predicted by familiar and/or trained listeners. NO other option than to follow inherent prompts of environmental activity or routine events. • Priority 2: Limited language skills in the modalities of speech, language, gesture or sign. Communication attempts are understood in context with familiar or trained listeners. Negative behaviors may be exacerbated by decreased communicative function. • Priority 3: Functional means of communication daily wants and needs through speech or alternative means of communication. Speech intelligibility may be affected, but the individual is understandable for all listeners. Generalized communication skills are limited, however specifically with conversation language, community interaction and independent self-management (E.g., making/keeping appointments, scheduling outings or medication management). • Priority 4: Appropriate speech and language skills. Pragmatic function is the primary concern for successful community re-entry at the least restrictive level. • Priority 5: Effective independent communication of needs with inference from the listener. Priorities per the undated plan submitted as requested at the time of this onsite review were as follows: • Priority 1= 34 • Priority 2= 29 • Priority 3= 42 • Priority 4= 91 • Priority 5= 17 Two individuals did not have a priority level listed (Individual #249 and Individual	

#	Provision	Assessment of Status	Compliance
		#330). The projected dates of evaluation for each of the individuals identified as Priority 1 was listed from 7/30/10 to 1/31/11. Projected assessment dates for those identified as Priority 2 ranged from 1/31/11 to 6/30/11; Priority 3 from 7/31/11 to 2/28/12; Priority 4 from 3/31/12 to 12/31/12 and Priority 5 by 1/31/13. There were approximately 30 individuals who had received a more current assessment since the previous onsite review by the monitoring team in May 2010. One of these did not have a priority level listed (Individual #330), one was listed as Priority 5 (Individual #298), seven were listed as Priority 4 (Individual #99, Individual #123, Individual #347, Individual #341, Individual #106, Individual #258, and Individual #196), one as Priority 2 (Individual #239), with the other 20 listed as Priority 1. Those with a designation other than Priority 1 had been recently admitted to SGSSLC and had received an assessment upon their admission. There were 14 individuals who were identified as Priority 1 who had not received a current assessment since the time of the previous review. Their projected completion dates were 9/30/10 (Individual #183 and Individual #111) and 11/30/10 (Individual #109, Individual #27 and Individual #253), 12/31/10 (Individual #185, Individual #287, Individual #18, and Individual #134) and 1/31/10 (Individual #216, Individual #165, Individual #288, Individual #344 and Individual #328). Susan Holler, MS, CCC/SLP reportedly worked 32-35 hours a week and the other clinicians worked only one day a week each. While these clinicians had clearly been working diligently to get the re-evaluations completed, the need for individuals living at SGSSLC will not be clarified for those at the highest identified priority levels for at least another six months. Certainly the schedule is based on availability of staff rather than need at this time. Another spreadsheet submitted in response to monitoring team's request for documents listed approximately 247 individuals with priority levels as follows: • 1=34 • 2= 28 • 3=42 • 4=89 • 5=54 There was a significant difference in the Master List provided at the time of the onsite review and this list related to Priority 5 (54 on this spreadsheet compared to 17 on the Master List). The five most current SLP assessments with the related PSPs were requested by the monitoring team. Only the PSPs were submitted for the following individuals: Individual	

#	Provision	Assessment of Status	Compliance
		#66 (4/16/10), Individual #210 (7/2/10), Individual #90 (3/3/10), Individual #146 (5/11/10), Individual #217 (8/10/10), Individual #389 (2/11/10), Individual #386 (1/14/10), Individual #180 (8/11/09), Individual #196 (8/25/10), and Individual #330 (8/4/10). No assessments were submitted related to this request. It was not possible to determine which clinician(s) completed these per the documentation submitted. An onsite request included a request for assessments for Individual #66 and Individual #146 and these were submitted, though this did not include PSPs. The assessments were dated 7/30/10 and 8/13/10, respectively. Other assessments requested included Individual #294, Individual #2, and Individual #126, again without PSPs. Each of these had been completed since the previous onsite review with the exception of Individual #126. Her assessment was dated 3/16/10, completed prior to the previous onsite review and as such would not be considered most current, however, the Master List indicated that she had received a more current assessment on 7/8/10, though this was not submitted. Per the Master List, evaluations that would be considered most current included: Individual #323 (10/8/10), Individual #341 (10/19/10), Individual #7 (10/7/10), Individual #39 (10/15/10), Individual #50 (10/25/10), Individual #203 (10/1/10), Individual #201 (10/22/10), and Individual #181 (initiated on 10/15/10). It was not possible to determine which clinician(s) completed these per the documentation submitted. Fortunately, however, some of these individuals were included in the sample records requested including Individual #7, Individual #203 and Individual #181. In the case of Individual #181, only a brief Speech-Language Therapy Annual Review was available in her individual record. As stated above, the Master List indicated that a more current assessment was initiated on 10/15/10, but was on hold due to health status. In the case of Individual #203, an evaluation dated 1/21/10, completed prior to the previous onsite review, was submitted. The assessment for Individual #7 was dated 10/7/10. Other assessments or annual reviews submitted in the sample records also included the following: • Individual #271 (no assessment submitted) • Individual #46 (7/28/09) • Individual #206 (3/9/10) • Individual #373 (7/29/09) • Individual #217 (8/27/10 – 9/20/10) • Individual #314 (3/16/09) • Individual #334 (1/2/09) • Individual #122 (no assessment submitted) • Individual #90 (8/14/10) • Individual #109 (5/11/09) • Individual #278 (12/7/09)	

#	Provision	Assessment of Status	Compliance
		• Individual #164 (11/10/09) • Individual #78 (5/2/09) • Individual #150 (6/30/09) • Individual #173 (4/30/09) • Individual #344 (7/1/08) • Individual #352 (11/12/09) There were seven assessments submitted that had been completed since the previous onsite review and included: • Individual #294 (9/10/10) • Individual #66 (7/30/10) • Individual #146 (8/13/10) • Individual #2 (7/10/10) • Individual #90 (8/14/10) • Individual #7 (10/7/10) • Individual #217 (9/20/10) Each of these individuals was described to have severe communication deficits and was identified as Priority 1 for AAC. With the exception of Individual #90, each was recommended for, or already had, some type of AAC beyond the standard Communication Dictionary. None were recommended for direct therapy services per the assessments submitted, however, Individual #66, Individual #2, Individual #146, and Individual #294 were listed as receiving direct SLP services related to AAC training. In addition, Individual #126 was also listed as receiving AAC training. There were approximately 20 additional individuals listed with some type of AAC system, per the Master List submitted. There were approximately 10 of these who were listed as Priority 1 and the others were listed as Priority 2 or 3. A third spreadsheet was submitted by the SLP, undated, that listed 33 individuals as Priority 1 and identified some type of AAC system for most of them. Only eight were listed with staff training completed for implementation however. The systems for individuals listed on this spreadsheet were not consistent with the Master List submitted onsite or the other spreadsheet submitted. None of these documents were dated.	
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	**Standard: All individuals in need of AAC were identified as being in need of AAC.** At the time of this onsite review, it was reported that not all individuals with a need for an AAC device had been identified to date. The baseline assessment format had been redesigned to identify each individual's need and potential to benefit from AAC systems	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	to enhance his or her communication skills to better meet the requirements of the Settlement Agreement. The clinicians were in the process of conducting re-assessments of all individuals per the Master Plan developed based on priority levels 1-5. There were 34 individuals who were identified at Priority 1 with a projected re-evaluation completion date prior to 1/31/11. Of those with projected completion dates prior to the onsite review (approximately 19), only 53% had been completed on schedule, though all but two had been completed at this time (Individual #183 and Individual #111). Documents requested by the monitoring team included the five most current assessments by each clinician along with the current PSP for those individuals. As stated above, no assessments were submitted related to this request, though assessments were submitted related to other requests, however, those assessments were not representative of the three clinicians. Of the seven current assessments reviewed five had been completed by Susan Reeves, MS, CCC/SLP, and two had been completed by Susan Holler, MS, CCC/SLP. None of the assessments reviewed had been completed by Erin Bristo, MS, CCC/SLP because she was still completing her format training during that period. Each of the assessments contained a section related to Augmentative/ Alternative Communication, though, in most cases, this was very brief and a number did not reflect a sound rationale to rule out whether the individual would benefit from some type of AAC system. For example, in the case of Individual #90, the clinician stated that this individual did not stretch out her arms or use her hands functionally. She was presented line drawings, photos, and objects with "no change in affect" noted. She was also reported to not respond to music. Based on this, it was determined that AAC would not be functional for her. While Individual #90 was 79 years old and, at that age perhaps would not be a strong candidate for AAC, it was of concern to the monitoring team that the clinician would not consider alternate means to stimulate a response (e.g., vibration, lights) or to consider use of another body part to activate a switch such as the head, for example. Recommendations appeared to be based primarily on existing abilities only rather than also on potential for benefit from structured exposure to and training opportunities related to AAC use. During the baseline review, a number of individuals were identified with inadequate assessments and communication supports. These included the following: Individual #126, Individual #287, Individual #331, Individual #90, Individual #7 and Individual #211. • Per her annual evaluation dated 03/16/10, Individual #126 was assigned at a high risk level with regard to her communication status in 02/23/09, based on a "comprehensive speech-language evaluation with recommendations for exploration and development of augmentative communication strategies and	

#	Provision	Assessment of Status	Compliance
		devices." She was again assigned as high risk on 05/07/09 and 08/06/09. A communication dictionary was developed, trained, and issued, though "no new recommendations were noted," despite a "Communication Focus" associated with her PNMP. During the annual review on 01/07/10, she continued to be identified at high risk, though only a communication dictionary was available to her. The assessment, submitted and dated 03/16/10, stated that Individual #126 had "NO EFFECTIVE means of communication." A recommendation stated that speech-language pathology consultation was indicated regarding "exploration, development and instruction of augmentative communication strategies." The only support provided to her in the last 12 months was a communication dictionary, though two assessments had indicated the need for the development of augmentative communication strategies or devices. Per the current Master Plan, Individual #126 had been reevaluated on 7/8/10 and "put 'em arounds" had been provided for dressing tasks and mealtimes as well as pictures for making choices during snacks. • Per his annual evaluation dated 03/16/10, Individual #287 was provided direct speech services initiated on 04/07/09 for development of AAC. He had been provided a communication dictionary, was assigned a high risk designation with regard to communication abilities and, per a PNM Clinic notation, the SLP was in the "process of development of a system for Individual #287 to use for routine activities." He was discharged from direct speech therapy in July 2009 with a "roundhead object" for "facilitation of awareness and predictability of daily routine." PNMP Clinic review in August 2010 indicated that his communication dictionary continued to meet his needs though the roundhead object was not mentioned at that time. Three months later, during the PNMP Clinic quarterly review, it was stated that his AAC device had been lost. It was recommended that the SLP acquire a replacement, though the device was no longer in production. Again two months later in January 2010, it was stated that the device was no longer in production and that the SLP would need to investigate other AAC options. This review of interventions and a statement that Individual #287 communicated his needs with facial expressions, behavior, body language and occasional vocalizations. His priority level continued to high as he had "NO EFFECTIVE means of communication." Recommendations included only that the SLP would continue to provide AAC consultation and that "devices, programs and/or plans will be reviewed during scheduled PNM Clinics." There was no plan outlined to provide a system of communication for Individual #287 over one year from when a need was identified. At the time of the current review, Individual #287 had yet to receive a re-assessment, though one was projected by 12/31/10. Still over one and a half years later, he did not have a system of communication despite an identified need. • Per her annual evaluation dated 03/15/10, Individual #331 was described as	

#	Provision	Assessment of Status	Compliance
		expressing herself verbally in short phrases. No examples were presented in the evaluation report submitted, but it was stated that her intelligibility continued to limit her ability to communicate and caused "visible frustration" when she was not understood. She had a communication book that was "rarely" used, though new pictures were added. Her priority level was a 2 because she had "LIMITED language skills in the modalities of: speech, language, gesture or sign." The evaluation further stated that negative behaviors may be exacerbated by decreased communicative function." Speech therapy consultation was recommended for AAC needs with review of supports in PNM clinic. There was no plan outlined to provide a system of communication for Individual #331. At the time of the current onsite review, Individual #331 continued to be identified as Priority 2 and was listed as a "possible candidate for higher tech device per the current Master Plan, however her re-evaluation was not projected for completion until 2/28/11. A picture communication book had been removed from use. • Per her annual evaluation dated 03/09/10, it was reported that Individual #90 participated in direct speech therapy to explore and develop an AAC system on 12/22/09. This was discontinued less than two weeks later "due to inability to establish a consistent skill set for development of communication devices." Her Priority Level Code was listed as a "1" because she had no effective means of communication. Per her PSP, the nursing evaluation stated that she was alert and attentive when spoken to and was able to nod to "yes" questions. There was no plan outlined to address Individual #90's communication needs other than the communication dictionary issued very recently on 01/14/10 per her PSP. A the time of the current onsite review, the Master Plan indicated that Individual #90 had been re-evaluated on 8/14/10 and there were no recommendations for AAC. She was scheduled for reevaluation again in August 2011 per the plan, but the need for this was not indicated in the most current assessment. She was 79 years old and was reported to smile when she had gained trust with staff and did not actively move her arms or use her hands functionally. The assessment did not describe trials for use of her head or rule out why this was not an option for her. Though it was reported that she did not respond to music, there was no evidence that other sensory strategies were explored to identify preferences for touch, vibration, olfactory stimulation, or others. The clinician reported that it was unlikely that Individual #90 would leave SGSSLC due to her declining health status. Only a communication dictionary was provided. • Per her annual evaluation dated 03/09/10, Individual #7 had a communication dictionary at least since 05/14/09. She was assigned a high risk level with regard to communication abilities in 08/13/09 and 11/19/09 with no additional supports provided though she had "NO EFFECTIVE means of communication." On 12/09/09, direct speech therapy was initiated to "focus on increased	

#	Provision	Assessment of Status	Compliance
		functional communication for socialization as well as communication of wants/needs." As of 01/07/10, direct intervention continued though there was no description of goals or progress per the evaluation submitted for review. The only recommendation was for speech therapy to continue "consultation for AAC needs" and review during PNM Clinic. The data base indicated that a device was being investigated. There was no indication as to the expected outcome of direct service for Individual #7. Per the current Master Plan, Individual #7 had been re-evaluated on 10/7/10 and a recordable button communicator was recommended, however it did not appear that this had been provided at the time of the current onsite review. • Per her annual evaluation dated 03/15/10, Individual #211 used facial expression, body language, occasional words, and a picture communication book. She initiated communication and sought socialization with others. She recognized familiar caregivers and followed simple directives with occasional verbal cues and/ or gestural prompts. The recommendation stated that speech therapy would continue to provide consultation for AAC needs. There was no plan outlined to further address her AAC needs beyond that of the communication dictionary. Per the current Master Plan, Individual #211 was listed as Priority 2 and was listed with a communication booklet. Though she was also identified a "possible candidate for higher tech device," she was not scheduled for re-assessment until 3/31/11. There were at least 55 individuals who were described with significant communication deficits in their PNMPs, either non-verbal or who used limited speech. Many of these individuals would likely benefit from AAC. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** The following individuals had been evaluated upon their admission per the Master List submitted: Individual #330, Individual #298, Individual #99, Individual #123, Individual #347, Individual #341, Individual #106, Individual #258, Individual #239 and Individual #196. Only one of these had received a communication assessment outside of the 30 day period. There was no indication that individuals were re-evaluated upon change in status. The SGSSLC POI indicated that as of 10/15/10 all individuals receiving services would be re-assessed annually and upon change in status. This Settlement Agreement refers to a change in status for any individual rather than only those who receive services. A change in health status should trigger a re-assessment to determine if the individual presented with concerns that may require services when previously they did not.	

#	Provision	Assessment of Status	Compliance
		Standard: Communication Assessment addresses: • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and** • **The need for further assessment in Augmentative Communication.** The majority of the assessments reviewed (only current assessments were reviewed for the above elements) generally addressed both verbal and nonverbal skills. In some cases, there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. In some cases, the assessment addressed expansion of current abilities via very limited recommendations for communication strategies, such as reinforcing the individual's communicative efforts or advising staff to refer to the individual's communication dictionary. There was no evidence that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. Even those who were listed as receiving AAC training were not identified as in need of such services in their most recent assessments (Individual #66, Individual #2, Individual #146, and Individual #294). None were listed as receiving direct therapy and it was not clear who was providing training for these individuals. All of the assessments identified active treatment instructions but did not offer how the SLP would provide any specific supports or services. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** Individuals were being assessed for communication needs per the Master Plan. Per the POI, it was reported that all individuals receiving services would be assessed on an annual basis. There was no evidence of this as yet and further assessment will be necessary in subsequent reviews by the monitoring team. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.**	

#	Provision	Assessment of Status	Compliance
		The development of the Master Plan had been developed and, by report, had included those with behavioral support needs in the prioritization system. There were approximately 139 individuals who had a PBSP per the list submitted (11/19/10). It was not identified on the Master List whether these individuals were verbal or non-verbal. The Master List did not clarify how behavior issues were considered in the prioritization of individual communication needs. There was no evidence that the SLPs collaborated with psychology regarding interventions to address these concerns, though the communication assessments indicated that for some, communication limitations often impacted negative behaviors (Individual #331 and Individual #211) per the existing assessments. The same sentence was used to describe each of these women: "Negative behaviors may be exacerbated by decreased communicative function." Neither had yet received a re-assessment as described above. **Standard: Communication programs were integrated into the BSP as indicated.** In the assessments reviewed, several made references to behavioral issues for individuals but did not refer to the PBSP or target behaviors identified. In several cases, a description of behavior was used to provide a rationale for a need for AAC (Individual #217, Individual #2 and Individual #294). Though it was reported that some inservice training related to communication had been recently provided to the psychology department, there was no evidence of collaboration with psychology in the development of communication plans or of integration of these plans into the PBSPs. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to prioritize assessments and services based on need. As stated above, the Master Plan was developed to prioritize completion of assessments. The clinicians were working through the plan, but adherence to the deadlines outlined was only approximately 50% likely due to the unavailability of speech clinical staff. As the assessments are completed it will be necessary to spend time implementing plans and training staff. Further delays will be likely as the numbers identified to be in need of supports and services increases.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would	**Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The PSPs offered very limited descriptions of how an individual communicated with	Noncompliance

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	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.	others and offered even more limited instructions as to how staff would best communicate with him or her. Generally, it merely stated whether the individual was verbal or non-verbal. In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. The communication section of the General Discussion Record typically referenced the Communication Dictionary, but the actual strategies were not addressed in the PSP itself. There was no reference to the AAC systems for individuals listed on the Master Plan in the PSPs reviewed. In some cases, there was no identification of need for communication services in the living options section of the PSP though a need for these was evident. Examples included Individual #146, Individual #2, and Individual #66. **Standard: AAC devices were portable and functional in a variety of settings.** In general, it appeared that the existing AAC systems were functional. It was not clear, however, that they were used consistently across a variety of settings and, in many cases, appeared to be left to the direct support staff and program training staff to implement without sufficient integrated support from the SLPs**.** In many instances, the system consisted of a community poster customized for a specific individual and located outside the door of their bedroom. The focus of use was in the home rather than across settings. There was no evidence of integration of communication systems in day program settings. In most cases, equipment listed in the communication database, was referenced in the PNMP. **Standard: AAC devices were individualized and meaningful to the individual.** In most of the more current assessments reviewed, the clinicians conducted observations in the individuals' home and in some cases conducted further assessment in a clinical setting. In most cases, the selection of a device was not typically well justified in the assessment. The descriptions of the individuals' interactions and response to assessment activities were thorough but when AAC systems were determined to be needed, there was little specificity. While the system selected by the clinician may have been appropriate, they did not provide sufficient rationale as to why a system was selected for a particular individual. For example: • Individual #294 was described as non-verbal and he did not point or look at pictures. He also presented with physically aggressive behavior, such as throwing objects, and was reported to have difficulties related to activity transitions. He was reported to respond to yes/no questions by nodding, for example. He had visual deficits and demonstrated a lack of response to auditory cues. While described as somewhat successful, the clinician had selected a	

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		system involving hand-over-hand drawing to augment auditory cues. Drawings of activities were used to guide transitions from one activity to another and to illustrate responses and interactions with others. This system was recommended for staff to use with Individual #294. There was no justification as to why this was attempted during the assessment session to the exclusion of other strategies. Since others were not attempted, it was not clear why it was presumed that this was the best option for him and recommended for implementation. • In the case of Individual #2, use of an augmentative system for communication to maximize his ability to engage his environment in a positive manner was recommended. The clinician further stated that he required a system with pictures for identification that he could point to. His active medical problems listed bilateral mild to moderate deafness, though it was indicated that this "may be somewhat selective." By report, he had previously used a Pocket Talker for amplification, though it had been lost. There was no discussion of how it was used or whether it was effective yet the clinician indicated that a replacement was to be ordered for him. An expandable picture board with yes/no options was also selected for him, but there was no description of what kind of board and whether it would have any voice output and why or why not. Specifics related to the number of icons or levels of complexity were not outlined in any way. • In the case of Individual #146, a low-tech communication board with voice option and direct access capability was recommended in the body of the report and most specifically the clinical impressions section did not provide any rationale as to why these properties were selected for her. A specific device or icons were not identified. • As stated above, Individual #90 was reported to not use her upper extremities functionally, though the clinician did not report exploration of use of her head to activate a device or training to conduct a trial for this as an aspect of active treatment, nor did she rule this out based on a sufficient rationale. There was a lack of justification by the clinicians to demonstrate how the selection of systems was individualized and meaningful to those for whom they were selected. There were a number of community boards mounted outside individual bedrooms that had been individualized based on interests and preferences for use by staff as prompts and conversation starts. In many cases, there were simple messages recorded with the items, though many were not accessible to those for whom they were intended. The temporary speech assistant provided inservice training to staff regarding the use of these systems, but reportedly participation was not noted by all staff as yet. These were	

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		excellent systems to encourage staff to act as communication partners and provide interactive activities, but did not suffice as the sole AAC system for many of the individuals. By report, there were plans to implement additional systems and these were considered a place to start by the clinicians. **Standard: Staff were trained in the use of the AAC.** At this time, the speech clinicians were primarily engaged in conducting assessments and opportunities for staff training were decidedly limited. The speech assistant was responsible for training in some cases. By report, this was documented in the integrated progress notes and the SLP co-signed the assistant's notes. There was no evidence of competency-based training for these sessions. Per the Master Plan, there were only 13 individuals listed with staff training completed and another seven were listed with "ongoing" training. The AAC curriculum was submitted for new employee orientation. This training focused more on familiarizing staff with the process to obtain AAC, rather than providing skills they could use to implement AAC or, more importantly, perhaps strategies that could be used by staff to be better communication partners. Currently, staff training was focused on implementation of devices issued to individuals and related to community systems in 516W and various communication boards related to nursing. It was reported, however, that implementation of these was not consistent at this time. Though a number of systems had been issued with staff training provided, none of the systems were observed in use during the onsite review. In fact, during an evening walk through the homes, staff were asked about an activity sequence schedule for Individual #2. The staff assigned to him did not know what the monitor was referring to and the monitor had to locate it for staff and describe the intended use. There were some written AAC instructions for the devices issued for Individual #66, Individual #2, though in the case of Individual #66, his name did not appear on the plan. **Standard: Communication strategies/devices were implemented and used.** As reported in the baseline review, a Plan of Care (12/09/09) was submitted for Individual #7 in which she was to activate a button AAC device to initiate interaction with a verbal cue and/or physical prompt from caregiver as necessary. Another objective for direct intervention was that she would respond to a "7-Space" device activated by caregiver upon transition to dayroom activities. She was to receive direct intervention at a frequency of three times a week. A monthly summary dated 01/07/10 also submitted indicated that she had only participated in three sessions during the month. The device identified to be appropriate (7-Step Take and Talk) had not yet been released for use in her home. Recommendations were to continue with ST intervention and "reduce frequency" to one time weekly. It was of concern that Individual #7 had not	

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		received communication supports at the frequency recommended by the clinician during the first month of implementation of a three-month program and already the intervention was being reduced. The most current assessment (10/7/10) for Individual #7 stated that these previous devices had been released for home use on 4/8/10, but that it was determined during the re-assessment that she did not use or recognize these devices. Individual #7 was identified with only a recordable button communicator at the time of the current review per the re-evaluation, there had been no staff training to date related to this device per the Master Plan. It was of concern that the previous inconsistency of intervention provided to her did not provide sufficient support for her to learn to use her device and that staff had been insufficiently trained to assist her. These systems were dismissed with insufficient evidence and a different device was recommended with no rationale or justification for its use. Skill acquisition training was not typically a consideration and when it was, there was a generic recommendation that staff implement a strategy without support from the SLP. Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful. The therapists did not have a reliable way via the existing monitoring system to accurately determine if their recommendations and other programs were appropriately implemented. **Standard: General AAC devices were available in common areas.** A number of community devices were available (posters and message buttons), but were not observed to be used during the onsite review by the monitoring team. It appeared that the purpose of these systems was so that individuals could point to items to make a request (or could receive assistance from staff to do so). Regarding these posters: • There was limited training for staff on how and when to use these posters. • A number of these were seen by the monitoring team, but no examples of their use were observed. • Posters could be used as a backup or extra system for individuals, but should not used as a primary augmentative or alternative means of communication for an individual.	
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	**Standard: A monitoring system was in place that: tracked the presence of ACC; working condition of AAC; the implementation of the system; and effectiveness of the system.** A system of monitoring of AAC utilized a form titled "PNMP Monitoring Form Augmentative Alternative Communication (AAC) Routine/Follow-up." Completed forms for the last quarter were requested and forms were submitted for review (18). The	Noncompliance

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	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.	forms were completed by PNMP Coordinators on a weekly basis and monthly by the speech staff. The Speech Assistant reviewed those completed by the PNMPCs and they were signed by Susan Holler, MS, CCC/SLP. The forms submitted were for seven individuals (Individual #179, Individual #345, Individual #222, Individual #7, Individual #278, Individual #111, Individual #325, and Individual #211) across September 2010 and October 2010 only. Issues identified included: • Dead batteries (Individual #325 and Individual #7) • Staff not following PNMP instructions (Individual #222 and Individual #211) • Staff not following AAC instruction card (issue identified for two consecutive weeks for Individual #278, Individual #222, and Individual #211) • Response log not present and/or documentation did not match recommended interval (issue identified for three consecutive weeks for Individual #278) • Photos/instruction card and equipment did not match (Individual #7) • AAC equipment was not available and was not in good condition (Individual #7) • DCP did not acknowledge training in use of AAC equipment (Individual #278) • DCP unable to demonstrate or describe features and use of AAC equipment (Individual #278 and Individual #7) It was of concern that only seven individuals were monitored during those two months when the Master Plan identified that at least 14 individuals with AAC should have been monitored at least one or two times during those months. There were several others that had AAC but were not listed to be monitored routinely. There was no evidence that effectiveness of each individual's AAC system was monitored by the PNMPCs or by the SLPs beyond the assessment updates. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Monitoring of AAC was conducted most often in the homes rather than across settings, per the monitoring sheets submitted. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no routine system to validate the continued competency of monitors at SGSSLC at the time of this onsite review by the monitoring team.	

Recommendations:

1. The Master Plan should be made public in order that PSTs understand how and why individuals were prioritized and also know what to expect. Completion of assessments in combination with implementation, staff training and monitoring of new systems will be slow given the current staffing level.

2. Assessments must provide a clearly stated and thorough rationale as to why or why not AAC is determined to be appropriate for an individual. In addition, greater specificity is needed to describe the clinical reasoning process used by the therapist to select a particular device. These are key elements to a comprehensive assessment that meets generally accepted professional standards of care.

3. Carefully define how the various types of assessments are differentiated. For example, how does an update differ from a baseline and when is a new baseline necessary via a comprehensive assessment? Most of the original baselines were not sufficiently comprehensive and as such do not provide an appropriate baseline from which to update individual status, though updates continue to be done. Once baseline is established, subsequent updates should refer back to baseline to demonstrate change and certainly a comparison from one year to the next is critical.

4. Ensure that the most current assessments (baseline and updates) are contained in the active record for each individual.

5. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted.

6. Consider implementation of more individualized AAC systems and greater variation in community systems as the majority of the existing systems for individuals were limited to community-based systems. It is understood that this is an excellent beginning. This is also a more manageable approach with the staffing limitations, however, recommendations must be based on identified need and not modified by the knowledge that implementation of an alternate approach could be difficult.

7. Consider expanding the NEO training to move out beyond AAC but rather also teaching staff to understand how to be an effective communication partner. As AAC is developed then it becomes a method much like speech is rather than a unique entity in which the functional purpose becomes lost on staff. When that happens it loses meaning for them as well. It becomes a "task" and not integrated into the individual's daily routine.

8. Many recommendations appeared to be left to the PST for the development and implementation of plans, even in the absence of sufficient staff training. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials, and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as training, modeling, and coaching for staff. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans. Communication goals can and should be addressed across the full gamut of training objective programming.

9. Clarification of expectations for monitors related to the indicators on the PNMP Monitoring Sheet must be provided. Each element must be well defined. This is reinforced through competency-based training and validation.

10. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs.

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:** <u>Documents Reviewed</u>: o Personal Support Plans (PSPs) for: • Individual #346, Individual #215, Individual #96, Individual #81, Individual #99, Individual #214, Individual #159, Individual #205, Individual #75, Individual #76, Individual #295, Individual #200, Individual #377, Individual #198, Individual #248 Individual #135, Individual #293, Individual #382, Individual #38, Individual #26, Individual #261, Individual #116, Individual #217, Individual #46, Individual #194, Individual #1, Individual #152 o Specific Program Objectives (SPOs) for: • Individual #40, Individual #321, Individual #380, Individual #371, Individual #105, Individual #215, Individual #382, Individual #38, Individual #96, Individual #261, Individual #205, Individual #26, Individual #116, Individual #217, Individual #46, Individual #194, Individual #215, Individual #321, Individual #105, Individual #371, Individual #380, o Dental Desensitization Plans for: • Individual #130, Individual #7 o Reviews of SPO data for: • Individual #40, Individual #105, Individual #215, Individual #382, Individual #38, Individual #96, Individual #26, Individual #261, Individual #205, Individual #321, Individual #371, Individual #380 o Comprehensive Residential Assessment of Living Skills (CRA) for: • Individual #215, Individual #382 o QMRP Program Observation Check Sheet, dated 5/6/10 o List of individuals under age 22 at SGSSLC and their current school assignment o ARD/IEPs for: • Individual #55, Individual #239, Individual #292, Individual #243 <u>Interviews and Meetings Held</u>: o Michael Davila, QMRP Coordinator o Tammy Ponce, Active Treatment Coordinator o Natalie Montalvo, Director of Residential Services o Noel Zapata, Vocational Training Director o Tammy Demeery, WISD school teacher at the SGSSLC campus school classroom o Kristin Lange, WISD school teacher at WISD school classroom o Jimmy Hannon, WISD superintendent of schools

	Observations Conducted: o Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing) • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans o WISD classroom at the SGSSLC campus o WISD classroom at WISD school building
	Facility Self-Assessment: SGSSLC's Plan of Improvement (POI) indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, since the baseline review the facility had begun several new initiatives. These included: • Recent trainings to improve the incorporation of individual's needs and preferences into specific program objectives (SPOs) • Development of new assessments of individual skills (including new vocational assessments) • Development of a new SPO monitoring form • Establishment of a multidisciplinary team to improve individual engagement • Development of a tool to measure engagement • Addition of six activity specialists that are responsible for planning community outings and improving community integration Many of these improvements were too new to be fully evaluated by the monitoring team, and will be examined during future monitoring reviews. Two areas of need noted by the monitoring team were related to healthy living: cigarette smoking and safe

	sex practices. Some progress was observed in the provision of educational services to individuals at SGSSLC who were under age 22 and still qualified for educational services. There was a positive working relationship between SGSSLC and the local school district, Water Valley Independent School District (WISD).

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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.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SGSSLC. As indicated below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Skill acquisition plans at SGSSLC consisted of: • Specific program objectives (SPOs) that were written and monitored by qualified mental retardation professionals (QMRPs). SPOs were implemented by direct care professionals (DCPs) • Medical desensitization programs written and monitored by the psychology department, and • Replacement behaviors written by the psychology department. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures had just begun to be developed by the psychology department at the time of the baseline review. Two of these plans (for Individual #7 and Individual #130) were reviewed by the monitoring team. As recommended in the baseline report, the plans were written by psychologists and were incorporated into the general training objective methodology for all SPOs. The plans represented forward chaining, and appeared to include the necessary components of an effective training program described below. According to the dentistry department, however, many more individuals were waiting for dental desensitization plans to be written. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with desensitization plans, will be reviewed in more detail in future site visits. SGSSLC included replacement behaviors in each PBSP. As discussed in K4, replacement behavior data were not consistently collected at the time of the onsite review. Additionally, as discussed in K5, many replacement behaviors appeared to be general and unrelated to the hypothesized function of the behavior. Additionally, there were no descriptions of teaching conditions, no specific teaching instructions, and it was not clear	Noncompliance

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		how, or if, staff were trained to teach the replacement behaviors. It is important that replacement behaviors be functional, and their implementation documented (i.e., data collection). Further, these replacement behavior training procedures, like those for the dental desensitization plans, should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed below. As discussed in the baseline report, an important component of an effective skill acquisition plans is that they should be based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. Conversations with the QMRP coordinator indicated that the facility did attempt to incorporate preferences and needs into the development of individual SPOs. Additionally, SGSSLC has recently adopted a new assessment tool (i.e., Comprehensive Residential Assessment of Living Skills) to better identify individual needs. Nevertheless, the monitoring team could not find examples in the personal support plans (PSP) that SPOs were developed to address individual preferences and needs. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference. Two areas of training and educational programming should be looked at by SGSSLC managers. The first are programs related to cigarette smoking. Many individuals smoked at SGSSLC, and many of those smoked at high rates. In some cases, issues around smoking set the occasion for behavior problems, some of which competed with individual's referral for community placement (e.g., Individual #119). Group and individual skill programs to learn to reduce smoking should be considered. Second, there appeared to be little, if any, instructional educational programming regarding safe sexual practices. This was concerning given the high numbers of sexual incidents reported at the facility. Once developed, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives	

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		• Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology As discussed in the baseline review, the SPOs at SGSSLC included some of these components. On the other hand, none of the SPOs reviewed included relevant discriminative stimuli or a plan for maintenance and generalization of achieved skills. Additionally, although all of the SPOs reviewed indicated that individuals should be encouraged and praised, specific consequences for correct responding were not included in the plans. The training methodology for all SPOs reviewed was identical. It included the training of one step of a task analysis at a time, and a least-to-most prompting procedure. As discussed in the baseline review, least-to-most training procedures can be very effective, however, they are not generally effective with every individual across all desired skills. SGSSLC needs to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. Conversations with the QMRP coordinator revealed that he is currently researching the use of additional methods of training. Examples of additional training methods include total-task chaining (i.e., the learner receives training on each step in the task analysis during every session), backward training (i.e., all the steps in the task analysis are initially completed by the trainer, except for the final behavior in the chain), and shaping. Another variable that would likely improve the overall effectiveness of SPOs at SGSSLC is the inclusion of regularly assessed integrity data. That is, a direct measure that DCPs are implementing SPOs as intended. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are implemented as written. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at SGSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. The facility employed an active treatment coordinator, three activity treatment coordinators, and six activity specialists to ensure that individuals	

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		were meaningfully engaged in activities. Engagement of individuals in the day programs and homes at SGSSLC was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each home and day program are listed in the table below. The monitoring team was encouraged by discussions during the week of the onsite review to improve the types and variety of activities available to individuals during the evening and weekend hours. The monitoring observed that many of the individuals were out of the homes, engaging in activities (e.g., playing basketball, at the park, in the community), however, as noted in sections F and E of this report, there was a need for more structure and more options for individuals during these hours. Many of the individuals observed in the homes, however, were engaged in other typical activities, such as listening to music, talking to friends, watching television, talking on the phone, or playing video games. In the homes where the individuals did not possess the skills to readily engage in independent activities, the ability to maintain individual attention varied widely. In these homes the monitoring team observed very few group activities designed to include multiple individuals at the same time. One notable exception was a group activity observed in 510 A, where the DCPs were conducting a bingo game that effectively engaged the majority of individuals present. It is recommended that DCPs be specifically trained and encouraged to conduct meaningful group activities. The average engagement level across the facility was 63%, a slight improvement from the level of engagement found during baseline (i.e., 60%). As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target level in a facility like SGSSLC, indicating that engagement has some room to improve. SGSSLC has recently organized an active treatment group to improve engagement across the facility. The newly formed group integrated individuals across several disciplines to better understand and eliminate the barriers to meaningful individual engagement. Additionally, the facility has developed, and begun to implement, a tool to collect	

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		engagement data. The average engagement reported in the month of September with this new tool was 73%, somewhat higher than the engagement level found by the monitoring team. In subsequent reviews to the facility, the monitoring team will attempt to understand why these two measures yield such different levels of engagement. Nevertheless, the monitoring team is encouraged by the facilities obvious commitment to improving engagement and the introduction of a methodology to measure engagement. It is recommended that SGSSLC now establish and track specific engagement goals in each home and day program site. Engagement Observations: Location / Engaged / Staff-to-individual ratio 516 West 1/1 0:1 516 West 0/4 1:4 516 East 0/7 2:7 516 East 1/1 1:1 502 A 1/4 1:4 509 A 2/3 1:3 511 A 1/1 1:1 505 A 3/4 1:4 505 A 1/1 0 :1 505 B 2/4 1:4 510 A 5/7 4:7 510 B 1/1 0 :1 508 A 1/6 0:6 508 A 0/1 0:1 508 B 1 /8 1:8 508 B 2/4 1:4 508 B 4/4 0:4 501 A 0/5 1:5 501 B 1/1 1:1 512 A 1/1 1:1 512 B 1/1 0 :1 Vocational Workshop 12/15 6:15 Vocational Workshop 2 /2 1:2 Educational Services The monitoring team had the opportunity to learn about the status of the educational school services by talking with the director of residential services, observing the WISD	

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		classroom on the SGSSLC campus, talking with the WISD teacher, observing at the WISD public school building, and talking with the WISD public school teacher and superintendent of public schools. Overall, improvements had occurred since the baseline review. Most notably, there appeared to be an excellent working relationship between SGSSLC and WISD. The director of residential services was the facility's liaison and she maintained frequent, open, and productive communication with the teachers on campus and at public school as well as with the superintendent. Moreover, SGSSLC staff were welcomed by WISD to be active members of the ARD for each student. The monitoring team wishes to acknowledge this and support its continuation. The school superintendent told the monitoring team that the school district served a total of about 300 students. He and the monitoring team spoke about inclusion and working towards the students at WISD participating in more activities with the rest of the students. He said that he's visited the SGSSLC campus and enjoyed the relationship with SGSSLC staff. The monitoring team was pleased that there appeared to be potential for continued improvement in educational programming for SGSSLC students. Three issues observed during the baseline review are discussed below: • Observations during the baseline review raised concerns regarding the amount of student active participation in educational activities from day to day and over the entirety of the school year. o <u>Compliance review status</u>: Eight students attended the SGSSLC campus school classroom. All students in the campus classroom were actively engaged during the monitoring team's observation. This was great to see. There was a WISD teacher, a WISD teacher's assistant, and an SGSSLC staff person. At the WISD classroom, there were only two students in the classroom. There was a WISD special education teacher, a WISD teacher's assistant, and two SGSSLC staff members (i.e., a total of four adults for the two students). The SGSSLC student's classroom was in the administrative building of the school district, that is, in a different building, across the campus from the regular high school and elementary school buildings. The SGSSLC students had little interaction and integration with the general population of students except for a daily physical education activity during which about a dozen students came over from the main building to this classroom, and during lunch when the SGSSLC students went to pick up their lunches from the cafeteria (but they did not eat their lunches with the other students). SGSSLC should continue to work with WISD towards opportunities for inclusion for their students.	

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		• During the baseline review, IEP objectives were from a variety of relevant areas, but none were written in a format that was measureable or that gave any indication of what the student was to demonstrate to indicate mastery.
		  ○ Compliance review status: The status of this issue remained the same. That is, the IEP objectives were from a variety of educational and functional areas. None were written in a measureable format (e.g., expands vocabulary through word relationships, discuss current events and their effects on local, state, national, and world politics).
		• During the baseline review, the SGSSLC campus school teacher reported that these grading numbers were not based on objective assessment, but rather on more subjective and intuitive processes that were unclear to the monitoring team.
		  ○ Compliance review status: There appeared to be a more structured manner in the determination of grading, however, it differed across the two classrooms. The grading on reports cards were codes and were the same for both classrooms: P1: inconsistent limited progress, P2: consistent satisfactory progress, P3: good progress, or N: not introduced. There was no indication of how these scores were arrived at for any specific objective.	

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.	SGSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, however, it is unclear how this information impacted the selection of specific program objectives. Therefore, this item is rated as being in noncompliance. At the time of the onsite review, the facility was beginning to use the comprehensive residential assessment of living skills and vocational assessments to better assess individual skills. It is recommended that the facility incorporate the results of these assessment results with individual needs identified in discipline evaluations and the PSP, to choose individual skills to be trained. As discussed in S1, it is also important that this process be more clearly documented in the PSP. Additionally, while the PSP attempted to identify preferences, no evidence of systematic preference and reinforcement assessments were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to		

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	develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Improvements are needed in the monitoring of SPO progress and outcomes before this item can be rated as being in substantial compliance. QMRPs at SGSSLC summarized SPO data monthly and presented those data at quarterly meetings. The skill acquisition plans appeared practical and functional for some individuals (e.g., Individual #261 learning how to brush his teeth independently), however, as discussed in S1, it was unclear how or why most SPOs were chosen. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., Individual #380's SPO of learning to cook), but not for others (e.g., locker use for Individual #40; bathing, tooth brushing, and self medication for Individual #Individual #321). The monitoring team was encouraged that some plans were modified based on the completion of goals (e.g., hair care for Individual #215), or lack of progress (e.g., bird care for Individual #371), however, for the majority of SPOs reviewed that did not show progress, no modifications in the plan or implementation was documented. It is recommended that SPO data be graphed so as to improve the QMRP's ability to evaluate the effectiveness of the plan. Additionally, it is recommended that that these graphed data summaries of individual SPO progress be used to make data-based decisions concerning the continuation, discontinuation, or modification of the skill acquisition plan. The monitoring team did not observe the implementation of SPOs in any of the day or residential homes during the onsite review. SPO data sheets were reviewed in several residences to evaluate if data were completed as scheduled. The monitoring team was encouraged that the majority of SPOs sampled were completed as scheduled. The only exception was four blank sessions out of 31 scheduled sessions for Individual #38's sensory stimulation SPO.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SGSSLC enjoyed various recreational activities in the community. It was not clear, however, if each individual was provided with training in the community that addressed specific needs for services or preference. Therefore, this item was rated as noncompliance. As in baseline, no individuals at the facility worked in the community at the time of the onsite review. Interviews with staff indicated that the primary reason for the absence of	Noncompliance

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		community employment was the economic recession. Subsequent reviews to SGSSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item (also see comments in section F of this report)	

Recommendations:

1. Medical and dental desensitization SPOs should be provided to all individuals identified to need them.
2. Replacement behavior training procedures should be incorporated into the general training methodology and conform to the standards of all skill acquisition plans at the facility.
3. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference.
4. SPOs should include the use of relevant discriminative stimuli, and plans for the maintenance and generalization of acquired skills.
5. SGSSLC needs to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires.
6. Examine the facility's need for educational programming and skill acquisition regarding cigarette smoking and safe sexual practices.
7. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are conducted as written.
8. The facility should establish and track specific engagement goals in each home and day program site.
9. Ensure that SPO progress is closely monitored, and modifications of SPOs reflect data-based decisions.
10. The facility should ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.
11. The facility should expand the number of individuals employed in the community.
12. Work with WISD and the student's ARDs regarding inclusion activities.
13. Work with WISD regarding wording IEP objectives in a measureable format that includes behavior, conditions, and criterion.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and five attachments (exhibits) ○ DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 ○ DADS Obstacles Report for SSLCs, October 2010 ○ SGSSLC Organizational chart, not dated ○ SGSSLC policy list, not dated ○ List of typical meetings that occurred at SGSSLC ○ SGSSLC POI, October 2010 ○ SGSSLC POI Supplement, October 2010 ○ SGSSLC Admissions and Placement Department Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 11/15/10 ○ SGSSLC Policy, Continuity of Service policy, 5/11/04, updated most recently 7/15/10 ○ Position description: Admissions/Placement Coordinator and Post-move monitor ○ Annual data totals for admissions and placements since 2000, updated 11/16/10 ○ List of individuals who were referred for placement and had been placed since 6/1/10, dated 11/16/10 (10 individuals) ○ List of individuals who were referred for placement and had not yet been placed, dated 11/16/10 (21 individuals) ○ List of individuals who themselves requested placement, but were not referred (44 individuals) and an indication of the reason why each individual was not referred ○ List of individuals who were not referred solely due to LAR preference (eight individuals) ○ Documentation from PSPAs regarding the rescinding of referral for five individuals: • Individual #234, Individual #2, Individual #25, Individual #96, Individual #261 ○ List of individuals alternately discharged (four individuals) ○ Documentation regarding one individual alternately discharged during the week of onsite review ○ List of alleged offenders as of 10/4/10 (39 individuals) ○ List of one individual who had returned to SGSSLC from a community placement ○ Description of how the facility assesses an individual for placement ○ List of all individuals at SGSSLC and whether or not each was referred for placement as of 10/7/10 (the list did not indicate the reason for the individual not being referred) ○ Various lists and documents related to the provider fair on 9/24/10 ○ Copy of PowerPoint presentation by local MRA regarding community living options ○ Various lists related to showing individual participation on tours of community providers, and facility staff exposure to community providers, through 9/24/10 ○ Completed monitoring form of living options discussion section of annual PSP meeting for

	Individual #190 o DADS reviews of CLDPs for six individuals o Example of proposed revised CLDP format (blank) o Proposed new post move monitoring form o New Style PSPs for: • Individual #123, Individual #163, Individual #60, Individual #271, Individual #194, Individual #321, Individual #264, Individual #298, Individual #294, Individual #252, Individual #57, Individual #120, Individual #265, Individual #292, Individual #193, Individual #75, Individual #213, Individual #214, Individual #251, Individual #190, Individual #359, Individual #327 o CLDPs for: • Individual #219, Individual #107, Individual #392, Individual #136, Individual #324 o Post move monitoring checklists for: • Individual #219, Individual #107, Individual #392, Individual #136, Individual #324, Individual #191, Individual #92, Individual #62, Individual #138, Individual #171 <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post-Move Monitor o Dr. Philip Baugh, Facility Director o Michael Davilla, QMRP Coordinator o Elsa Dela Rosa, QMRP o Natalie Montalvo, Director of Residential Services o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o PSP Meeting for: • Individual #190, Individual #359 o PFA Meeting for: • Individual #119 o Community group home visit, post-move monitoring for • Individual #136 o Self-advocacy meeting o Many residences and day programs at SGSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, for section T indicated that all items were in noncompliance, except for one. That one item was the completion of the community placement report and, as indicated in the report to follow, additional information is required in this report in order for the monitoring team to rate is

	as being in substantial compliance. The monitoring team, however, found three other provision items to be in substantial compliance: T1c2 and T1c3 (both related to specific components of the CLDP), and T4 (regarding alternate placements). The facility did not provide much information in the POI for this section. The following three comments were repeated throughout the provision T section of the POI document. • SSLC on 11/04/09. State Office revised policy released to SSLC on 3/31/10. • 10/11/10 State office is currently revising policy and procedure due date unknown. • 10/11/10 Record review begun Oct. of 2010. 10/22/10, the process has begun. The POI did not indicate that the facility looked at any of the PSPs, LODs, optimistic vision statements, CLDPs, or post-move monitoring forms to make a determination of their own substantial compliance or noncompliance. Given the many upcoming changes to most integrated setting and community placement processes that are anticipated to occur at SGSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components. This will probably involve monitoring, sampling, and providing feedback to PSTs, post-move monitors, and facility management. The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment. The APC's presentation book indicated that he had recently begun to implement monitoring checklists for section T.
	Summary of Monitor's Assessment: SGSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and improvements to a number of activities, as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, SGSSLC had made progress in some areas since the baseline report. For example, the new PSP process was in place, referrals and placements were maintained at the same rate, and all three post move monitoring visits were occurring at the community residence. On the other hand, not a lot had changed since the baseline review, especially regarding the addressing of obstacles to placement, the determination and defining of essential and nonessential supports, and the reporting of post move monitoring. The number of individuals placed in the community represented a relatively small percentage of the SGSSLC population, that is 9% of the individuals over the past 12 months (23 placements since December

	2009). The facility created listings of individuals for whom LAR preference was the only reason for he or she not being referred for placement. The lists did not include all of the individuals to whom this applied and it is recommended that the lists be corrected so that this important information can be regularly shared with SGSSLC management. The new PSP was recently initiated at SGSSLC. Three annual PSP meetings were observed by the monitoring team. The new process appeared to have the potential to improve the depth and breadth of discussion regarding optimistic optimal living characteristics for each individual. At the time of this onsite review, however, the new style PSP meetings were not accomplishing this goal. This was not surprising given that it was only the second or third time that each QMRP had implemented the new process. It seemed apparent, however, that the QMRPs needed to become more fluent with this new process. In addition, the QMRPs would benefit from, and should be given, training in how to facilitate and lead these types of meetings. Twenty-two new-style PSPs were reviewed. There was consistency in format, but more information was needed regarding the supports and services needed by the individual, obstacles to placement, and comprehensiveness of training objectives chosen. Specific questions were raised for four of the PSPs. SGSSLC continued to engage in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. SGSSLC, however, should consider ways of assessing the effects of these activities and making improvements. For example, regarding the provider fair, the facility could determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. Similarly, the CLOIP process had been in place for a number of years. Outcomes of the CLOIP should be determined and the effectiveness of the CLOIP assessed. Further, as noted below, more work should be done on the system of community tours, and the self-advocacy group could be used as an opportunity to educate individuals about community placement. The CLDP process was also being revised. Comments are provided regarding the proposed new CLDP and post-move monitoring forms and procedures. A continuing problem was the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. The ability of PSTs to play a more active role was needed; examples are provided. Post move monitoring was occurring, however, 25% of the visits occurred later than required by the timeframes of the Settlement Agreement. Further, there continued to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home for a 90-day post-move monitoring visit occurred. Important information was obtained and the post move monitor conducted the visit in a professional and organized manner. Improvements, however, were needed to ensure that adequate evidence was observed to indicate the presence of each support. Further, the home was in poor condition indicating that further action was required of the post move monitor.

	Specific quality assurance procedures were not in place (see section E above), however, admissions and placement staff, as well as one QA staff member, had recently begun to complete monitoring tools regarding some of their work. Modifications are recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	SGSSLC and the state continued to engage in activities to encourage and assist individuals to move to the most integrated setting. These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. This provision item, however, cannot be considered to be in substantial compliance due to the need for further actions and activities to occur, including the implementation of the state's newly revised policies for PSP development, and upcoming changes to the way the CLDP is to be developed and implemented. These changes are expected to make the referral and placement process more consistent with each individual's PSP. In addition, although SGSSLC had continued to move ahead with referrals and placement, little change or progress had occurred since the baseline monitoring review regarding: • determination of needed supports • identification of obstacles • identification of essential and nonessential supports • objective determination of the presence or absence of essential and nonessential supports following community placement. The monitoring team, as noted above, learned about many changes that were in the works at both the facility and state levels regarding PSP processes, CLDP contents, determination of evaluation of essential and nonessential supports, and training of all facility staff and departments regarding the community referral and placement process. The new PSP process was observed in action during the onsite review, and a draft of a revised CLDP format was presented to the monitoring team for review. These two new processes are discussed in this section (T) of the report. Referral and placement activities were overseen by Tim Welch, the Admissions and Placement Coordinator (APC). He was assisted by the post move monitor, Denise	Noncompliance

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		Copeland. She was in that role for about a year at the time of the onsite review. The APC had more than 10 years of experience in admissions and placement, and the post move monitor had worked at SGSSLC in a variety of capacities for more than 25 years, including as a therapy technician and caseworker. Thus, the department lead staff had years of experience and knowledge of the SGSSLC facility, systems, and practices. It was clear that SGSSLC continued to take the Settlement Agreement provision requirements for most integrated setting practices very seriously. This was most evident by the facility's numbers as of the week of the onsite monitoring review: • 10 community placements occurred since the baseline review, • 21 individuals were on the active referral list. Most of these occurred within the previous six months. One additional referral occurred during a PSP meeting observed by the monitoring team. This was similar to the number of placements and referrals at the time of the baseline review, indicating a stable amount of referral and placement activity at SGSSLC. The facility also maintained a list of individuals who themselves requested to move, but were not referred (44 individuals). The size of this group was not surprising given the characteristics of many of the individuals at SGSSLC (i.e., verbal, expressive, capable of advocating for themselves). Of these 44, 29 were not referred due to problem behaviors or unstable psychiatric conditions. Three others were not referred due to legal reasons. Surprisingly, however, three individuals were not referred solely because a staff person from the MRA was not present at the annual meeting. If this was indeed the only reason that the referral did not occur, it should be corrected immediately and not create an obstacle for placement. This was noted as a problem during the baseline review, too. At the time of this review, the three individuals were Individual #373, Individual #368, and Individual #330. Moreover, Individual #368 was listed in the baseline report with this same obstacle. The facility should check on this immediately. In addition, the facility maintained a list of individuals for whom LAR preference was the only reason for a referral not occurring (eight individuals). This list, however, was only for those individuals who also expressed their own preference. The facility should expand this list to include all individuals, whether or not the individual can independently express his or her own preference. Five referrals had been rescinded since the baseline review. The accompanying documentation indicated a thoughtful team process regarding the decision to initially have made the referral, the decision to rescind the process, and steps and actions that would occur to keep the individuals focused on the possibility of successful transitions to	

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		the community in the future. The five individuals are listed below, along with a summary of each of their unique situations. • Individual #234: escalation in serious aggressive behavior. • Individual #25: change in medical status, fracture of hips that required a longer period of time to heal. • Individual #2: PST initiated a new PNM procedure to allow for pleasure feedings. This was seen as an important preference of the individual, but required a delay in referral. • Individual #261: individual expressed his own decision to not want to move from SGSSLC. He expressed this clearly on four different occasions. He said that when he first agreed to a referral, he thought it meant he was going to go on visits to his family's home. • Individual #96: court-related issues around her commitment to SGSSLC (she was discharged during the week of the onsite review as per the provision item T4, see below). To help make placements successful, PSTs at SGSSLC must also feel empowered to not make a referral if the team members do not feel a referral is appropriate or safe. Further, special attention (e.g., peer review) should be considered for those individuals who have been referred, but have exhibited behavioral or psychiatric problems (e.g., Individual #213, Individual #351). It was not clear to the monitoring team as to whether SGSSLC senior management received regular reports and updates regarding referral status of each individual (as well as all of the ongoing activities related to most integrated setting practices, including, for example, educational activities, community tours, rescinded referrals, and obstacles to placement). This should occur regularly if it is not already in place. One way to do so is to have referral information be part of the facility's quality assurance program and part of the comprehensive list of data collected at the facility (see section E1 above). Overall, funding did not appear to be an obstacle to any individual's transition. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding and that there were plenty of slots available to individuals at SGSSLC.	
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	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. This provision item was found to be in noncompliance due to upcoming changes in the state and facility policies that were being designed to improve current practices regarding most integrated setting practices. These practices are discussed below in all of the following subsections of this provision T1b.	Noncompliance

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	related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that SGSSLC had adopted the state policy and was working under the policy, however, a number of revisions to policy and practice were in process and being updated. The revised policies were likely to include more involvement of the PST in the referral process and the post-referral process, PST involvement in visits to community providers, a review of post-move monitoring with the PST, and extra assurances and procedures regarding the determination of essential and nonessential supports in the CLDP. In addition, SGSSLC had a facility policy related to admissions and placement. It was called "Continuity of Services" and was updated on 7/15/10. The APC told the monitoring team that the only changes to this policy since the baseline review were the deletion of items so as not to duplicate what was already in the state policy.	

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		The monitoring team also looked to see if the policies and procedures were being implemented consistently. SGSSLC staff were working towards implementing the DADS policy #018.1 and expected to modify facility practice based upon upcoming policy updates.	
	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.	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. New statewide policies and procedures were being implemented at SGSSLC regarding the PSP process. These policies and procedures were recently taught to QMRPs sometime over the few weeks prior to the onsite monitoring review and implementation had recently occurred. All three of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. These were implemented under the new PSP format. It was only the second or third time that each of the observed QMRPs had used the new PSP format. In addition, 22 new-style PSP documents listed in the Documents Reviewed list at the beginning of this section of the report were reviewed. The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. The PSPs represented all of those that had occurred since 9/14/10 and for which the completed PSP document was available for review. The monitoring team only reviewed these PSPs for the purpose of monitoring this provision item because the old-style PSPs had been completely replaced by these new style PSPs. These 22 PSPs included the three PSP meetings that occurred during the week of the onsite review. The monitoring team appreciates that the facility sent these for inclusion in this report shortly after the conclusion of the week of the onsite review. <u>Protections, Services, and Supports</u> The new-style PSP for each individual noted a variety of needs, required supports, and objectives (though only a few) for the individual while he or she lived at SGSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the section titled "Integrated Discussion - Optimistic Living Vision." This terminology, however, did not reflect the contents or the observed content of this section of the PSP meeting. That is, although many important	Noncompliance

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		topics were discussed regarding the individual's preferences and needed supports, it was not what one would call a discussion of the ideal optimistic or optimal living vision. The discussion about the ideal optimistic vision should focus on the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, and skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The optimistic vision should not merely be a listing of the individual's preferred items. If so, it will not meet the goals of what is now called the "Integrated Discussion, Optimistic Living Vision." The written PSPs, for the most part, however, reflected individuality. The PSP then listed the individual's needed supports, following the structure of the PSP form. The actual discussion observed by the monitoring team (as noted below), however, was more open and free flowing, setting the occasion for the new-style PSP to meet the goal of having greater participation and individualization of discussion. A challenge for SGSSLC will be ensuring that all important topics, including a thorough discussion of the optimistic living vision, occurs for those individuals who are active and assertive participants in their own meetings. It is wonderful to have a high level of individual participation, however, it should not detract from the PST's ability, and requirement, to ensure that certain topics (some that apply to all individuals, and some that are based on the individual) are thoroughly and adequately addressed. As noted throughout section F of this report, the content of the written PSPs did not provide great enough detail to guide staff in providing all necessary supports. A review of these 22 new-style PSPs showed that they followed the required standardized format, included some individuality, did not contain a great deal of important information regarding the individual, contained many relevant service objectives, and included very few relevant training objectives. Each PSP began with a listing of the individual's preferences. This list came from a meeting held a couple of weeks prior to the annual PSP meeting called the PFA (Personal Focus Assessment). Below this listing was a short paragraph describing which of these preferences was most important. Following this was a heading "Integrated Discussion – Optimistic Living Vision" followed by standardized sections: awareness of community options, preferences of individual and LAR, obstacles, needed supports, and a statement about the most integrated setting and the PST's determination as to whether or not to make a referral for community placement.	

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		• Nineteen of the 22 PSPs (86%) were completed using this new format (one had blank sections [Individual #321s], one was incomplete and needed additions and editing [Individual #294], and one was in the old-style format [Individual #214]). • All PSPs included an action plan for the individual to go on tours of community providers and to go to community events (unless the LAR stated that the individual could not go on provider tours). All of the PSPs were short, only one to four pages, plus the list of action plans and the signature attendance page. The monitoring team suggests that a section be added to the form regarding relevant history. In many of the PSPs, this type of information was put in the "awareness of community options" section. More detail should be included regarding the individual's needed supports and services. In this sample, the PSPs for Individual #163 and Individual #271 contained the most thorough information regarding supports and services, including some recommendations from service disciplines. Individual #271's and Individual #327's PSP documents were the lengthiest at only four pages. The two PSP meetings observed by the monitoring team did not follow the format of the written PSP. As indicated above, this was by design and, as a result, they were more free-flowing, especially given the verbal nature and participation of both individuals observed. The written documents, however, did not accurately reflect the likely breadth (or brevity) of the discussion in each of the areas of the written report. Although the written PSP needs to follow a structured format, the resulting document needs to reflect the level and intensity of discussion that occurred during the meeting. The monitoring team also looked at the skills chosen by the PST to be taught in a formal structured manner, using training objectives. Across the 21 PSPs reviewed (one PSP was incomplete and did not contain any training objectives), there was an average of just over five training objectives per individual (range was three to eight). This was a relatively small number of training objectives per individual, considering that two of each individual's objectives were the state-required self-administration of medication and money management objectives. Some of the training objectives demonstrated individuality, such as gardening (Individual #214), taking care of her bird's cage (Individual #75), and using a loom (Individual #265). The training objectives, however, were not related to what the individual might need in the community, or to the identified obstacles to transition (however, obstacles were not clearly identified in most of the PSPs). Most concerning was the lack of training objectives for the three individuals in the sample of 22 who were referred for placement (Individual #213, Individual #60,	

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		Individual #359). Given that these individuals were referred for placement, the facility should be taking the opportunity to do as much specialized and individualized training as possible for them. Instead, two of the individuals had only two objectives (in addition to the two state-required objectives). Individual #213 only had training objectives for cooking and cleaning her room. Individual #60 only had training objectives for privacy and communicating with his sister. These objectives appeared to be relevant, the concern, however, was the absence of training objectives for the many other areas of training from which they might benefit given their impending transitions. Individual #359 had six additional objectives in relevant areas, such as laundry, cooking, and socialization. Again, once a decision to refer has been made, the PST should take the opportunity to thoroughly explore what training objectives should be included in the PSP. It is not unreasonable for an individual referred for placement to have 10 to 15 training objectives. Please also see further discussion of training objectives in sections F1d, F2a1, and S of this report. Three annual PSP meetings occurred during the week of the onsite monitoring review. All three were observed by members of the monitoring team. Details are provided below for two of these meetings. The content of each of the LODs (now called Integrated Discussion) was inadequate to meet the requirements of this provision item as noted in the descriptions below and in the comments that immediately follow. • For Individual #190, his PSP was led by his QMRP. The individual attended the meeting along with his house manager, dentist, nurse, direct care staff, psychologist, therapy group leader, and local MRA. The individual spoke a lot during the meeting talking about some incident at the facility's park where he used his "tools" (regarding appropriate social interactions). He also spoke about wanting to move to San Angelo and attending college in the future. He talked about wanting to learn to cook, and to get a job in the community. There was discussion of his alleged offending history and recent behavior problem incidents. Then discussion went on to medical-related topics, personal spending money, a smoking management program, and rights restrictions. There was discussion of recommending him for a move to a less restrictive home on campus. He stated that he did not want to move from SGSSLC right now. The identification of specific obstacles and specific action plans (for service and training objectives) was not evident to the monitoring team. Overall, the individual was an active participant and the QMRP did a good job of trying to keep the individual on topic. • For Individual #359, her PSP was also led by her QMRP. Her mother was on speakerphone and attendance in the room included her psychologist, nurse, nurse case manager, direct care staff, and home manager. The individual read	

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		her list of preferences and they spent time talking about how to get her more involved in her preferred activities, such as model cars, football, and music. The PST team members talked about the progress that she'd made over the past year and her knowledge of community group homes. The team agreed to refer her for placement in a group home. The individual's mother was in agreement. There was good discussion regarding the potential location for a group home, such that the PST agreed that she should live closer to her mother, but not in the same town. Overall, it was a positive meeting that appeared to satisfy the preferences of the individual, her mother, and the PST members. Monitoring of the PSP meeting was being done by the QMRP Coordinator. The post move monitor was not doing any monitoring of the PSP LOD. The current form used for PSP monitoring needs to be revised to reflect the new-style PSP. Also, the form did not include any items related to most integrated settings, such as awareness of community, obstacles to placement, and ways to address these obstacles. It may be helpful to have the APC attend and observe some PSP meetings to help develop an appropriate monitoring tool as well as to provide feedback to the facility regarding the way most integrated setting practices are addressed in the new-style PSP format. Based on these observations, review of documents, and discussions with one of the QMRPs and the QMRP coordinator, the following comments are provided regarding the new PSP process at SGSSLC. Positive comments: • The process was very new and will take some time for QMRPs to be comfortable and competent with it. • It was implemented fairly consistently across QMRPs. • Participation from PST members appeared to be greater than in the old style format. • Time was not wasted on topics that were not relevant to the individual or for the bland reading of reports and assessments. • Individuals had opportunity to participate (and did). Comments requiring attention: • PSTs may fail to cover all of the important areas due to the more open and free flowing nature of the new format. The QMRPs may benefit from having some sort of checklist. • The LOD/Integrated Discussion was weak in the PSP meetings observed. It will require attention from the QMRP facilitating the meeting if the required components are to be addressed.	

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		• The characteristics of an ideal successful most integrated setting (i.e., optimistic vision) were not discussed, but should be. • Obstacles to community placement should be identified. • A relevant set of training objectives should be identified. • QMRPs will need support and specific training on how to lead a meeting and to be an effective facilitator. The advantage of the new format also sets the occasion for PST discussions to become in depth, to stray from the important topics at hand, and to include disagreements, especially at SGSSLC where many of the individuals are able to actively participate in the discussions that occur at their PSP meetings. Therefore, QMRPs as facilitators (and <u>leaders</u> of these meetings) must be confident and skilled. The monitoring team believes the QMRPs would welcome this type of training. • Regarding specific PSPs: o Individual #298: PSP noted that he was readmitted back to SGSSLC for greater structure and support, but it did not say what supports were needed, or what supports were put in place for him. o Individual #194: Actions Plans in the PSP were from 2007 and had not been updated. It appeared that they should have been. o Individual #264: the PSP indicated that a DNR order is in place, but does not provide a reason for this. Also, the PSP noted the facility physician not agreeing with another physician's orders, but no rationale was provided. o Individual #294: as noted above, this report was not edited; it has numerous typographic and wording errors. <u>Obstacles to Movement</u> There continued to be no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility (also see T1g below). SGSSLC submitted to the monitoring team information regarding the reasons why 44 individuals who had requested placement were not referred (see T1a above), however, this was not summarized or addressed in any systemic manner. Moreover, the obstacles noted in the 19 of 22 PSPs reviewed, that did not include a referral for placement, indicated that 10 were related to behavior problems, two were LAR preference, one was the individual's preference, and two were due to legal issues. For the other four individuals (Individual #120, Individual #264, Individual #214, Individual #190), the obstacles were unclear. Furthermore, strategies to overcome obstacles were not in place at SGSSLC as evidenced	

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		in the action plans, specifically in the training objective action plans. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary.	
	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.	SGSSLC continued to engage in activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. This provision item is rated as being in noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. In addition, no changes or improvements from the time of the baseline report were evident to the monitoring team. First, SGSSLC had conducted a fair for all providers to present information to interested individuals, family members, LARs, staff, and families from the community. It occurred in September 2010. Participation included 14 staff from five local providers, 140 SGSSLC individuals, 83 SGSSLC staff, and one family member. This showed that there was a great deal of interest from individuals at the facility and that many staff were exposed to information about community living. The APC, however, noted that this was the poorest turnout yet from providers and families (though in the baseline report, it was noted that no family members attended the previous fair). SGSSLC should consider ways of making the provider fair more effective. One way to do so is to determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. In addition, the facility might focus on increasing attendance, providing family members with sufficient guidance before the fair and then escorting them during the fair to ensure that they have an opportunity to interact with providers who might best meet their family member's needs, and helping providers prepare to answer the types of questions most often raised by family members. Furthermore, the facility should consider other creative ways of educating family members and LARs, such as pairing LARS whose individual has successfully moved with LARS with similar concerns, highlighting success stories, and offering options for individuals to reconnect with families or friends who have moved to the community. Second, the APC reported that there was a very good working relationship between the facility and the local MRA. The next MRA training was scheduled for December 2010. A copy of the presentation slides was sent to the monitoring team a few weeks after the onsite review. The monitoring team appreciated receiving this information. It gave a	Noncompliance

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		good overview of the types of residential, day, and vocational services available, and the names of provider agencies. The monitoring team, however, was not sent any other information regarding the overall outcome of the training, such as who was in attendance, and what types of questions were raised. Therefore, no further comment can be provided regarding this activity. Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. The purpose of the CLOIP was to educate individuals and family members about community living options. The CLOIP process had been in place for a number of years. The monitoring team, therefore, recommends that the facility assess the effectiveness of the CLOIP process, that is, whether or not it achieved the outcomes the facility intended it to achieve. Fourth, the facility took individuals on visits to community providers. This was discussed with the admissions and placement staff during the onsite baseline monitoring review, and addressed in the baseline monitoring report. Five months of sign in sheets for provider site tours (May 2010 through September 2010) were provided to the monitoring team. • There were two or three tours each month (less than the three per month during the baseline review). • Each tour was scheduled for approximately eight individuals, though there were many instances when an individual refused to go (these were larger groups than during the baseline review). • There were a total of almost 100 names on these lists, but there were no summary data, making it impossible for the monitoring team to determine the number of unduplicated individuals (data on number of individuals who went on provider tours were reported to the monitoring team during the baseline review). It was good to see that provider tours were occurring. The monitoring team's recommendations from the baseline review for creating a tracking database regarding each individual, number of visits, goal and outcome for each individual, and whether the visit was in line with the information in the PSP, however, were not acted upon Further work may help to make the system of tours more effective at SGSSLC. First, ensure that all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). Second, ensure that PSTs know what information is needed by the APC to make the tour meaningful (e.g., type of home, location, mobility needs). Third, obtain comments from	

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		staff and individuals, if possible, about the individual's response to the tour. The current reporting were statements regarding the group's overall response to the tour. Fourth, incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system (see section E above). Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work (including training and support of the QMRP facilitators) was needed to have these discussions be more comprehensive and meaningful, especially given the new PSP format. Finally, although not solely related to education about community placements and providers, the active self-advocacy group at SGSSLC provides an opportunity for another venue to educate individuals about community placement and the community placement process.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility provided the monitoring team with a description of what it considered its assessment for placement and with a list of all individuals at the facility and whether or not each individual was recommended for placement. The description listed out the components of the LOD as well as a number of steps taken directly from the DADS policy on most integrated setting practices. This was the same information submitted for the baseline monitoring review. The monitoring team understands the difficulty in determining a process for assessing an individual for placement, that is, what tools, questions, or criteria, if any, should be included. Therefore, as noted in the baseline report, the facility will need guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. If the position of the facility is that the PST goes in with concept that all individuals can be supported in the community (with very few exceptions), the PSP meeting and PSP document will need to clearly show discussion of the supports the individual needs wherever he or she will be living, obstacles to community placement, and methods to address these with action plans. As indicated above in section T1b1 (and section F), more work needed to be done in these areas Note that the CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement.	Noncompliance
T1c	When the IDT identifies a more	As noted in section T1b above, the DADS policy on most integrated setting practices was	Noncompliance

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	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:	being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form. Many of the changes to the CLDP format were in response to discussions that monitoring team members had with facility and state staff during onsite monitoring reviews, as well as in response to findings noted in baseline monitoring reports. The monitoring team appreciates and acknowledges the facility and state's responsiveness. Some comments regarding the new CLDP form are presented below. Note that this new format CLDP had not been implemented at the time of the onsite monitoring review. Therefore, these comments are based solely upon a review of a blank form. • Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. • The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. It sets the occasion for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. • A list of standard items to be completed and in place prior to every individual's move now appeared on page 6 (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus upon identifying those essential and nonessential supports that were truly based upon individual needs and preferences. • The list of summaries and recommendations on page 9 was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or nonessential supports. • Psychiatry should be added to the list of summaries and assessments. • The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the monitoring team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports if the PST believes that implementation of any	

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		of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the state's desire for transition to grow out of the PSP process. An example occurred during the CLDP observed by the monitoring team and described in more detail below in T2a and T2b. The PST, with encouragement from the monitoring team, included instruction in communication and language (i.e., a training objective) for an individual with autism as a nonessential support in his CLDP. The community provider readily agreed to it. • It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or nonessential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. • The pre-move site review should also be sure to include the list of standard items on page 6. This could be added to the list on page 23. The monitoring team looks forward to reviewing the implementation of these new procedures.	
	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.	The DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST submit a current assessment and/or discharge summary for inclusion in the CLDP. As noted above, this policy, including the CLDP process, was being revised. The CLDPs reviewed in this section of the report were implemented as per the current policy and procedures. Five CLDPs and their associated documents (e.g., discharge assessment summaries, PSPs, post move monitoring checklists) were submitted to the monitoring team and were reviewed. Overall, processes were in place at SGSSLC for this provision item. The impending changes to the process are likely to lead the facility towards substantial compliance with this provision item. At SGSSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits,	Noncompliance

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		exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports. The facility planned to address this with the upcoming CLDP changes. The CLDP activities were coordinated and managed by the APC and the post move monitor. They gathered documents, put together a draft CLDP, and organized and ran the meeting. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections V. and VI. and was standard in all CLDPs. The CLDP also included a list of essential and nonessential supports, each of which was assigned to a staff member at the provider agency or at the facility. Essential and nonessential supports and their implementation responsibilities are addressed in section T1e below. The CLDP included updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet, but the CLDP document itself only included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. The provision item on assessments is addressed below in section T1d. At SGSSLC, the CLDP document was an appropriate length and contained information about the individual, including for example: • reason for referral • general information about the individual • history of placement and the activities taken during the referral and search for an appropriate provider • a summary of assessments (e.g., social, medical, psychological, daily living skills, vocational, leisure and recreation) • essential and nonessential supports • signatures from the SSLC, MRA, and Provider • a description of monitoring activities • agreements The DADS central office had conducted reviews of six CLDPs. Of these six, two were from the group of five CLDPs reviewed by the monitoring team (Individual #392, Individual #136). Two appeared to have been for recent CLDPs that were not submitted to the monitoring team (Individual #131, Individual #334). The monitoring team would have	

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		liked to have had the opportunity to review these two most recent CLDPs, but they were not submitted. For future reviews, the facility should submit the most recent CLDPs to the monitoring team for review when the monitoring team arrives onsite. The comments from the DADS review were detailed, appropriate, and individualized. These DADS comments should be incorporated into a revised CLDP for each individual.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and/or his staff had responsibility and had agreed to the contents of the CLDP. (Actions specific to essential and nonessential supports are considered in section T1e below.) Each CLDP also referred to a specific date for moving to the new placement.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Narrative sections of the CLDPs indicated a high level of involvement by individuals (when appropriate) and by their LARs and family members. There was evidence of individual (signature) and LAR review in the CLDP documentation submitted.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. Full assessments were provided as part of the referral packet of information to the provider. In preparation for the CLDP meeting, assessments were updated and summarized. Therefore, the CLDP document contained these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The APC reported that he reviewed all assessments and all assessments updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. A review of the five CLDPs indicated a standard set of assessment updates/summaries in the following areas were submitted and dated within 45 days prior to the individual's scheduled transition move date: • Social • Psychological • Nursing • Dental • Community living	Noncompliance

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		• Vocational • Communication • Rehabilitation therapies • Dental • Audiology The monitoring team recommends that some sort of checklist or tracking tool be used by the APC to ensure that all relevant assessment updates/summaries are submitted. This was also recommended in the baseline report and should also be submitted as part of the documents sent to the monitoring team either prior to, or at the time of, the onsite review. Completed checklists would indicate to the monitoring team that all required assessments were indeed submitted, thereby indicating that a comprehensive assessment of needs and supports was completed by the facility.	
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.	A key part of the community placement process was the identification of essential and nonessential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Nonessential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all nonessential supports needed to be in place and addressed. Nonessential did not mean not needed. The APC described the facility's process for creating a list of essential and nonessential supports to be a work in progress. He described the process as occurring during the CLDP meeting. The APC reported that he also reviewed the individual's assessments in an attempt to ensure that the CLDP content was consistent with the assessments. Each of the SGSSLC CLDPs had a table that listed out essential and nonessential supports. Across the five CLDPs, there was improvement noted since the baseline review. First, the list of essential and nonessential supports included almost all of the recommendations and comments from the assessment updates and the PSP. This showed an attention to the assessments. Second, there was individualization across the supports. Third, the PSTs required providers to continue to conduct training objectives and, in some cases, to initiate new training objectives. This was good to see and demonstrated the PST's capability in directing the occurrence of important activities for the individuals. The CLDPs appeared to improve across the five CLDPs reviewed from the first to the most recently completed. The best list of supports was in the most recently completed CLDP (Individual #219). It had more than 40 supports listed. Of course, it is the relevance of the supports listed, not the number, that is most important, however, this	Noncompliance

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		CLDP indicated that the PST and APC were taking a more thorough and thoughtful look at supports than they had been doing at the time of the baseline review. Examples of individualization across all five CLDPs included: • Training objectives on room cleaning, typing in a journal, and eating safely • Obtain substance abuse counseling • Have a quiet, calm, dark personal space • LAR provision of positive feedback to the provider • Learn pedestrian skills Examples of standard supports across the CLDPs included: • Site review indicating the home meets all safety requirements • Staff inserviced on CLDP and BSP • Suitable transportation • PCP scheduled The listed supports continued to be written in a way that made them difficult, if not impossible to measure or observe. This was noted in the baseline review and continued to be a problem. Almost every support was written in this way. The revised CLDP process will require the CLDP to describe, in defined observable terms, each support so that it can be observed, measured, and recorded. This will be important in order for SGSSLC to achieve substantial compliance with this provision item. Unfortunately, no CLDP meetings were scheduled during the week of the onsite review, therefore, the monitoring team was unable to observe the facility's implementation of this important part of the transition and placement process. The monitoring team hopes that a CLDP meeting can be observed during the next onsite review.	
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.	As noted in section E (Quality Assurance) in this report, quality assurance process were at the early stages of development at SGSSLC and, therefore, there was no organized quality assurance process regarding this section T of the Settlement Agreement. As also noted in section E in this report, the quality assurance department was creating a list of all data that were collected at the facility. A great deal of data were collected by the APC and PMM. Their data should be part of the facility's comprehensive list and some of these data should be regularly reviewed by the QIC. Examples include the number of individuals placed, referred, and requesting placement; obstacles to placement; action plans to address obstacles; educational activities; and so forth. The monitoring team recommends that the APC contact the Lufkin SSLC APC to learn	Noncompliance

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		about the types of quality assurance activities that have been initiated there.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	SGSSLC was not in compliance with this provision item. SGSSLC was not gathering, and was not analyzing, information related to identified obstacles to individuals' movement to more integrated settings. Please also see the discussion in section T1b1 above. SGSSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. At the time of the onsite monitoring visit and subsequent preparation of this report, DADS developed an initial report designed to ultimately meet the requirements of this provision item. The statewide report provided an overview of how obstacles were to be identified, a definition of each of 12 different categories of obstacles, and a description of 11 steps the state and facility might take to address some of these obstacles. As discussed with DADS management, the goal was for the state to gather all of the data on the 12 categories of obstacles and create a statewide plan. In addition, the statewide report would include • an appendix for each of the SSLC that provided data specific to that facility, • additional information specific to that facility, such as related to location, population, staffing , and • steps to overcome that facility's specific obstacles. Some obstacles might be able to be resolved at the facility-level, while others will need state intervention. The data that will be used were being entered into the system as each individual planning session transpired. This was to occur beginning 9/1/10. This appeared to be a reasonable approach to reaching substantial compliance with the requirements of this provision item. The monitoring team recommends that further information be collected regarding one type of obstacle, that is, LAR preference for the individual to remain at the SSLC. Rather than solely listing this as an obstacle, the report should indicate the reasons for the LAR's preference (i.e., reluctance to support referral). This information will be helpful to DADS and to each facility.	Noncompliance

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T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a one-page document titled "Community Placement Report." The report was dated 10/6/10 and listed 35 individuals, their date of referral, date closed (if any), and reason closed (if any). To meet this provision item, the report needs to contain three separate lists as follows: • those individuals whose PSTs have determined, through the PSP process, that they can be appropriately placed in the community and receive community services (i.e., those individuals who have been referred for placement), • those individuals who have been placed in the community during the previous six months, and • those individuals whose PSTs have determined that they can be placed, but have not been referred due to LAR preference. To meet this provision item, the facility needs to put these three lists into one report.	Noncompliance
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	SGSSLC was implementing the post-move monitoring process. The APC and the post-move monitor (PMM) did not maintain a post-move monitoring schedule that listed each individual's name, the new provider, and the dates by which the three required post-	Noncompliance

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	years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	move monitoring visits were required to be completed. Post-move monitoring checklists for the most recent seven placements were reviewed by the monitoring team (three of the 10 most recent placements were being post-move monitored by other facilities and, therefore, were not part of this review, Individual #171, Individual #191, Individual #92). SGSSLC was not post-move monitoring any individuals who had moved to the SGSSLC area from any other SSLC. Across these seven sets of post-move monitoring checklists, 12 of the 16 (75%) required visits were completed within the required timelines. The late monitoring was for two visits for two individuals (Individual #392, Individual #324). SGSSLC should ensure a higher percentage for future reviews. Following the onsite review, the facility noted that there were discrepancies in actual move dates across different documents, such as the community placement reports and the post move monitoring checklists. SGSSLC should ensure that all dates on post move monitoring checklists are correct. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. The monitoring team, however, was pleased to learn that all post-move monitoring including a visit and observation at the residence when the individual was at home. This was an improvement from the baseline review. A new post-move monitoring checklist form was developed, but not yet implemented. The monitoring team reviewed this new form. For the most part, it was the same as the previous form, but included improvements, such as a place to indicate where the visit occurred (e.g., home, day program), and a column for "evidence" for each support. It seemed this column was to indicate the evidence as per the CLDP. The PMM will need to enter the evidence found in the comments section. The completed checklists indicated a number of problems of which the facility and state were well-aware, and all of which were being addressed via the new CLDP and post-move monitoring formats. The post move monitor was a professional, organized, and competent individual. It is likely that she will be successful in meeting the requirements of this provision item as she continues to get more experience in her position. Further, substantial compliance is likely to occur given the new post move monitoring form, new expectations, and modifications based upon the contents of this monitoring report, including the items described immediately below. First, most of the essential and nonessential supports were not defined in a way that specified what evidence needed to be observed by the post-move monitor. This, not	

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		surprisingly, led to inconsistency and errors in the way items were rated. Items, such as 24-hour awake staff, staff inservices, and suitable transportation need to be defined, and the way in which the post move monitor is to validate their presence, needs to be described. For example, the statement, "The home setting provides the structure required" does not provide any detail as to how that was determined (Individual #219). In another example, it did not seem that talking at the dinner table should have met the required support for socialization skills (Individual #392). Second, more detail needs to be included in the post move monitoring report. Solely scoring a Yes, No, or NA does not provide enough information for the PST, APC, or monitoring team to determine the nature and extent to which the support was (or was not) occurring and the steps the post move monitor and provider agency had taken (or were going to take). For example, the post move monitoring checklist had a short comment indicating that Individual #107 had raised serious questions about his desire to continue to live at the community group home. The post move monitoring checklist should indicate what the post move monitor was going to do to follow-up on this concern. The monitoring team recommends that the APC and PMM look at the post move monitoring checklists completed by the PMM at the EL Paso SSLC. These contained a great deal of information. Moreover, the information for each subsequent post move monitoring review was added to the previous review. As a result, by the third review, a single document contained information from all three reviews. The post move monitor might also talk with the El Paso SSLC post move monitor regarding the completion of detailed post move monitoring checklists. In addition, the post move monitor would benefit from the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. Third, items that are "in process" should be scored as a No, rather than a Yes. Examples were found for all individuals reviewed. Similarly, items that have not yet occurred also should be scored as a No. The report can then indicate the reason for each No. Fourth, the post move monitor, and the APC, should be empowered to comment on any relevant and important aspect of the individual's living, work, or day situation, even if the item is not a specific support identified during the CLDP process. Examples include a dirty home, unacceptable individual personal hygiene, and individual at risk of injury due to aggression of a housemate. The PMM and APC should act on these concerns in the same way they would if the item had been a specified support. This was evident during the observation of post move monitoring described below in T2b, during which the condition of the home (dirty), the condition of the individual's bedroom (bad odor), and the hygiene of the individual (unshaven) were evident.	

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		The APC and PMM reported that they had a very good working relationship with the providers and had not needed to resort to notifying the MRA, DADS, or any regulatory agency in order to gain their compliance in providing any of the required supports.	
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.	As noted above in section T2a, post-move monitoring visits were occurring at SGSSLC. The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of Individual #136 for the conduct of the 90-day post move monitoring visit. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. Individual #136 lived with two other individuals. During the visit, his house manager and agency case manager were present. Both appeared to be very knowledgeable about the individual. We began by sitting at the kitchen table with the individual and these staff. The individual immediately raised two of his own concerns regarding carrying own cigarettes, and having no limitations on soda. He became quite agitated and said he didn't want to live there any longer. The staff were very patient with him and described the way he handled cigarettes (gave them away to others) and his soda limitation while at SGSSLC. The PMM agreed to follow up. She was extremely professional and direct; this helped to calm the individual. In the report sent to the monitoring team later that week, there was indication that the soda restriction had been addressed and removed because it was no longer necessary. After calming, the individual said that overall he was doing well and wanted to remain living there. The post move monitoring process at SGSSLC did not thoroughly look at evidence of the occurrence of many of the supports. Most of the items on the checklist were scored as Yes based solely on the provider staff saying that the support was in place or had occurred. As indicated above, this is likely to change given the newly revised CLDP planning process and the newly revised post move monitoring checklists. These will require a listing of the evidence required to indicate presence of a support as well as the evidence directly examined by the post move monitor. The condition of the home was of concern to the monitoring team. The house was worn and needed to be painted inside. The kitchen cabinets were worn and broken, the refrigerator had no handle, the ceiling fan was full of dust, the toilet in the bathroom was not set straight, and the backyard porch chairs were torn. The individual's bedroom smelled like dirty clothing, and the closet doors needed painting. The facility APC and	Noncompliance

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		PMM should follow up on these concerns and ensure they are corrected (as indicated in T2a above).	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of 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	SGSSLC presented six individuals who were discharged under provision T4 according to the APC. Two of these individuals were discharged after SGSSLC found them fit to proceed based on court-ordered evaluations. Therefore, provision T3 applied to these two individuals and their information is not included in the review of this section T4. The discharge planning procedures for section T4 required that there be a documented reason for transfer or discharge, indication that the facility provided a reasonable amount of time for preparation (except in emergencies), documentation of a facility-developed a discharge summary (that included developmental, behavioral, social, health, and nutritional statuses), and a post-discharge plan of care that was written to assist the individual to adjust to the new living environment. • Individual #96: discharged pursuant to a court order. • Individual #204: family took him to live at home following a hospitalization. • Individual #152: family brought individual to live at home due to unhappiness of individual. Her placement duration at SGSSLC was less than two weeks. • Individual #301: transfer to other SSLC due to increased medical needs. SGSSLC appeared to follow the requirements of T4 in these four cases and, therefore, this provision item was found to be in substantial compliance.	Substantial Compliance

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	services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Implement updated policies and procedures when they are disseminated.
2. Ensure that a thorough and meaningful discussion of optimistic optimal living characteristics occurs during the PSP meeting. Ensure that the optimistic living vision section of the PSP addresses the individual's needs for success in the community, not only his or her preferences.
3. Identify and address the identified obstacles to individuals' movement to the most integrated setting within the PSP for each individual.
4. Examine and correct any situations in which MRA absence from a PSP meeting resulted in the individual not being referred.
5. Ensure that training objectives are related to community living and to any identified obstacles. For those individuals who are referred, a larger set of training objectives should be considered.
6. Add a section to the PSP form to allow for a brief description of relevant aspects of the individual's history.
7. Provide competency-based training for QMRPs regarding how to facilitate and lead a meeting of this type.
8. The APC should attend and observe a sample of PSP meetings.
9. The PMM should do monitoring of the portions of the PSP meeting relevant to this provision section T.
10. Identify and address obstacles across the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g.
11. Create a list of individuals for whom LAR preference is the only reason a referral has not occurred (whether or not the individual himself or herself requested placement). This information should be reported as part of the admission and placement department's data/QA activity.

12. Create a review process for any referred individuals who begin to exhibit problem behaviors after referral.

13. Continue to work on the education of individuals and LARs regarding most integrated setting practices.
    a. Determine measureable outcomes for the provider fair.
    b. Assess the outcome/effectiveness of the MRA annual training.
    c. Assess the outcome/effectiveness of the CLOIP.
    d. Improve the system of community tours as described in provision item T1b2, including ensuring that every individual who should have the opportunity does have the opportunity. Track and summarize relevant tour information, including making sure that the tours are in line with the individual's needs and preferences.
    e. Use the self-advocacy group as an opportunity to educate individuals about community placement.

14. To address the provision for assessing each individual for placement, include a specific statement in the PSP as to how this was accomplished.

15. Create and use a checklist to ensure that all required assessments (and updates) are received and included in the CLDP.

16. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Begin developing the list of supports prior to the CLDP meeting.
    b. Ensure that all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
    c. Define each support in observable and measureable terms.
    d. Define the manner in which the presence of each support will be verified.
    e. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.

17. Develop a quality assurance process for this provision. Ensure that relevant information is submitted and monitored by the QA department. Ensure that quality assurance processes are applied to all of section T, including, but not limited to, T1g. Consider the creation of a weekly report, such as that used at the Lufkin SSLC to help manage this information week to week. Determine what information needs to be reviewed regularly by senior management and the QIC.

18. Ensure post move monitoring occurs within the required timeframes. If not, provide a clear reason as to why the timeframe was not met.

19. Implement the new post-move monitoring checklist, including detail regarding
    a. each of the sites visited
    b. how the presence or absence of supports was assessed (i.e., evidence), and
    c. follow-up activities for both essential and nonessential supports.
    d. other areas of concern that have come up since the placement (e.g., cleanliness of house, personal hygiene of individual, risk of injury from a housemate).

20. Create a Community Placement Report as described in provision item T1h above (i.e., three listings of individuals).

21. Address the specific comments made above in section T1b1 regarding the PSPs of four individuals (Individual #298, Individual #194, Individual #264, Individual #294).

The following are offered as additional suggestions to the facility:

22. Make minor edits to the new CLDP form as follows: (a) add psychiatry to the list of assessments, (b) reword or remove the comment on page 12 regarding action plans, and (c) include the standard items from page 6 in the pre-move list on page 23.

23. DADS should continue to provide feedback and suggestions on SGSSLC's CLDPs to the APC. Consider creating a metric to measure the quality of the CLDPs and consider creating a criterion to indicate that the facility has mastered CLDPs. This might then result in less frequent reviews of CLDPs being necessary.

24. Make the post-move monitoring checklist reports cumulative for each individual, that is, add new information to the previous report to result in a single document.

25. Consider allowing PSTs to extend the 90-days of post-move monitoring if warranted.

26. Provide opportunities for the post-move monitor to network with other post-move monitors at other facilities.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o Human Rights Committee (HRC) meeting minutes 3/25/10 – 9/16/10 o List of guardianship status for 168 individuals, undated o DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans for: • Individual #64, Individual #60, Individual #251, Individual #120, Individual #213, Individual #123, Individual #379, Individual #160, Individual #315, Individual #18 o Rights Assessments for: • Individual #64, Individual #60, Individual #123, Individual #379, Individual #160, Individual #315 Interviews and Meetings Held: o James Reid, Residential Services Coordinator o Roy Smith, Rights Officer Observations Conducted: o Observation at homes and day programs o Human Rights Committee Meeting 11/18/10 o Daily Incident Management Review Team Meetings 11/17/10 and 11/19/10 o Restraint Reduction Committee Meeting 11/18/10 o Self-advocacy Meeting o PST annual meeting for Individual #327
	Facility Self-Assessment: The facility's POI indicated that the facility had developed a prioritized list of individuals in need of an LAR and was waiting on further direction from the state office in terms of a policy to address this provision. They had assigned a rating of noncompliance to all items in this provision. The monitoring team agreed with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: Since SGSSLC did not indicate it was in compliance with any of the provisions of this section, and particularly since it indicated it was waiting on the final statewide policy before taking most actions, the monitoring team did not examine these provisions in tremendous detail. Instead, the team reviewed a small sample of documents in order to be able to assess progress, if any, from the baseline review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. The findings are as follows:

	Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, not all individuals had been assessed and not all PSTs were adequately addressing the need for a LAR or advocate. Provision item U2 was determined to be in noncompliance. The facility reported little activity or planning to solicit guardians for those determined to be in need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility did have an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were holding good discussions around the need for guardians while other teams were only minimally discussing the capacity for individuals to make decisions and give consent.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their 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.	SGSSLC did not have a policy in place for developing and maintaining 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. The state developed a draft policy to address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it plans to take action in these areas once the policy is finalized. According to the Rights Officer, the facility did have a procedure in place for determining need for guardianship. They used a standardized tool titled Determination for Need of Guardian/Priority Tool. The tool was designed to be completed by the QMRP with input from the PST and assigned a priority rating of Priority I, Priority II, Priority III, or non-priority based on the list of five factors: • Has been deemed incompetent through the court system and currently does not have a guardian • Has a high risk and/or history of abuse, neglect and /or exploitation • Has serious ongoing medical/psychiatric issues • Has severely impaired communication/developmental disability and/or diagnosis of severe/profound mental retardation • Other as determined by the PST This was rated with consideration of whether or not the individual had a guardian, involved family member, correspondent, or advocate. The facility provided the monitoring team with a prioritized list of 168 individuals at the facility and their guardianship status. The individuals were rated as follows: • 51 had guardians	Noncompliance

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		• 46 were non-priority • 28 were priority I • 25 were priority II • 18 were priority III Five of the individuals on the Priority I list had been declared incompetent, but did not have a guardian in place. The PSPs reviewed did not indicate that PSTs routinely used an individualized assessment process to determine that an individual was in need of an LAR or to what extent or for what purposes guardianship was required. In nine of 10 PSPs reviewed, there was at least minimal discussion of the individualized need for an LAR. Examples included: • For Individual #64, the PST documented the individual was an adult without a guardian, LAR, or advocate. His rights assessment indicated appropriate restrictions for the individual were his freedom of movement; his diet; managing his money; and ability to give informed consent with regard to medical, programmatic, financial, restrictive, media decisions, or release of records. His PSP indicated that a pre-planning packet had been sent to his family contact, but the facility had not received a response. The PSP stated that his father had been appointed as guardian, but passed away in 1974. His family no longer had any direct contact with him. It further noted that he had a poor understanding of his basic rights and would benefit from a guardian. He had not been assigned a priority rating for guardianship needs on the list provided to the monitoring team. • For Individual #60, the PST documented the individual was an adult without a guardian. His sister-in-law was his primary correspondent. The PSP noted that she was discussing the possibility of pursuing guardianship. The team agreed if she did not seek guardianship, he would benefit from being appointed a guardian. He had numerous restrictions approved through the HRC, including providing or withdrawing informed consent to medical, programmatic, financial, and restrictive practices. He was listed as a Priority III for guardianship needs. • Individual #251 had a guardian and his PSP indicated that his guardian participated in the development of his PSP. • The PSP for Individual #120 documented that the team discussed guardianship and determined that he was "able to voice his opinions, wants, and desires very well and makes informed decisions very proficiently." It was determined that he did not need a guardian. The PSP indicated that he had limited family contact and had not seen his family in "quite some time." He had rights restrictions for tobacco use, psychotropic drug use, and diet. He had not been assigned a priority rating for guardianship needs on the list provided to the monitoring	

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		team. • Individual #213's PSP indicated that she did not have a guardian and the team agreed that she did not need a guardian. Her current restrictions included right to own and sell property, freedom of movement regarding her LOS and living in a locked home, dietary restrictions, and money management restrictions. She had a CLDP meeting scheduled for 12/2/10 prior to plans to move into the community. • The Rights Assessment for Individual #123 indicated that he was an adult without a legal guardian and he advocated for himself. It also indicated that his mother advocated for him. His PSP stated that "the team determined he does not need a guardian using the need for guardianship tool." There was no further information offered on his capacity to make decisions on his behalf. He was listed as a non-priority on the SGSSLC need for guardianship list. His rights assessment indicated that he had restrictions on movement (enhanced LOS), restrictions on money management, restrictions on his right to give or withdraw informed consent in regards to medical, programmatic, financial, restrictive practices media/photo, and release of records. It was not clear why the restrictions to give or withdraw informed consent were necessary if he was able to give informed consent. • Individual #379's Rights Assessment indicated that he was an adult with no guardian in need of assistance from an advocate. His PSP indicated that he did not have an LAR or advocate. His PSP did not document any discussion around the need for a guardian or advocate. It did, however, indicate that the PST had met and requested a meeting with the transfer committee to look at a safer environment for him, but the request was denied. The HRC had approved monetary and dietary restrictions. His right to give and withdraw informed consent regarding medical, programmatic, financial, restrictive/intrusive practices, media/photo, and release of records was restricted with the justification that he "may be able to reason and understand consent to some degree in these areas, he would not be able to understand the full implications of some of the decisions that would need to be made in each area." He had not been assigned a rating on the need for guardianship list. • Individual #160 was an adult with no LAR, advocate, or family contact. The team discussed guardianship and concluded that based on the Need for Guardianship Tool, he did not have priority need for a guardian. His rights assessment included the following right restrictions: freedom of association, privacy, freedom of movement, freedom of choice, diet, and money management. It did not indicate that the HRC had approved the rights restrictions. • Individual #315's PSP indicated that he was an adult with no LAR, advocate, or involved family. It was noted in his PSP that a letter was mailed to Guardianship	

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		Alliance on 8/3/10 requesting an advocate or guardian for him. A Rights Assessment was completed on 8/3/10. It included monetary and dietary restrictions, right to give and withdraw informed consent regarding medical, programmatic, financial, restrictive/intrusive practices, media/photo, and release of records. It was not signed by the HRC committee indicating approval. • The PSP for Individual #18 indicated that he had no LAR or advocate. The Determination for Need of Guardian/Priority Tool was completed by the PST and it was determined that he would benefit from the services of a guardian to assist him in making decisions for his life.	
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.	SGSSLC did not have policy or procedure established to implement this provision item. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. According to documentation provided to the monitoring team, there were no individuals at the facility who had obtained a guardian since 1/1/10. The facility did have some rights protections in place including an assistant ombudsman housed at the facility and a Rights Officer employed by the facility. Both were well known and actively involved with the individuals at the facility. There was a Human Rights Committee (HRC) at the facility that met weekly to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at SGSSLC. The HRC, chaired by the Rights Officer, included individuals who resided at SGSSLC, representatives from the community, family representatives, and facility staff from a number of disciplines. During an HRC meeting observed by the monitoring team, one of the individuals serving on the committee (Individual #195) reported that he had been a long term member of the committee. He had, in fact, been present at the HRC meeting observed during the baseline visit. He was obviously familiar with the process and provided input at the meetings. Another individual was fairly new to the committee. HRC minutes described restriction reviewed, the reason for the restriction, required a plan in place to remove the restriction, a summary of HRC discussion regarding the restriction, the date of the next PST review and indicated if the restriction was approved or not and when the HRC would review it again. This ensured that restrictions continued to be reviewed and plans were in place to review the restriction. There was also a self-advocacy group on campus. The monitoring team attended the self-advocacy meeting held the week of the monitoring visit. The group was led by the Rights	Noncompliance

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		Officer, but elected individuals to begin leading the meetings during the meeting observed. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals. The facility was not in compliance with this provision.	

Recommendations:

1. Continue to prioritize the list of individuals who need LARs at the facility.
2. Develop a list of LAR providers in the area.
3. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.
4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.
5. Continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.
6. Ensure that any restriction of rights for an individual is approved through the Human Rights Committee approval process.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SGSLC policy: Active Records Guidelines, dated 11/18/10 o SGSSLC policy list, not dated o List of typical meetings that occurred at SGSSLC o SGSSLC POI, October 2010 o SGSSLC POI Supplement, October 2010 o SGSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 11/15/10 o Table of contents for the active record and the individual notebook o Master record file table of contents/record order o List of all staff responsible for management of unified records o Completed audit sheets of two active records done by the URC on 10/29/10 o Active records of many individuals who lived at SGSSLC during observations in residences o Review of active records and individual notebooks of: • Individual #229, Individual #190 o Review of master records of: • Individual #330, Individual #210 Interviews and Meetings Held: o Marsha Jones, Unified Records Coordinator o Ruby Heldenbrand, Settlement Agreement Clerk o Juanita Brake, Director of Client Records Department o Penny Bivens, Settlement Agreement Coordinator o Natalie Montalvo, Director of Residential Services o Residential Unit Directors: • Melinda Gentry, Cedric Woodruff, Vicki Hinojos o Numerous staff and clinicians during observations in residences Observations Conducted: o Records storage areas in residences o Master records storage area o Overflow records storage area
	Facility Self-Assessment: The facility's self-assessment, called the POI, for this provision indicated that all four provision items were

	self-rated as being in noncompliance, but one portion of V1 was self-rated as being in substantial compliance, that is, the creation of the three components of the active record. The monitoring team was in agreement with the self-assessed ratings provided in this section of the facility's POI. Very little additional information, however, was provided regarding the methods, activities, and criteria used to make these determinations. The review that follows below provides some direction for the facility towards continuing to develop its recordkeeping practices to meet the requirements of this provision. Corrective action plans should also be included in the self-assessment actions for these provision items where appropriate.
	Summary of Monitor's Assessment: SGSSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and recordkeeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. The unified records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. The facility had edited the state's table of contents making it a lengthier, but thorough list. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. Two practices required attention from the facility. First, all volumes of the active record were transported whenever any portion of the active record was taken from the residence for any activity, even if much of the record was not going to be used, such as for a medical appointment. Second, the individual notebooks did not stay with most individuals at the facility, but instead remained in the residence office. Other recommendations for modifications to the records are made below and include addressing inconsistencies in where breaks occur across volumes, and whether any unnecessary documents are in the individual notebooks. The Unified Record Coordinator was committed to having an organized, user-friendly recordkeeping system. She was knowledgeable about the records and was interested in improving the records as implementation of this new system moved forward. Comments from staff at all levels indicated an overall satisfaction with the new recordkeeping practices. Audits as per provision item V3 had only begun a few weeks prior to the onsite review and, as a result, only two had been completed. Even so, useful information was obtained during these audits. A system, however, was needed to ensure that corrections were made to the records based on the audits. It will be important for SGSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the recordkeeping system.

#	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.	The monitoring team looked to see if SGSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. In addition, SGSSLC had its own policy, called "Active Records Guidelines," dated 11/18/10 (it was approved during the week of the onsite review). This was a short policy, only two pages, and provided details regarding filing, document headings, entries, error correction, how to handle visitor passes (an issue noted in the baseline report), and the checking out of active records and individual notebooks from the residence office. This policy was written succinctly and appeared to be an appropriate adjunct to the state policy. SGSSLC should be prepared to revise this policy as the facility becomes more experienced in using the new unified record system. Revisions may include changes as well as additions and deletions. The monitoring team's review of this document raised two questions: • The facility policy required the signing in and signing out of both active records and individual notebooks. The monitoring team believes that the state's intention was that individual notebooks would be with the individual throughout the day, therefore, it appeared counterintuitive to require a system of signing out these individual notebooks. The monitoring team later learned that SGSSLC facility practice was to have individual notebooks remain in the residence office (i.e., not be with the individual) except for those individuals who had a PNMP that required documentation. The facility's management needs to examine this practice and ensure that they are following state policy. It may be that the facility planned to implement this next component of the recordkeeping system at a later date. • The facility policy required that all volumes of the active record be checked out together, even, for example, if only one volume was needed by the reviewer or treating clinician. The facility should examine this procedure. Requiring all volumes to travel together made for (a) cumbersome movement of multiple volumes when many of the volumes were not needed, and (b) volumes missing from the residence that were needed by other disciplines or clinicians. Many staff told the monitoring team about this problem and the monitoring team recommends that facility management review this practice. SGSSLC made considerable progress in meeting this provision since the baseline review. At the time of this onsite monitoring review, all of the records at the facility had been	Noncompliance

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		converted, and every individual was reported to have an active record that was in the new format, as well as an individual notebook. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record • Overflow files The conversion of the old records to the new active records, and the creation of the individual notebooks was a very large task and required a great deal of effort from the recordkeeping department staff as well as from other departments and operations at the facility. The monitoring team wishes to acknowledge this as well as the ongoing efforts at the facility to meet this provision of the Settlement Agreement. The records were completed only a few weeks prior to the onsite review and more work was needed (and was going to be done) to ensure they were useable, of a manageable size, and that all aspects of Appendix D were being followed. Therefore, this item was rated as being in noncompliance, however, it is likely that the facility will achieve substantial compliance in the near future. SGSSLC was fortunate to have maintained the same three staff who had primary responsibility for addressing the requirements of this provision (V). The unified records coordinator was the lead for this provision. Since the baseline review, she had provided training to staff across the facility on the new recordkeeping system. This started a few months prior to this onsite review and began with the home secretaries followed by the direct care staff. The Settlement Agreement Clerk now had almost a year's experience in her position and provided a lot of support to the facility in addressing this provision. The Director of Client Records was also very experienced at SGSSLC and continued to manage the master records and overflow files. Although these three staff reported to different supervisors, they appeared to have a very productive and effective working relationship. In addition, there were nine home clerks (i.e., one for each building). The home clerks worked for the unit directors, not for the records department. This arrangement appeared to be working fine at SGSSLC. The home clerks' duties included every day filing, thinning records, sending records in for long term filing, and doing other clerical tasks, such as printing out and distributing monthly instructional procedure data sheets and diet management sheets. The home clerks were trained on the active records and individual notebooks by the URC. They then created these new record binders. <u>Active records</u> The new active records varied in size based upon the amount of information in the	

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		individual's record. Most records contained three three-inch binders. Some contained only one or two binders, and others contained four binders (one individual had five binders). The active records were constructed following the order of sections from the state's table of contents. The active records were not divided across the binders in the same way for all individuals across the facility. This should be corrected because identical breaks between binders makes for more efficient record usage by staff, managers, clinicians, and reviewers. In the opinion of the recordkeeping staff, home secretaries, direct care staff, and managers (e.g., unit directors, director of residential services), the active records were neater, more organized, and information was easier to find. They reported that the new plastic tabs were sturdier than what they had been using. The active records contained the state-provided table of contents. SGSSLC had added a lot of additional items (e.g., list of all consent forms, desensitization program information, medical consultation for nephrology and rheumatology, forms to include in the IPN section, nutritional progress notes). In addition, some items were deleted (indicated with a strikethrough font). (SGSSLC also made similar modifications to the table of contents for the individual notebooks.) All of this appeared reasonable to the monitoring team, however, the facility should get approval from the state office to ensure that these edited tables of content are still in line with state policy and acceptable to the state office. If so, some of these edits may be appropriate and useful to all of the state's facilities. A review of observation notes and IPNs in the active records indicated that they appeared to be in good format, easy to read, and ordered correctly (note, this comment refers to the format and appearance of the observation notes and IPNs, not to their content; content is reviewed when applicable in the review of each provision of the Settlement Agreement in the other sections of this report). The observation notes, however, were entered in three different color inks, depending upon the shift. Entries by the day shift were written in blue ink, afternoon shift in black ink, and overnight shift in red ink. This seemed to be allowed by the Settlement Agreement Appendix D and the state's policy. Both contain this sentence: "All entries that are not typewritten should be made with a non-erasable ballpoint pen (black recommended)." The facility should ensure that this practice is in line with the state's expectation. If not, a change will need to be made. SPO instructional plans and monthly data were included in the active record . A green blank page was used to separate each of the SPOs within the tabbed section that contained all of the SPOs. The use of the green divider page was a good idea and helped to organize that section of the active record. It would be helpful for there to be some sort	

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		of listing so that the home secretaries and the reviewers of the records would know whether all required SPOs were indeed included in this section and that none were missing. This list of SPOs would likely come directly from the current PSP document. The active records of Individual #229 (three volumes) and Individual #190 (two volumes) were reviewed. The edited table of contents was present and contained detail on consents. Eight specific consents were listed; this provided good detail as to what was required for each active record. A similar listing was included in the functional skills section. Documentation regarding interim PSP meetings (i.e., PSPAs) was in the record. Some items needed attention. This was not unexpected given the recency of the changeover to this new format and the recency of implementation of audits (see section V3 below). Examples included it being unclear whether outside medical consultations were initialed (reviewed) by the physician or the nurse, the active problem list being in the wrong section of the record, and the record missing a quarterly review for June 2010 (for Individual #229). <u>Individual notebooks</u> Individual notebooks were in place as per the state's policy. The individual notebooks reviewed by the monitoring team appeared to contain most everything required by the facility's edited table of contents. As noted above, individual notebooks were <u>not</u> observed in all day and residential locations for all individuals. Even so, the unit directors reported that the individual notebooks were helpful and "pretty handy." The recordkeeping staff reported that all documentation was in one place instead of in different parts of the record. Home secretaries appeared to like the individual notebooks because it was easy to get all of the relevant information at month's end to transfer to the active record binders. Individual #229's individual notebook was with him because he had an active PNMP (according to facility practice). His individual notebook contained data on his SPOs and all of the data were up to date. The individual notebook also included extra documents, such as his consent/authorization for rights restriction. It did not seem that this lengthy document was necessary to be in his individual notebook. The facility should review what is required to be in the individual notebook to ensure that it does not contain unnecessary information because unnecessary documents will make the binder more cumbersome than it needs to be. <u>Master records</u> A master record was kept for each individual. It was managed by the director of client records. Some of the items in the master record were used regularly by some of the departments at SGSSLC, such as medicine or psychology. The recordkeeping staff said	

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		that they made sure that documents were available as needed. The director of client records used a table of contents for master records to guide her in the management of these records. The table of contents was detailed and indicated all of the information that should be in each of the six sections of the master record. The monitoring team recommends that the state office review this table of contents and compare it to the tables of contents used at other facilities to determine whether or not to have a single consistent table of contents across all facilities. SGSSLC's might provide a good foundation or starting point for a statewide table of contents for master records. All of the master records, since SGSSLC became a facility for individuals with developmental disabilities were in one room (1,861 records). Two master records were reviewed in some detail. One was for an individual who had lived at SGSSLC for many years (Individual #210) and the other record was for an individual who had been placed at SGSSLC more recently (Individual #330). There were no discernible differences between these two master records other than the older master record being larger than the newer master record. <u>Overflow files</u> Documents taken from each individual's records were stored and managed by the home secretaries according to the record thinning schedule provided by the state. The overflow documents were kept in the office of the home clerks for one year, then sent to the director of client records for storage in a special room at the facility. Overflow files were destroyed when an individual had not been at SGSSLC for 10 years (the master record, however, was not destroyed and was retained as noted above).	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy. DADS maintained a spreadsheet indicating the status of policies, protocols, and procedures for each provision in Part II of the Settlement Agreement (i.e., sections C through V). Facility policies are likely to be developed as DADS completes its set of statewide policies. Then, as noted throughout this report, the facility will need to ensure that any facility-specific policies are in line with the state policy and that approval is obtained from the DADS central office.	Noncompliance
V3	Commencing within six months of	Quality assurance procedures to meet the requirements of this provision item were not	Noncompliance

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	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.	yet in place, but the facility had very recently begun some activities in this area. That is, the URC had begun to do reviews of a sample of unified records each month. She began by completing two audits in October 2010 (Individual #51, Individual #235). This represented a good start to the quality assurance process required by this provision item (also see section E above regarding quality assurance). The URC used the monitoring team's checklist tool for provision V and scored the sections for V1 through V4. In addition, she used a checklist based on the facility's table of contents for the active record volumes and for the individual notebook. This was good to see, that is, that the URC used both of these checklists. This set the occasion for a thorough review of these two components of the unified record. The review should be expanded, however, to also include a review of the master record. Specific comments and detail were provided for each of the items. A lot of useful information was provided by these reviews. The auditing system needs to include a method for summarizing the data from the audits into a manageable understandable list that can be presented to the home manager and home secretary. The auditing system also needs to include a method for tracking needed corrections to completion. Below are examples of the URC's findings and the topics of feedback are below: • some signatures not legible • overdue assessments • blanks on SPO data sheets • incorrect (old) PSP in record • old BSP in individual notebook • question regarding implementation of PNMP recommendation correctly The monitoring team had the opportunity to discuss the auditing process at length with the URC. The monitoring team appreciated her interest in improving her service and meeting the requirements of this provision item. In addition, SGSSLC should get feedback and suggestions from staff who use the records. This information can be used to improve the recordkeeping system and components. Implementation of the new recordkeeping system had only occurred a few months prior to the onsite monitoring visit. Once staff have used the system, useful feedback can be obtained from clinicians, managers, and direct support professionals.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four	The facility did not have a means to assess this provision item. The monitoring team discussed this provision item at length with the URC. The URC said that following this discussion she had a better understanding of this provision item.	Noncompliance

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	years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The facility will have to come up with a way to determine if facility staff are routinely utilizing the records in making care, medical treatment, and training decisions. The facility should work with DADS central office, as well as with the other SSLCS to determine how to do so. Most likely a set of activities will have to occur, including, for example, interviews of clinical staff to learn how they use the records (e.g., psychology, nursing, habilitation), a review of the contents of IPNs, and an examination of medical consultations. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the facility to address in meeting the requirements of this provision item. • During the annual PSP meetings for Individual #190 and Individual #359, the records were not used at all. • During the annual PFA meeting for Individual #119, the records were not used at all. • Primary care providers did not utilize records effectively. They reviewed labs and consults in their offices, so the records were not available. It would be difficult to always know the implication of a study result without full access to the records. • During the monitoring team's visits to all homes, it was common for the individuals' records to be "off the home" and not available or accessible to the nurses, who needed the records to ensure that accurate, pertinent health and medical information was available to the clinical professionals who needed the information in order to provide safe and necessary care/treatment to the individuals. • Nurses' notes were frequently limited to documentation of nurses' conduct of discrete tasks/interventions. Nurses' notes were not consistently documented in the SOAP (Subjective and Objective (data), Analysis, and Plan) format. • The content as well as signature/credentials appearing in some nurses' notes were not legible and/or properly documented with the specific time, versus shift, of the entry. • In all psychiatry clinic observations, the individual's record was available for psychiatrist review, and was reviewed by the psychiatrist. • During the observations of psychiatry clinic, the nursing case manager, psychiatric assistant, and the psychologist provided the psychiatrist and the advance practice nurse with historical data verbally. There were instances where the psychologist provided information regarding target symptoms via a	

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		grid and/or graph with numbers of specified target symptoms occurring within a reporting period. • The graphs reviewed did not include noteworthy events (e.g., medication changes, situational stressors) and, therefore, these graphs were not as useful as they might have otherwise been. • Psychology staff were not observed using records, other than looking at monthly progress notes during psychiatry clinic. • The PNMPs were included in the individual notebooks. The plans were well written in user friendly, first person language ("I need help to reposition myself in bed" for example) and photographs were provided to reinforce the written instructions. Staff referred to these to answer questions by the monitoring team. • The Dining Plans were typically out at each meal and readily available for staff reference. A number of staff were observed to read them before assisting an individual at mealtime and the PNMPCs referred to these as well.	

Recommendations:

1. Examine the facility practice of not having individual notebooks be with the individuals throughout the day.
2. Examine the practice of having all volumes transported (e.g., to appointments) when not all of the volumes will be needed or used.
3. Make the binder breaks the same across the facility so that the breaks are the same for all two-volume, three-volume, and four-volume versions.
4. Ensure edited tables of content for the active records and the individual notebooks are acceptable to DADS state office.
5. Add a list of SPOs to the front of the SPO section of the active record to indicate all SPOs that should be included in that section of the record. The list should come from the current PSP.
6. Examine whether there are unnecessary documents in the individual notebooks.
7. Complete the development of policies as described in provision item V2.
8. Incorporate recordkeeping activities into the facility's quality enhancement program, including ensuring the data collected by the URC during their record audits are included in the QA program.
9. Include the master record in the audits done by the URC.
10. Develop a method to ensure that any needs or problems identified in the record audits are corrected.

11. Ensure records are used in making care, medical treatment, and training decisions. Determine a way to assess whether or not this is occurring.

The following are offered as additional suggestions to the facility:

12. Ensure that the use of the three-color system of entries in the observation notes is acceptable to central office.

13. DADS central office should consider whether or not to standardize the table of contents for the master records across SSLCs. If so, SGSSLC's might provide a good starting point.

14. Obtain feedback and suggestions from those staff who regularly use any components of the unified records.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABI	Ankle-Brachial index
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFO	Ankle Foot Orthosis
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARD	Admissions, Review, and Dismissal
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice A Day
BLS	Basic Life Support
BMI	Body Mass Index
BP	Blood Pressure
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Criminal Background Check
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCA	Clinical Certificate of Competency Audiology
CEU	Continuing Education Units
CIR	Client Injury Report
CIT	Crisis Intervention Team
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process

CM	centimeter
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
COTAL	Certified Occupational Therapy Assistant, Licensed
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Department of Assistive and Rehabilitative Services
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual-energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DJD	Degenerative Joint Disease
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
ED	Emergency Department
EDWR	Established Desired Weight Range
e.g.	exempli gratia (For Example)
EEG	Electroencephalography
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank.
EMR	Electronic Medical Record
EPS	Extra Pyramidal Symptoms
ER	Emergency Room
ER	Extended Release
EXT	Extraction
FAST	Functional Analysis Screening Tool
FBG	Fasting Blood Glucose
FDA	Food and Drug Administration
FES	Functional Eating Skills and Swallowing Assessment

FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Grams
GU	Gastro-urinary
HCG	Health Care Guidelines
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HRC	Human Rights Committee
HRS	Hours
HST	Health Status Team
HTN	Hypertension
HX	History
IC	Infection Control
ICN	Infection Control Nurse
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Infectious Disease
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IV	Intravenous
LAR	Legally Authorized Representative
LOD	Living Options Discussion
LSC	Life Safety Code
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBA	Masters, Business Administration
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MG	Milligrams

MIN	Minutes
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MRA	Mental Retardation Authority
MS	Master of Science
MSN	Master of Science, Nursing
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NCC	No Client Contact
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
N/V	Nausea Vomiting
OIG	Office of Inspector General
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PAP	Papanicolaou
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PE	Physical Examination
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PICC	Peripherally Inserted Central Catheter
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PO	By Mouth (per os)
POC	Plan of Correction

POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PROM	Passive Range of Motion
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
Psy.D.	Doctorate, Psychology
Pt.	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
QA	Quality Assurance
QAD	Quality Assurance Director
QE	Quality Enhancement
QI	Quality Improvement
QIC	Quality Improvement Council
QMRP	Qualified Mental Retardation Professional
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
ROM	Range of Motion
RPH	Registered Pharmacist
RR	Respiratory Rate
RRC	Restraint Reduction Committee
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SFBA	Structural Functional Behavioral Assessment
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Antidiuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIT	Skin Integrity Committee
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Specific Program Objective
SPOI	Supplemental Plan of Improvement
SSLC	State Supported Living Center
STACS	Specialized Treatment and Consultative Services
STAT	Immediately (statim)
STEPP	Specialized Teaching and Education for People with Paraphilias
T	Temperature

TID	Three Times A Day
TIVA	Total Intravenous Anesthesia
UIR	Unusual Incident Report
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VNS	Vagus nerve stimulation
WISD	Water Valley Independent School District
WU	Work Up