United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: May 23-27, 2011

Date of Report: July 26, 2011

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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; Jodie Holloway 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, at-risk individuals, and for a variety of other sections of the report.

The Monitor's role is to assess and report on the State and the Facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes 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. The facility director, Dr. Philip Baugh, was, as always, supportive of the monitoring team's activities throughout the week of the onsite review.

The monitoring team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Penny Bivens. Her knowledge of the facility and her professionalism helped the monitoring team accomplish what it needed to during

the onsite week. She was particularly helpful in the coordination of documents, arranging for meetings, handing schedule changes, and ensuring administrative availability to the monitoring team.

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, management, clinical, and direct care professionals continued to be 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. Moreover, these discussions allowed for SGSSLC to demonstrate continued progress in many of the provision items. 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, SGSSLC was working to implement the many new service provision changes that were occurring across all of the DADS SSLCs. These changes included

- New PSP documents and new style PSP meetings
- New Community Living Discharge Plan activities and documents
- New assessment and management of individual at-risk procedures
- New Physical and Nutritional Management Team procedures
- At risk and aspiration initiative
- Nursing department training in assessment

Moreover, SGSSLC had initiated, or was in the process of initiating a number of other new service components:

- New activities for day, evening, and weekend
- New psychology procedures and committees
- A new therapy program (DBT) had recently begun
- A new Sexual offender treatment program was near completion
- A new lead psychiatrist
- A new lead psychologist
- A new QA report and a new, additional meeting of the QI Council to review data
- A new committee to address the provision of integrated clinical supports
- The self-advocacy, had some new components

Fourth, as detailed in the full report below, SGSSLC had made progress in some areas, but a lot of work was still required in order for the facility to achieve substantial compliance in the many provisions of the Settlement Agreement. As the reader will see below, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are some comments on a few general topics that affected all areas of operation at the facility.

- At-risk and aspiration: SGSSLC was just beginning to implement the statewide initiative on the new at-risk policy and procedures, with a specific focus on aspiration and pneumonia issues. Implementation was not yet adequate as evidenced by meeting contents and staff interview as noted in this report (see sections F, M, and O). In addition to observing during PSP meetings, the monitoring team held meetings with two PSTs to discuss how each team assessed and managed risks for two specific individuals. The monitoring team greatly appreciated the efforts of two QMRPs, Russell Peterson and Matt Nelson, to lead these discussions. Both did an outstanding job. From this discussion, the monitoring team learned more about how the facility approached risk issues, and was able to provide feedback and suggestions that may be useful as the QMRPs and PSTs move forward.
- Integration of services. There was a lot of discussion and comment around the facility regarding a desire to meet the provision of integrated clinical services (see section G) and integrated individual program plans (see section F). Managers and clinicians were already engaging in some activities towards greater integration. And taking this very seriously. To that end, the assistant director or programs chaired a committee specifically focused on achieving an integration of clinical service provision. Additional comments and suggestions are below, in section G.
- Engagement and activities. A facility-wide project over the past few months was the development of a variety of new and organized activities for individuals throughout the day, evening, and weekend. A tremendous amount of work and collaboration across the facility was evident. The new program had only begun a week or two prior to the onsite review, but appeared promising. It was developed in response to comments in previous monitoring reports, as well as the facility's own assessment, of the relationship between a lack of stimulating activities and the occurrence of problem behaviors.
- QA and the QI Council. Continued progress was demonstrated in the development of quality assurance activities, including policies, plans, and reports. The QI Council was functioning for many months and had recently created a second group to focus more upon the details of QA data review.
- Staffing. Residential, unit, and facility directors reported that direct care staffing rates were improved, that is, fewer positions were vacant and there were fewer instances of understaffing.
- Monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility

staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below).

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

- Between 11/1/10 and 3/31/11, 79 individuals were the subject of 441 restraints:
  - 209 (47%) were programmatic physical restraints;
  - 240 (53%) were emergency restraints;
  - 154 (64%) of the emergency restraints were physical restraints;
  - 8 (3%) were mechanical restraints (body wrap or mittens);
  - 78 (33%) were chemical restraints; one individual accounted for 22 of th3 78.
- There had been a total of 367 restraints during the 1st quarter of FY11 and 291 restraints implemented during the 2nd quarter of FY11, indicating a 21% reduction in restraint instances.
- The Restraint Reduction Performance Improvement Team and the psychology department had focused on reducing restraints for the three individuals involved in the greatest number of restraints. Restraints for those individuals were reviewed in greater detail and technical assistance was provided to their PSTs to address restraint reduction.
- The Restraint Reduction Performance Improvement Team members were trained on the new statewide restraint monitoring tool and had begun using the tool to monitor a sample of restraints monthly. The restraint checklist had been revised and all staff were trained on completing the new form. There were fewer errors and incomplete forms found in documentation.

Abuse, Neglect, and Incident Management

- Investigation of 484 alleged cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/10 through 3/31/11. These cases included 817 allegations. Of these 817 allegations, 29 (4%) were confirmed allegations by DFPS, 501 (61%) were unconfirmed allegations, 53 (6%) were unfounded allegations, 47 (6%) were inconclusive, and 171 (21%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. There had been a decrease in the number of abuse and neglect allegations from FY11 1st quarter (371) to FY11 2nd quarter (345). The facility investigators conducted investigations for 34 additional serious incidents during the same time period. This included five serious injuries, 26 sexual incidents, and three unauthorized departures.

- There were a total of 2385 injuries reported since 9/1/10. Of these injuries, 17 were serious injuries, 1736 were non-serious injuries requiring treatment, 191 required no treatment, and 441 were no apparent injury. It should be noted that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there was no injury. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility.
- Considering the large number of incidents occurring at the facility, both DFPS and facility investigators conducted consistent, well-documented, and organized investigations of cases reviewed in the sample.
- Incidents and injuries were reviewed daily Monday through Friday at meetings held by each Unit Director, then reviewed daily by the Incident Management Review Team. Both groups briefly reviewed incidents and tracked follow-up to the incident. PSTs met routinely to look at individual incidents and put protections in place when necessary.

Quality Assurance

- SGSSLC demonstrated continued progress regarding the items in this provision, such as developing a facility-specific policy on QA, a listing of all data collected at the facility, a number of evolving drafts of a QA table/matrix that detailed the types of data to be managed by the QA department, and a QA report.
- The QI Council was meeting regularly and had formed a secondary meeting to focus more specifically on data at the facility. The QI Council had set up eight performance improvement teams in a variety of important areas based on previous monitoring reports, external reviews, the facility's own internal monitoring, and discussions at QI Council meetings.
- Family satisfaction measures were recently initiated. Data results needed to be reviewed and incorporated into the QA program. Satisfaction measures for staff, individuals, and from the community still needed to be implemented.
- The facility had used the set of self-monitoring tools that were designed to be used at all of the SSLCs. The monitoring team, however, recommends that the facility and state work to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams.
- A system for the management of corrective actions as per provisions E2, E3, E4, and E5 was not yet in place.

Integrated Protections, Services, Treatment, and Support

- 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.

- The QMRP coordinator and the director of residential services shared a number of new processes that had been implemented since the last monitoring visit in terms of PSP development and implementation. A number of new monitoring procedures had been implemented in regards to PSP development and monitoring. Staff had been retrained on the assessment process and participation at PSP meetings. All staff had also been trained on the new risk identification procedure.
- Four annual PSP meetings were observed by the monitoring team. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. QMRPs had recently completed facilitation training and most were still adapting the meeting process to try to capture all information needed to develop a comprehensive plan.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- Some continued progress was evident. First, the medical director had taken actions towards integration of the medical and psychiatry departments with other clinical disciplines. Second, senior administration (the assistant director of programs) headed a regularly occurring meeting of all clinical department heads with the primary, if not sole, purpose of working towards the provision of integrated clinical services. This involved sharing of information, and addressing challenges and barriers. Below, the monitoring team makes some comments for the ADOP to consider as this group moves forwards.
- A number of specific examples were provided to, or observed by, the monitoring team that showed some ways in which SGSSLC was making service provision more integrated across clinical service departments. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided.
- A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility. It provided some detailed guidance to the facility regarding provision H.
- It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision. It is recommended that the facility's QA department play a role in addressing this provision.

At-Risk Individuals

- The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk

process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance.

- SGSSLC had taken steps towards compliance with this provision including:
  - Implementation of the revised process began in January 2011. Training on the new process was provided to all PST members by 12/28/10.
  - Staff physician had traveled to Lubbock as part of the first team to participate in internal facility to facility record audits to monitor the new risk process.
  - Staff physician had begun auditing records of individuals at high risk for compliance using the newly developed state audit tool. Twelve records had been audited over the past three months.
  - Aspiration trigger data sheets were initiated for all individuals determined to be at risk for aspiration.
- SGSSLC had some challenges unique to the facility in terms of risk factors due to the forensic population being supported at the facility. The number of individuals at risk for challenging behaviors put a large number of individuals at risk for injury. Due to the removal of many direct support staff from contact with individuals during investigations, it appeared to be routine for staff to be assigned to homes where they were not familiar with the individuals in the homes.

Psychiatric Care and Services

- The lead psychiatrist and new family nurse practitioner were both new to SGSSLC and learning the system and meeting the individuals assigned to their caseloads. There was, however, no child and adolescent psychiatrist, forensic psychiatrist, and/or board-eligible forensic child and adolescent psychiatrist providing services at SGSSLC for the minors at the facility. Minors were admitted for assessment and secondary to court commitment.
- The psychiatric practitioners were encouraged to meet together routinely to implement the provisions outlined in the Settlement Agreement in order to establish a psychiatric system of care that met generally accepted professional standards of care.
- The psychiatric clinic was organized due to psychiatric assistant functioning in this role. The director of psychology, medical director, CNE, lead psychiatrist and the psychiatrists were receptive to working together to establish revisions to the delivery of psychiatric services for the individuals at SGSSLC.
- While psychiatry was interacting with psychology on some levels, there were marked deficits in the delivery of integrated care.

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance, there was continued progress in several areas. These include all psychologists (that write Positive Behavior Support Plans) were enrolled in coursework for board certified behavior analyst certification, one additional psychologist recently

became a board certified behavior analysis, the development of both internal and external peer review, continued improvements in the data collection system, improvements in the graphing of data, a plan for the collection of replacement behaviors, an increase in the variety of therapies offered, and improvements in ensuring these therapies were goal directed, with measurable goals and progress towards those goals.

- The areas for SGSSLC to work on for the next onsite review include to ensure that internal peer review occurs at least weekly, and external peer review monthly, implement the planned, simplified data system, ensure that data are reliably collected by collecting and tracking objective measures of data reliability, ensure that psychological assessments contain all the necessary components, add indirect and direct data to functional assessments, ensure that all functional assessments have a clear summary of the variable or variables hypothesized to affect target behaviors, ensure that all Positive Behavior Support Plans are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions. Finally, fully implement the psychological group counseling sessions.

Medical Care

- Continued progress from the November 2010 review was noted. The facility completed its first external medical review in March 2011 and the review generated some excellent feedback for the medical staff. The medical department implemented new policies related to medical consultations and tracking of consultations and labs. When fully implemented, this process change should improve the delays that were occurring. The facility's lab matrix had been expanded and this was good to see. The lab matrix provided guidance related to drug use monitoring parameters and preventive care services, such as cancer screenings and immunizations
- Annual medical assessments continued to be problematic with a significant number of assessments noted to be delinquent. Overall, however, there was some improvement. Active problem lists presented another concern because none of the problem lists contained within the records reviewed were updated in the manner required by the Health Care Guidelines. Physician orders for routine matters were too frequently given verbally and orders and were not always timely. Additionally, quarterly medical summaries were not found consistently in the records.
- Compliance ratings for some key preventive services, such as cancer screenings were unfortunately low. Compliance with core immunizations was very good. Screening for osteoporosis appeared to be low based on risk factor assessments. The expanded lab matrix, if followed, should prove beneficial in increasing compliance rates with some key preventive services.
- Do not resuscitate orders were in place for 13 individuals and many of these had been in place for several years. One individual's DNR order was implemented in 2003 and did not appear to be questioned by the PST.
- Finally, the provision of neurologic services appeared to be good, but was not without some concern. Primary providers and psychiatrists missed the recommendations from the neurologist on several occasions.

Nursing Care

- 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. The majority of the individuals' HMPs and ACPs continued to need improvement, especially with respect to the development of acute care plans in response to acute illness and injury and the review/revision of health management plans in response to changes in clinical indicators.
- It continued to be commonplace for the individuals' records to be "off the home" and not available or accessible to the physicians and/or 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. In addition, many nurses' notes continued to be inconsistently documented in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format. Also, as noted in the prior review, the content as well as signature/credentials appearing in some nurses' notes were not legible.
- Several PST Health Risk Assessment reviews that were completed more recently were more comprehensive and ensured more realistic ratings of risk, however, a number of individuals had yet to receive risk assessment reviews and ratings, in accordance with the newly implemented policy and procedures. Also, as noted in the prior review, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred.
- The administration of medication and the management of the medication administration system at SGSSLC had not substantively improved since the prior monitoring review. According to the Pharmacy Director, on a monthly basis, hundreds, if not thousands, of medications continue to be unaccounted for and returned to the pharmacy. 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

- This monitoring review was impeded by document production. In one instance, the sample provided turned out to be half of what was requested because the documents were submitted in duplicate. The ADR reports were unsigned and lacked documentation of the required P&T Committee review and recommendations. Minutes and meeting agendas for the same date and time were listed for different meetings, such as Medical/Psychiatry/Pharmacy Meeting (12/9/10) and Medication Error Committee Agenda (12/9/10).
- Small incremental gains were noted in some areas while other areas failed to achieve any measure of progress. Outdated policies and procedures were reflective of the lack of forward movement. The clinical pharmacist, who

appeared eager to effect departmental change, reported that he and the pharmacy director worked independently. This disconnect may have contributed to the limited progress demonstrated.

- The pharmacy director reported that the facility had not received any training on the use of the WORx system since the last onsite review. The SPI and notes extracts were reported to be used to document interactions between the pharmacist and the clinicians. The documents provided did not contain adequate evidence to support compliance with this requirement.
- Improvement was noted in the requirements for completion of QDRRs, though this area will require additional work. The reports were handwritten and many were difficult to read due to side notes, comments, and strikethroughs. The reports also lacked the detail required to substantiate compliance with appropriate laboratory monitoring of drug use.
- The MOSES and DISCUS assessment tools were completed, but provider response and use remained problematic. DUEs were completed and provided useful information. Corrective action plans commensurate with the deficiencies documented, however, were not evident. The facility implemented a new ADR policy and ADRs were reported. Some were formally reported using the ADR report forms while others appeared in the P&T minutes. Finally, medication variances were examined by several committees, yet no progress was made in determining the reason that hundreds of medications were returned to the pharmacy each month.

Physical and Nutritional Management

- There was a full complement of core PNMT members with a soon to be dedicated RN. The other team members were not, and could not be, dedicated team members given the current staffing levels for OT, PT, SLPs, and the single dietitian. One dietitian was insufficient to address the nutritional needs for 245 individuals as well as take on the responsibilities of the PNMT role. The clinicians are to be commended for moving forward with the process with the understanding that this is a work in progress and that they will learn as they go.
- There were some noted improvements related to mealtimes in several of the homes and the Performance Improvement Team approach to addressing system issues appeared to be effective as well as the focused commitment to the training of the PNMPCs. There were some noted issues related to staff having difficulty with cues to slow individuals down or to take smaller bites and the current SPOs to address this did not provide sufficient activity analysis to break down the activity into component parts or learning objectives.

Physical and Occupational Therapy

- Assessments were improving with efforts to begin to link the health risk assessment process to the OT/PT assessment process and in the development of the PNMP. The focus continued to be primarily on health risk and measurable goals developed were generally related to those risk indicators identified for an individual. Efforts to address functional skill acquisition were noted, but generally recommendations shifted to the PST

rather than also the identification of potentials and need for motor skill acquisition or increased independence in activities of daily living requiring the design and implementation of training objectives directed by the therapists as well. These meaningful and functional learning opportunities must be recognized as equally important as physical health concerns and that independence, engagement and participation are also critical to positive health outcomes for individuals.

- There were few intervention plans, (none were SPOs in the PSP) and measurable goals were not consistently established with performance criteria clearly outlined, though there was a noted improvement in this area. Follow-up was likely addressed but inconsistency of documentation was noted.
- There continued to ongoing concerns related to positioning and alignment of individuals in wheelchairs. Direct support staff did not demonstrate sufficient knowledge and skills to implement plans appropriately. There was significant progress noted however with regard to the knowledge, skills, and confidence of the PNMPCs. It was anticipated that their monitoring and training efforts will begin to impact the competency and performance of the direct support staff in the implementation of the PNMPs over the next six months.

Dental Services

- Progress was noted in the processes related to the provision of dental services. The use of suction toothbrushes was implemented and desensitization plans were being implemented. There was a plan to begin a pretreatment notification process that involved dental clinic, psychology, and the psychiatry departments. Suction toothbrushes were implemented just two months prior to the onsite review, so data related to the impact of this service were not available. Likewise, four desensitization plans appeared to have been signed off on in March 2011 and April 2011. One appeared to have been implemented in January 2011. Status reports on progress made with these plans were not provided
- Failed appointments were barriers to dental treatment. Strategies to decrease failed appointments were evident in the documents, such as IPNs and PSP addendums. Desensitization plans, as discussed above, had been developed for a small percentage of those who were considered. In spite of these efforts, the last two months of data showed an increase from 25% to 35 % in failed appointments. That increase was without explanation.

Communication

- Speech clinicians were extremely busy with assessments and attempts to implement recommendations for communication-related supports. A number of very creative individual, though largely community, systems were in place or ready for implementation pending maintenance tasks, such as mounting in the living areas. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them.

- The Master Plan had been refined and made available to the PSTs. One speech clinician participated regularly on the BSP Committee and the newly formed PNMT. Only 49 evaluations had been completed since June 2010. At least 19 of those completed to date had been new admission assessments. Only 12 of the completed assessments had been completed prior to the date estimated in the Master Plan. The focus on assessment also made timely implementation of supports and services and, more importantly, greatly limited opportunities for effective staff training. Staff did not demonstrate an understanding of how to capitalize on teachable moments to promote communication skill acquisition or how to integrate existing systems into the daily routine.
- A focus on engagement in functional activities designed to promote actual participation, making requests, choices and other communication-based activities, using assistive technology, was a critical priority. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, the monitoring team noted several improvements since the last review. These include modifications to the skill acquisition training sheet/format, expansion of the training methodology used at SGSSLC, initiation of graphing of skill acquisition data, development of a QMRP monitoring tool, development of a data system to track and improve training of individuals in the community, and continued work with the local public school.
- The monitoring team believes that the primary barriers to these improvements translating into the acquisition of meaningful skills are ensuring that SPOs are meaningful to each individual (e.g., based on documented need and preference), ensuring that the continuation, modification, or discontinuation of SPOs are the result of data-based decisions, ensuring that the SPOs are implemented with integrity, and coordination of public school objectives with SPOs and/or informal activities at SGSSLC.

<u>Most Integrated Setting Practices</u>

- SGSSLC continued to engage in many activities to encourage and assist individuals to move to the most integrated setting. A number of individuals had successful moves to the community and appeared to be enjoying active and happy lives. The specific numbers of individuals who were in the referral and placement process, however, remained low, given the size of the facility (i.e., 27 out of 245, that is, 11%).
    - 10 individuals were placed in the community since the last onsite review
    - The referrals of three individuals were rescinded since the last review.
- It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the

previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document.

- The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. There was wide variability in the amount of information included in the PSPs within each subsection of the LOD.
- Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability).
- The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. There were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports.
- Post move monitoring had greatly improved since the last onsite review. The PMM's reports were more detailed than last during the last review. Moreover, the PMM had taken a more assertive role, especially in one case described in T2a below. Detail regarding whether a support was being provided, the providers response and plan when a support was not being provided adequately, and more involvement of the PMM in other situations are required. Two post move monitorings were observed by the monitoring team. They were done in a professional manner. In order to achieve substantial compliance, every item on the list of supports needs to be directly observed and PMM actions need to be taken when a support is not being provided adequately. The facility had just begun to hold PST meetings following each post move monitoring visit.

<u>Consent</u>

- Recently, some positive steps were taken in regards to consent and guardianship issues, including that the Rights Officer had met with the QMRPs regarding the determination of informed consent and pursuance of guardianship by family members. In addition, a self-determination/self-advocacy course and a conflict resolution course were offered by the psychology department for individuals at the facility, local resources for obtaining advocates was explored, and the Guardianship Committee continued to meet and discuss guardianship issues. The Human Rights Committee continued to meet and review all restriction of rights

Recordkeeping and General Plan Implementation

- SGSSLC had made continued progress. The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. Areas for improvement included ensuring that all medical consultation documents were in the active record and that entries in the integrated progress notes were legible, with a legible signature, and with the clinician's credentials included.
- Individual notebooks were also in place for each individual. The facility had followed the state's new procedure of allowing the SSLC to determine how it wanted to handle individual notebooks. As noted below, the facility will need to demonstrate that direct care staff do have information and data collection readily available to them. The master records continued to be maintained appropriately by the director of client records.
- A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. Two new spreadsheets were being used to manage and track the existence and development of both the state and the facility policies for each provision of the Settlement Agreement.
- Thorough reviews of all three components of the unified record were conducted by the unified records coordinator. Items needing correction were noted in the comments column of the review tool. A systematic way to provide PST members with feedback on corrections that were needed (e.g., missing documents, out of date documents) was not yet in place.
- SGSSL had not yet taken any steps towards ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4. More guidance is expected from central office.

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 SGSSLC Policy: Use of Restraint Policy dated 4/14/11 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines 9/9/05 o SGSSLC Procedure: Restraint Notification Process and Responsibilities of Restraint Monitors and Health Care Professionals dated 2/24/11 o List of all restraints used for crisis intervention for the past six months o List of all chemical restraints for the past six months o List of all restraints occurring away from the facility in the past six months o List of individuals with medical and/or dental desensitization plans o Documentation of restraint monitoring tools completed since 1/1/11 o SGSSLC Restraint Trend Analysis for FY11 o Restraint documentation for the last 10 medical restraints o List of individuals with dental desensitization plans o SGSSLC Plan of Improvement o Restraint Reduction Committee meeting minutes since 9/1/10 o List of all individuals who had a Safety Plan o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o Restraint Monitor Training Curriculum o Crisis Intervention Team Training Curriculum o Training transcripts for 24 SGSSLC employees o Sample of Daily Incident Management Team Meeting Minutes o Dental desensitization plans for Individual #7, Individual #130, Individual #18, Individual #217, and Individual #198 o PSPs for Individual #126, Individual #287, Individual #313, Individual #128, Individual #283, and Individual #38 o A sample of restraint documentation for medical restraints including: • Individual #128 dated 3/31/11 • Individual #130 dated 3/4/11 • Individual #384 dated 3/4/11 • Individual #283 dated 3/25/11 • Individual #216 dated 3/4/11 • Individual #294 dated 3/8/11 • Individual #116 dated 3/16/11

- Individual #236 dated 3/21/11
- Individual #122 dated 3/23/11
- Individual #38 dated 3/24/11

o PBSPs, safety plans, functional assessments, and PSPAs related to C7 compliance for Individual #239, Individual #346, Individual #116, Individual #34, and Individual #292

o A sample of restraint documentation for behavioral intervention including:

Individual	Date/Type	Restraint Checklist and Face to Face Assessment	PSP Addendum(A)	PBSP	Safety Plan
#247	3/30/11 Physical	x	3/3/11	2/25/11	
	3/30/11 Physical	x			
	3/20/11 Chemical	x			
#346	10/4/10 Chemical	x			
#178	10/11/10 Chemical	x			
#239	10/25/10 Chemical	x			
#215	10/27/10 Chemical	x			
#213	10/14/10 Chemical	x			
#186	3/31/11 Chemical	x	7/28/10 4/1/11 (A)	3/4/11	
#249	10/7/10 Chemical	x	11/2/10 11/22/10 4/1/11 (A) 4/11/11 (A)	3/4/11	
	3/31/11 Physical (x7)	x			
	3/31/11 Chemical	x			
#99	3/31/11 Physical	x			
#243	3/25/11 Physical	x	2/18/11	8/5/10	7/16/10
	11/22/10 Physical/Mechanical	x			
	11/12/10 Physical	x			
	10/15/10 Physical	x			
	10/14/10 Physical	x			
	10/11/10 Physical	x			
#116	1/3/11 Physical (x2)	x	9/1/10	4/7/10	7/30/10
	1/2/11 Physical	x			
	12/31/10 Physical (x2)	x			
	12/28/10 Physical (x2)	x			
	12/28/10 Mechanical	x			
	12/27/10 Physical (x3)	x			

12/25/10 Physical	x				
12/15/10 Physical	x				
11/30/10 Physical (x3)	x				
11/29/10 Physical	x				
11/13/10 Physical	x				

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- John Church, Associate Psychologist
- Jalown McCleery, Incident Management Coordinator
- Natalie Montalvo, Director of Residential Services
- Mary Holmes, Lead Investigator
- Michael Davila, QMRP Coordinator
- Roy Smith, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Morning Unit Meeting 5/24/11
- Daily Incident Management Meeting 5/24/11 and 5/26/11
- Human Rights Committee Meeting
- Annual PSP meetings for Individual #169 and Individual #134

Facility Self-Assessment:

The facility's Plan of Improvement for section C indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. Most significantly, a new monitoring process was initiated in January 2011. The facility, however, had not implemented the process long enough to address trends identified. The facility is aware of problems with monitoring and documentation of restraints, and was in the beginning stages of addressing those issues. The monitoring team agreed with the facility's compliance self-assessment. Positive steps taken by the facility are noted in the summary section.

Summary of Monitor's Assessment:

Based on information provided by the facility in a list of all restraints used for crisis intervention, between 11/1/10, and 3/31/11:

- 441 restraints occurred;
- 209 (47%) were programmatic restraints;
- 209 (100%) of the programmatic restraints were physical restraints;
- 240 (53%) were emergency restraints;

	• 154 (64%) of the emergency restraints were physical restraints;
	• 8 (3%)were mechanical restraints;
	  o body wrap or mittens were used with four individuals
	• 78 (33%) were chemical restraints.
	  o 25 individuals were restrained with chemical restraint
	  o Individual #116 was the subject of 22 (28%) of the chemical restraints
	• 79 individuals were the subject of restraints.
	
	The facility's trend analysis report for FY11 indicated that there had been a total of 367 restraints during the 1st quarter of FY11 and 291 restraints implemented during the 2nd quarter of FY11, indicating a 21% reduction in restraint instances.
	
	Some areas where the monitoring team saw positive progress in addressing section C of the Settlement Agreement included:
	• The Restraint Reduction Performance Improvement Team members were trained on the new statewide restraint monitoring tool and had begun using the tool to monitor a sample of restraints monthly.
	• The Restraint Reduction Performance Improvement Team and the psychology department had focused on reducing restraints for the three individuals involved in the greatest number of restraints. Restraints for those individuals were reviewed in greater detail and technical assistance was provided to their PSTs to address restraint reduction.
	• Restraint monitors were retrained on monitoring restraints
	• The restraint checklist had been revised and all staff were trained on completing the new form. There were fewer errors and incomplete forms found in documentation.
	
	Additionally, significant changes were being made at the facility to address earlier concerns by the monitoring team over the lack of adequate meaningful programming. This should have a positive impact on the engagement levels of individuals at the facility thus reducing some of the behavioral issues leading to restraints.
	
	As discussed further in C1 below, inadequate documentation of restraints made it difficult to track activities that individuals were engaged in prior to the behavior resulting in restraint and learn from previous restraint incident.

#	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	<u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklist, prone restraint was not identified.	Noncompliance

#	Provision	Assessment of Status	Compliance
	that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	A sample, referred to as Sample #C.1, was selected for review. This included 11 individuals and was selected to ensure that some of the most recent restraint incidents and a random sample of restraint incidents of the individuals with the highest numbers of restraint were included. The individuals in this sample included Individual #247, Individual #249, Individual #99, Individual #178, Individual #346, Individual #239, Individual #213, Individual #243, Individual 116, Individual #186, and Individual #215. The sample did not include all restraints for these individuals. • Individual #116 had the greatest number of restraints, accounting for 143 (32%) of the 441 restraints between 11/15/10 and 3/31/11. • Individual #243 had the second greatest number with 29 (7%) of the restraints. Based on a review of 42 restraint records for individuals in Sample #C.1 involving 11 individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> Based on document review, the facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included 42 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 42 of the 42 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • Aggression towards staff and/or peers, self-injurious behavior, and property destruction was indicated as the reason for the restraint on all forms that described behavior leading to the event. • For the 42 restraint records in the sample, a review was completed of <u>the description of events leading to behavior that resulted in restraint</u>. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but not all described events leading up to or causing these behaviors. Thirteen of the checklists (31%) gave a brief description of events that occurred prior to the restraint. This information would be useful for direct care staff to know to avoid future restraint incidents. Restraint checklists that gave a description of events leading to the behavior included: restraints for Individual #116 on 12/31/10, and 1/3/11; restraint for Individual #99 on 3/31/11; restraints for Individual #215 on 10/27/10; restraints for Individual #243 on 10/11/10, 12/12/10 and	

#	Provision	Assessment of Status	Compliance
		11/22/10; and restraints for Individual #249 on 10/7/10 and 3/31/11(5). Examples of good documentation included: o The restraint checklist for Individual #243 dated 10/11/10 indicated that the individual became upset after she did not win at bingo. She became physically aggressive towards staff. o The restraint checklist for Individual #99 dated 3/31/11 indicated that she became aggressive toward a peer after her milkshake did not arrive for lunch and the peer tried to hug her. o The restraint checklist for Individual #215 dated 10/27/10 indicated that prior to the behavior leading to the restraint, staff prompted her to return home from the token store to eat lunch. She wanted to continue to talk to her peers. She picked up rocks and began throwing them at staff. Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #116 on 1/2/11, staff documented "she was being PA (physically aggressive) towards staff by scratching them multiple times. She was attempting SIB (self injurious behavior)." o On the restraint checklist for Individual #178 dated 10/11/10 the description of events leading to the behavior noted "prolonged SIB with injury." Staff did not document what activity the individual was involved in at the time of the incident. o On the restraint checklist for Individual #247 dated 3/30/11, staff did not indicate what precipitated the individual's behavior that necessitated restraints. The area to describe events leading to the behavior stated "Drs order chemical restraint." • In 35 of the records (83%), staff documented that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered in a clinically justifiable manner. o The restraint checklist for Individual #247 dated 3/30/11 did not indicate that other interventions were attempted prior to the implementation of a physical restraint. o On the restraint checklist for Individual #116 dated 12/27/16, staff indicated interventions in safety plan and verbal prompts were attempted prior to restraint. The narrative noted she did not respond to staff's prompts to stop. Other interventions described in her safety plan for crisis intervention (SPCI) were not attempted. o On restraint checklists dated 1/2/11 and 12/31/10 for Individual #116, the staff had checked verbal prompts and redirection on the checklist of actions taken prior to restraint. The narrative repeated this	

#	Provision	Assessment of Status	Compliance
		information, but did not indicate how staff attempted redirection or what other action might have been taken. There was no indication that other interventions were attempted. Her SPCI directed staff to attempt to alter the situation by separation from the cause of irritation, reducing excess noise, or verbally directing her to a quiet area. o Two restraint checklists dated 12/27/10 for Individual #116 indicated that staff implemented a restraint after verbal prompts to stop failed to work. Her SPCI instructed staff to use restraint after other interventions are exhausted and have been inadequate. o The restraint checklist for Individual #346 dated 10/4/10 indicated a chemical restraint was administered. There was no documentation that other intervention strategies had been implemented prior to the restraint. Thus, it was not clear that all restraints used were the least restrictive intervention necessary. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. It was also not evident that restraints were not used in the absence of or as an alternative to appropriate programming and treatment. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint, Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 42 restraints, 42 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of medical pretreatment sedation and medical restraints between 10/1/10 and 3/31/11: • 5 individuals were the subject of restraints, • 40 incidents of restraint occurred, • 40 were pretreatment sedation for routine appointments or procedures, • 5 individuals had dental desensitization programs in place. The facility was not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint. Further, as noted throughout this report, it was not evident that adequate treatment and programming was	

#	Provision	Assessment of Status	Compliance
		being consistently implemented that might reduce the number of behavioral incidents leading to restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 11 individuals in Sample #C.1 where physical restraint was used were reviewed. Of these, seven of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. The SPCI was reviewed for the two individuals in the sample with the highest number of restraints. • For Individual #116, her SPCI did not describe clear indicators for when staff should attempt release from restraint. The plan stated that to be released, "she will need to no longer be a danger to herself or others." • Individual #243's SPCI included an identical statement. There were no specific indicators included of what behavior would be considered no longer a danger to herself or others. A sample of restraint documentation for physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Ten (59%) restraints of 17 reviewed indicated that the individual was released immediately when no longer a danger. Findings in regards to restraints in this sample were as follows: • Restraints for Individual #249 dated 3/31/11 (7); o A restraint at 2:10 pm lasted seven minutes; she was released because staff could not maintain the restraint correctly. o She was restrained again at 2:20 pm for one minute and released because staff could not maintain the restraint correctly. o She was restrained again at 2:25 pm for two minutes. Documentation indicated that she escaped the restraint. o At 2:31 pm she was again restrained and released after two minutes because staff were unable to maintain the restraint correctly. o At 2:33 pm she was restrained again for 12 minutes. She was released when staff were unable to maintain the restraint correctly. o At 2:45 pm, a chemical restraint was administered and she was physically restrained for 14 minutes. The documentation indicated that she was again released because staff were unable to maintain the restraint correctly. o The restraint review and assessment forms completed by the restraint monitor for these restraints did not address the staff's inability to maintain an appropriate restraint. The PST met the following day to review the restraints. The PSP addendum indicated that the PST agreed no further training was needed at that time, no additions were needed to the BSP, and no further preventative measures could have been taken.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Restraints for Individual #247 dated 3/30/11 (2) o Both restraints lasted 10 minutes. Documentation indicated that the individual was released immediately because no longer a serious risk of harm to self/others. • Restraints for Individual #116 dated 12/27/10 (3), 12/28/10 (2), 12/31/10, 1/2/11 and 1/3/11; and o Restraints dated 12/27/20 (12:15 pm), 12/31/10, 1/2/11, and 1/3/11 indicated that the individual was released immediately because she no longer was an immediate and serious risk of harm to herself or others. o The restraint dated 12/27/10 at 8:45 am indicated that she was restrained for 30 minutes. Staff attempted to release her after 15 minutes, but she continued to display self-injurious behaviors and aggression. Documentation indicated that she was released when no longer an immediate danger to herself or others. o The restraint dated 12/27/10 at 10:05 am lasted for 79 minutes to prevent self-injurious behaviors. Documentation indicated that release was attempted three times prior to release at 11:24 when she was no longer an immediate and serious risk to herself or others. o The restraint dated 12/28/10 at 6:00 pm indicated that she was restrained for 30 minutes. Staff did not document her behavior while in restraint prior to her release. Documentation was not sufficient to determine if she was released immediately when no longer a danger to herself or others. o The restraint dated 12/28/10 at 2:54 pm indicated that she was restrained for 35 minutes. Staff documented attempts to release the restraint twice prior to her release when she was determined to no longer be a danger to herself or others. The facility was not in substantial compliance with this provision. SPCIs should describe behavioral indicators specific to each individual that would allow staff to consistently determine when the individual is no longer an immediate risk to him/herself or others. When staff are unable to safely maintain a restraint, the PST needs to meet to develop a plan for safely restraining the individual and staff need to be retrained.	
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 facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	• Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. This sample included 24 current employees at the facility A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • Twenty-four (100%) had current training in RES0105 Restraint Prevention and Rules. • Twenty-four (100%) completed the RES0105 refresher training within 12 months of the previous training. • Twenty-four (100%) had completed PMAB training within the past twelve months. • Twenty-four (100%) completed PMAB refresher training within 12 months of previous restraint training. The facility is in substantial compliance 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.	Based on a review of 42 restraint records (Sample #C.1), 42 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. The facility had not developed medical desensitization plans for individuals who required the use of restraint for routine medical care. Dental desensitization programs had been implemented for five individuals who had needed pretreatment sedation or restraint to have work completed in the past. PSPs reviewed did not always address strategies to reduce the use of medical restraints. • The PSP for Individual #38 included a good example of discussion regarding restraint needed for medical appointments and strategies to reduce his anxiety during medical procedures. • Individual #126's dental exam dated 4/1/11 indicated that she was sedated for a routine dental exam, but was still uncooperative. She did not have a dental desensitization plan in place and the PSP did not address the need for one. • Individual #44 was sedated for a vision exam on 4/6/10. Her PSP did not address the need for pretreatment sedation or a desensitization plan. • The PSP for Individual #313 noted that she would have a vision exam with	Noncompliance

#	Provision	Assessment of Status	Compliance
		pretreatment sedation. There was no discussion documented regarding the need for a desensitization plan. • The PSP for Individual #128 did not discuss medical/dental restraints other than a statement that pretreatment sedation was not needed. A restraint checklist indicated that he was physically restrained for a medical appointment on 3/31/11. • In regards to pretreatment sedation and restraint, the PSP for Individual #283 stated "none so far, however the PST is working on a desensitization program for him." He received pretreatment sedation for an eye exam on 3/25/11. The facility did not maintain a "Do Not Restrain" list. Each individual's PST should discuss risk associated with restraint for the individual based input from PNMT and medical staff. A list of individuals for whom restraints would be contraindicated due to medical or physical conditions should be developed and maintained by the facility. For example, PSPs for individuals at risk for aspiration or fractures should clearly state that the individual should not be physically restrained or offer clear guidelines for safely restraining the individual. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint. The facility is not in compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 42 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 42 out of 42 incidents of restraint (100%), there was assessment by a restraint monitor. • In 37 out of 42 instances of physical restraint (88%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint assessment for Individual #243 dated 11/22/10 indicated that the restraint monitor did not arrive until 30 minutes after the restraint was initiated. o The restraint assessment for Individual #243 dated 10/15/10 indicated that the restraint monitor arrived one hour and 40 minutes after the restraint was initiated. o The restraint assessment for Individual #116 dated 11/30/10 indicated that the restraint monitor arrived 25 minutes after the restraint was	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	administered. o The restraint assessment for Individual #116 dated 12/31/10 indicated that the restraint monitor arrived 29 minutes after the restraint was administered. o The restraint assessment for Individual #116 dated 12/27/10 indicated that the restraint monitor arrived 20 minutes after the restraint was administered. • In 35 instances (83%), the documentation showed that an assessment was completed of the application of the restraint. o The restraint checklist for Individual #99 dated 3/31/11; Individual #178 on 10/11/10; Individual #249 dated 3/31/11 (2:10 pm); and Individual #116 dated 1/3/11 (11:30am), 1/3/11 (12:40 pm), 12/27/10, and 12/31/10 did not include an assessment of the application. The restraint monitor noted that she was not present for the restraint. In all cases, the restraint monitor arrived within 15 minutes of when the restraint was implemented, but the individual was released prior to her arrival at the home. • In 42 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 42 behavioral restraint records for restraints that occurred at the facility there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in 34 (81%) of the instance of restraint. Restraint records where this did not occur as required included: o Individual #243 was restrained and transported back to the facility at 9:00 am on 11/22/10. Documentation indicated she was placed in a basket hold, horizontal hold, and body wrap. According to the restraint checklist, she was not assessed by a nurse until 4:00 pm. o Individual #243 was restrained in a horizontal hold on 10/15/10 at 5:55 pm. According to the restraint checklist, the nurse did not assess her until 7:35 pm. o Individual #116 was restrained on 11/13/10 at 4:20 pm. According to the restraint checklist, the nurse did not assess her until 7:25 pm. o Individual #116 was restrained on 11/3/10 at 12:45 pm. According to the restraint checklist, the nurse did not assess her until 1:25 pm. o Individual #116 was restrained for 79 minutes on 12/27/10 beginning at 10:05 am. According to the restraint checklist, the nurse did not assess her until 11:30 am. A second assessment was completed two hours later.	

#	Provision	Assessment of Status	Compliance
		o Individual #116 was restrained on 1/3/11 at 12:40. The nurse completed an assessment, but did not indicate what time the assessment was completed. The individual refused the initial assessment of her vital signs. The nurse indicated that she was unable to assess her mental status. Even if the individual refused to have her vital signs taken, the nurse could have visually assessed her mental status. o Individual #116 was restrained for 21 minutes on 1/2/11 at 2:59 pm. The restraint checklist indicated that the nurse did not assess her until 7:05 pm. o Individual #116 was restrained for 25 minutes on 11/29/10 at 2:00 pm. The restraint checklist indicated that she was not assessed by a nurse until 3:00 pm • Monitored and documented vital signs in 41 (98%). o For Individual #247, a chemical restraint was administered on 3/30/11. Documentation indicated that the nurse attempted to monitor her vital signs every 15 minutes for two hours following the restraint. According to the nurse's documentation, the individual refused to have her vital signs taken. • Monitored and documented mental status in 41 (98%). o The nurse documented that Individual #116 refused to have her vital signs taken following a restraint on 12/28/10. She did not document her mental status. Based on a review of 10 pretreatment sedation for medical restraint records, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint for a minimum of two hours in eight (80%) of the instances of restraint. Restraint records where this did not occur as required included: o The restraint checklist for Individual #216 on 3/4/11 indicated the nurse continued to assess him throughout the day following pretreatment sedation for a medical appointment. The assessments did not occur at least every 30 minutes. o Individual #283 was sedated prior to a vision exam at 8:00 am. The nurse documented an assessment at 7:45 am, 8:45 am, and 11:30 am. The physician's orders were for the individual to be monitored every hour for three hours. • Physician orders were written for the use of the chemical restraint in eight of nine (89%) records, • And physician orders specified the frequency of monitoring in nine (100%) records.	

#	Provision	Assessment of Status	Compliance
		Monitoring and post restraint review should be consistently documented on the restraint checklist. Not all restraints were being monitored as required by this provision. This is a repeat from the last monitoring review. 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 exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample of 42 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 42 (100%), continuous one-to-one supervision was indicated as having been provided. • In 42 (100%), the date and time restraint was begun were indicated. • In 42 (100%), the location of the restraint was indicated. • In 13 (31%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Twenty-nine did not indicate what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 42 (100%), the specific reasons for the use of the restraint were indicated. • In 42 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 42 (100%), the names of staff who applied/administered the restraint was recorded. • Observations of the individual and actions taken by staff while the individual was in restraint for 32 physical or mechanical restraints were recorded, including: o In 31 (97%), the observations were documented every 15 minutes and at release. For Individual #116 on 12/28/11, staff did not document observation while mittens were being used for restraint for self injurious behavior until release from restraint after 30 minutes. o In 31 (97%), the specific behaviors of the individual that required continuing restraint were recorded. For Individual #116 dated 12/28/10 this information was not documented during a mechanical restraint. • In 32 (100%) of physical restraint incidents, the date and time the individual was released from restraint was indicated. • In 38 (90%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. Four restraint checklist for Individual #249 dated 3/31/11 indicated that the nurse was unable to assess. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In a sample of 42 records (Sample #C.1), restraint debriefing forms had been completed for 42 (100%). A sample of 10 individuals subject to medical restraint was reviewed and in eight (80%), there was evidence that the monitoring had been completed as required. See section C.5 for details of this finding. Monitoring of restraints as required should be documented on the restraint checklist for each restraint incident. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. As noted in the review of documentation above, the facility was not in compliance with the requirements of 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:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to SGSSLC documentation, during the six-month period prior to the onsite review, a total of 30 individuals were placed in restraint more than three times in a rolling thirty-day period. Five of these individuals (i.e., Individual #239, Individual #346, Individual #116, Individual #34, and Individual #292) were reviewed (17%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) were requested for all five individuals. A functional assessment was not available for Individual #239, and a safety plan was not available for Individual #34. One of the five PSPAs minutes reviewed (20%) reflected a discussion an individual's adaptive skills, and biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Individual #116's PSPA of 3/1/11 reviewed a medical condition that may contribute to her self-injurious behavior (SIB). The PBSP discussed that her SIB may be related to her legs itching or irritating her. The team discussed several medications that have or were recommended be used to decrease the irritation. This represented a good example of a PSPA that achieves compliance with this item because it documents a discussion of a potential medical condition that affects a dangerous	Noncompliance

#	Provision	Assessment of Status	Compliance
		behavior that provokes restraint, and a plan is to address the medical condition. This item was rated noncompliance because only one of the five PSPA reviewed reflected a discussion that included potential biological, medical, and/or psychosocial factors affecting restraint. Each individual's PSPA should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(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. All PSPAs should reflect a discussion of possible contributing environmental factors, and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them 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 potential antecedents to the behavior that provokes restraint. One (20%) of the PSPAs reviewed reflected a discussion of possible antecedents to the behavior or behaviors provoking restraint. Individual #292's PSPA reflected a discussion of demands not being met as an antecedent to her dangerous behavior. No discussion, however, of how this environmental factor could be addressed (e.g., attempt to provide desired items non-contingently, modify how staff inform Individual #292 that she will not get the desired item) was apparent in the PSPA reviewed. Examples of other issues that could be discussed here would be the role of antecedent conditions, such as the presence of novel or unfamiliar staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease the future probability of the dangerous behavior.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. None of the PSPAs reviewed contained a discussion of variables that may be maintaining the dangerous behavior that provokes restraint. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing staff attention. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		minutes.	
	(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 five individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Five (100%) were based on the individual's strengths; • One (20%) of the PBSPs reviewed (e.g., Individual #239) specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors ; • Five (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the five plans); and • Five (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Two of the five PBSPs (40%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be inadequate (i.e., Individual #346, and Individual #239) because they did not contain clear, precise interventions based on a functional assessment (see K9). The four Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In all four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In none of the safety plans reviewed (0%), was the maximum duration of restraint authorized specified; • In all (100%), the designated approved restraint situation was specified; and • In none (0%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was evidence that at least one PBSP (i.e., Individual #346) of the individuals reviewed was modified (when necessary) to decrease the future probability of him	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		requiring restraint.	
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.	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 Meeting (DIMM) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Observation of the Daily Incident Management Meeting (DIMM) meeting confirmed that restraint incidents were reviewed by the team. Restraint incidents were referred to the PST for follow-up. PSTs met following restraint incidents to review restraints, but as noted in section C7, supports and prevention strategies developed by teams were often not consistently implemented and revised when not effective. A sample of Face-to-Face Debriefing and Review Form related to 42 incidents of non-medical restraint for was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team. • In review of 42 restraint review forms for sign off by the Unit Director and IMC Designee, 20 (48%) were reviewed by either the Unit Director and/or the IMC Designee within three days. o Restraint documentation for Individual #247 dated 3/30/11 (2) was reviewed by the Unit Director the following day. It was reviewed by the DIMM five days after the restraint incident. o Restraint documentation for Individual #346 dated 10/4/10 was reviewed by the IMC Designee the following day. It was reviewed by the Unit Director five days after the restraint incident. o Restraint documentation for Individual #239 dated 10/25/10, 10/14/10, and 10/7/10 was reviewed by both Unit Director and the DIMM within three days. o Restraint documentation for Individual #243 dated 11/22/10, 11/13/10, 11/12/10, 10/15/10, and 10/11/10 was reviewed by the Unit Director and the IMC Designee within three days. o Restraint documentation for Individual #116 dated 12/27/10 (2) was reviewed by the Unit Director three days following the restraint incident, but was not reviewed by the IMC Designee until 1/24/11. o Restraint documentation for Individual #116 dated 12/2/10 was reviewed by both the Unit Director and the IMC Designee three days after the restraint incident. o Restraint documentation for Individual #116 dated 1/2/11 was reviewed by the Unit Director and the IMC Designee two days after the restraint incident.	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Restraint documentation for Individual #116 dated 12/28/10 (2) was reviewed by the Unit Director two days following the restraint incident, but was not reviewed by the IMC Designee until 1/13/11. o Restraint documentation for Individual #116 dated 12/27/10 was reviewed by the Unit Director three days following the restraint incident, but was not reviewed by the IMC Designee until 1/24/11. o Restraint documentation for Individual #116 dated 11/29/10 was reviewed by the Unit Director three days following the restraint incident, but was not reviewed by the IMC Designee until 12/6/10. o Restraint documentation for Individual #116 dated 11/30/10 was reviewed by the Unit Director two days following the restraint incident, but was not reviewed by the IMC Designee until 1/24/11. As noted throughout Section C, restraint documentation contained errors in documentation and monitoring. Only one of the Restraint Review forms in the sample addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. • The restraint review documentation for Individual #116 dated 12/15/10 noted that staff involved in the restraint needed to be retrained. The facility had implemented a quality assurance process to monitor restraints in January 2011. Members of the restraint reduction team were reviewing a sample of restraint documentation for individuals with the highest number of restraints monthly. Reviewers were utilizing a tool developed by the state office based on requirements of Section C from the Settlement Agreement. Findings were similar to the findings in this report. In the sample reviewed by the facility, there were problems noted in documenting events leading to the restraint and nursing assessments. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation.	

Recommendations:

1. SPCIs should describe behavioral indicators specific to each individual that would allow staff to consistently determine when the individual is no longer an immediate risk to him/herself or others. When staff are unable to safely maintain a restraint, the PST needs to meet to develop a plan for safely restraining the individual and staff need to be retrained.

2. A list of individuals for whom restraints would be contraindicated due to medical or physical conditions should be developed and maintained

by the facility.

3. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint.

4. Monitoring and post restraint review should be consistently documented on the restraint checklist.

5. Monitoring of restraints as required should be documented on the restraint checklist for each restraint incident.

6. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming.

7. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. 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. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation.

9. Discuss and document in the PSPA all the variables presented in C7 when an individual has more than three restraints in any rolling 30 day period.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy: Incident Management #002.2, dated 6/18/10 o SGSSLC Policy: Incident Management dated 3/31/11 o SGSSLC Policy: Individual Levels of Supervision dated 1/14/06 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o SGSSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation dated 3/31/11 o SGSSLC Policy: Spurious Allegations of Abuse/Neglect/Exploitation dated 3/30/11 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents. o Abuse and Neglect: Identification, Reporting and Prevention Training Curriculum o Incident Management Committee meeting minutes for each Monday of the past six months o Unit Level Meeting minutes 1/1/11-3/31/11 o SGSSLC Plan of Improvement updated 5/9/11 o Log of employees reassigned due to allegations of abuse and neglect since 10/1/10 o Three most recent five-day status reports o Training transcripts 24 employees o Acknowledgement to report abuse for all employees hired in the past two months o Training and background checks for the last three employees hired o Training transcripts for facility investigators o Training transcripts for DFPS investigators o Abuse/Neglect/Exploitation Trend Reports since 10/1/10 o Injury Trend Reports since 10/1/10 o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o Injury reports for three most recent incidents of peer-to-peer aggression incidents o List of individuals on the DFPS "frequent caller list" o List of all serious injuries for the past year o List of Injuries by individual since 3/1/10 o List of all A/N/E allegations since 1/1/10 including case disposition o List of employees reassigned due to ANE allegations o Injury reports and supporting documentation for the past four months for Individual #186, Individual #365, Individual #382, and Individual #34 o A sample of investigations of discovered injuries of unknown cause for Individual #17, Individual

#294, Individual #134, Individual #346, Individual #60, Individual #385, Individual #316, Individual #76, and Individual #328.

- PSPs for:
  - Individual #32, Individual #94, Individual #12, Individual #59, Individual #313, Individual #331, Individual #247, Individual #232, Individual #287, and Individual #44.

- Documentation from the following completed investigations including follow-up:

Case #	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
Sample D.1					
#3679	Emotional Verbal Abuse (2) Sexual Abuse (2)	Unconfirmed (2) Unconfirmed	11/21/10 3:45 pm	11/21/10 5:54 pm	12/10/10*
#3680	Sexual Abuse (3)	Unconfirmed (3)	11/21/10 3:45 pm	11/21/10 6:28 pm	12/10/10*
#3684	Neglect	Inconclusive	11/22/10 2:40 pm	11/22/10 3:50 pm	11/29/10
#3903	Physical Abuse	Confirmed	2/7/11 7:43 pm	2/8/11 3:06 pm	2/17/10
#3906	Physical Abuse	Unconfirmed	2/8/11 6:08	2/10/11 1:40 pm	2/18/11
#3928	Neglect (3) Physical Abuse (2)	Unconfirmed (2) Other (1) Inconclusive (2)	2/15/11 3:44 pm	2/15/11 2:20 pm	3/5/11
#3930	Physical Abuse	Inconclusive	2/16/11 11:03 am	2/17/11 12:20 pm	2/25/11
#3921	Physical Abuse	Unconfirmed	2/14/11 1:43 pm	2/14/11 3:33 pm	2/23/11
#3926	Physical Abuse	Unconfirmed	2/15/11 10:41 am	2/15/11 1:59 pm	2/22/11
#3931	Physical Abuse	Unconfirmed	2/16/11 10:13pm	2/17/11 1:56 pm	2/23/11
#3935	Emotional Verbal Abuse	Unconfirmed	2/20/11 8:53 am	2/20/11 5:00 pm	3/1/11
#3945	Physical Abuse	Confirmed	2/23/11 5:10 pm	2/24/11 1:43 pm	3/4/11
#3948	Physical Abuse	Unconfirmed	2/23/11 5:53 pm	2/24/11 6:10 pm	3/4/11
#3721	Physical Abuse (2)	Unconfirmed (2)	12/7/10	12/7/10	12/16/10

	Sexual Abuse (2)	Unconfirmed (2)	5:28 am	1:43 pm	
#3766	Sexual Abuse	Unconfirmed	12/21/10 1:39 pm	12/22/10 12:15 pm	12/29/10
#3769	Sexual Abuse (2)	Unconfirmed (2)	12/21/10 9:45 pm	12/22/10 10:35 am	12/28/10
#3771	Physical Abuse Sexual Abuse	Unconfirmed Unconfirmed	12/22/10 1:38 pm	12/23/10 8:01 am	12/28/10
#3779	Sexual Abuse	Unconfirmed	12/23/10 8:47 pm	12/24/10 5:31 pm	12/31/10
#3960	Physical Abuse	Unconfirmed	3/2/11 1:45 am	3/21/11 2:18 pm	3/11/11
#3966	Physical Abuse	Unconfirmed	3/2/11 6:06 pm	3/4/11* 6:07 pm	3/13/11*
#3964	Physical Abuse (4)	Inconclusive (4) Administrative Referral	3/3/11 9:11 am	3/3/11 4:45 pm	3/10/11
#3986	Physical Abuse	Unfounded	3/12/11 5:41 pm	3/13/11 5:41 pm	3/18/11
#3972	Emotional verbal Abuse	Unconfirmed	3/7/11 6:28 am	3/7/11 11:35 am	3/17/11
#3976	Emotional Verbal Abuse	Unconfirmed	3/7/11 9:12 pm	3/8/11 10:03 am	3/11/11
#3979	Emotional Verbal Abuse Physical Abuse	Unconfirmed Unconfirmed	3/10/11 6:51 pm	3/11/11 2:26 pm	3/18/11
#3987	Physical Abuse	Unconfirmed	3/12/11 10:10 pm	3/13/11 5:31 pm	3/21/11
#4027	Sexual Abuse	Unconfirmed	3/31/11 11:42 am	3/31/11 2:55 pm	4/7/11
#4029	Physical Abuse	Unconfirmed	4/1/11 7:57 pm	4/6/11* 10:18 am	4/11/11
#3994	Sexual Abuse	Unconfirmed	3/16/11 11:38 am	3/16/11 4:58 pm	3/25/11
#4004	Neglect (4)	Unconfirmed (2) Confirmed (2)	3/20/11 1:22 pm	3/20/11 3:24 pm	3/25/11
#4032	Emotional Verbal Abuse (7) Physical Abuse (7)	Unfounded (3) Inconclusive (4) Unfounded (3) Inconclusive (1) Confirmed (2)			
Sample D.2	Type of Incident	DFPS Disposition	Time of	Began	Closed

			Incident	Investigation	Investigation
#3734	Neglect	Referred Back	12/10/10 9:33 am		12/16/10
#3755	Neglect	Referred Back	12/18/10 8:14 pm		12/27/10
#3922	Emotional Verbal Abuse	Referred Back	2/14/11 4:47 pm	2/14/11	2/28/11
#3927	Emotional Verbal Abuse	Inconclusive Referred Back	2/15/11 3:44 pm	12/19/10 8:00 am	3/1/11
#3929	Neglect	Referred Back	2/15/11 6:54 pm		3/1/11
#3962	Neglect	Referred Back	3/2/11 11:24 pm	Unknown	3/7/11
#3971	Emotional Verbal Abuse	Referred Back	3/6/11 8:37 pm		3/15/11
#3983	Emotional Verbal Abuse	Referred Back	3/11/11 7:40 pm		3/19/11
#4011	Neglect	Referred Back	3/25/11 12:30 pm		3/25/11
Sample D.3					
#3667	Death	n/a	11/21/10 1:52 am	Unknown	11/23/10
#3753	Sexual Incident	n/a	12/16/10 11:22 pm	Unknown	12/17/10
#3766	Other – Unauthorized Departure		12/23/10 10:40 pm	Unknown	12/28/10
#4055	Serious Injury	n/a	4/11/11 10:40 am	Unknown	4/14/11
#4007	Serious Injury	n/a	3/21/11 9:50 pm	Unknown	3/23/11
#3701	Serious Injury AGP Offender	n/a	11/25/10 8:45 pm	Unknown	11/29/10

* = late

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Jalown McCleery, Incident Management Coordinator
- Natalie Montalvo, Director of Residential Services

	o Mary Holmes, Lead Investigator o Michael Davila, QMRP Coordinator o Roy Smith, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Morning Unit Meeting 5/24/11 o Daily Incident Management Meeting 5/24/11 and 5/26/11 o Human Rights Committee Meeting o Annual PSP meetings for Individual #169 and Individual #134
	Facility Self-Assessment: The facility POI indicated that SGSSLC had updated policies to meet compliance in areas cited during the last monitoring visit. The facility had also implemented new procedures to address delinquent training in abuse and neglect. While this appeared to have impacted the number of staff in compliance with training requirements, the facility was still not in compliance with this item due to the number of staff that did not receive retraining in a timely manner. The facility had also implemented a new tracking sheet for investigations that had improved the facility's ability to ensure consistent procedures were followed in investigations. A number of monitoring tools had been developed that were identifying problems in this area. The facility was in the beginning stages of addressing these provisions through the quality improvement process. The findings in this section of the report evidence of positive steps that the facility had taken to meet this provision.
	Summary of Monitor's Assessment: According to a summary of abuse, neglect, and exploitation trends provided to the monitoring team, investigation of 484 alleged cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 9/1/10 through 3/31/11. These cases included 817 allegations. Of these 817 allegations, 29 (4%) were confirmed allegations by DFPS, 501 (61%) were unconfirmed allegations, 53 (6%) were unfounded allegations, 47 (6%) were inconclusive, and 171 (21%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect and 16 were other (including pending). A list of all DFPS investigations at the facility from 10/1/10 through 4/1/11 indicated that there had been 45 confirmed allegations of abuse, neglect and exploitation. This did not match the numbers in the trend reports for the same time period. The list included 13 confirmed allegations of abuse, 31 confirmed allegations of neglect, and one confirmed allegation of exploitation. There had been a decrease in the number of abuse and neglect allegations from FY11 1st quarter (371) to FY11 2nd quarter (345). The facility investigators conducted investigations for 34 additional serious incidents during the same time period. This included five serious injuries, 26 sexual incidents, and three unauthorized departures.

	There were a total of 2385 injuries reported since 9/1/10. Of these injuries, 17 were serious injuries, 1736 were non-serious injuries requiring treatment, 191 required no treatment, and 441 were no apparent injury. It should be noted that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there is no injury. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility. Considering the large number of incidents occurring at the facility, both DFPS and facility investigators conducted consistent, well-documented, and organized investigations of cases reviewed in the sample. A majority of the incidents occurring at the facility were the result of behavioral issues. The large number of staff routinely assigned to "no client contact" positions left the facility short staffed or utilizing staff that were not familiar with the individuals to whom they were assigned to support. This resulted in additional incidents. For example, in one incident (UIR #4004), the DFPS investigator concluded that there was a preponderance of evidence to indicate that there was not an adequate number of properly trained staff on the home, which may have contributed to one individual cutting herself with a piece of plastic and may have contributed to the delay in discovering another individual with a headband wrapped too tightly around her neck. As noted throughout this report, the facility had implemented a number of procedures to try to address some of these issues. The monitoring team noted efforts made to address these issues, however, still found a significant number of serious incidents and injuries at the facility as indicated by the data reported above. Incidents and injuries were reviewed daily Monday through Friday at meetings held by each Unit Director, then reviewed daily by the Incident Management Review Team. Both groups briefly reviewed incidents and tracked follow-up to the incident. PSTs met routinely to look at individual incidents and put protections in place when necessary.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, and • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples:	Noncompliance

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		• There were posters regarding this mandate posted throughout the facility with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. The facility provided evidence that checks of living units were being conducted to assure that posters were posted. • In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the monitoring team questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they would report the incident to DFPS by calling the 800#. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months. In practice, the facility did not adhere to the policy for zero tolerance for all employees at SGSSLC. Documentation for UIR #3945 indicated that the perpetrator involved in an incident of physical abuse was allowed to return to work after a seven day suspension. Although this may have been consistent with policy, it did not appear to be consistent with a commitment to not tolerate abuse and neglect. The facility had 45 confirmed allegations of abuse or neglect in a six month period. This number would indicate that employees did not recognize that the facility was serious regarding zero tolerance for abuse and neglect. Given the high incidence of abuse and neglect, the facility needs to take a much stronger stand in demonstrating abuse and neglect will not be tolerated by any employee at the facility. Therefore, the facility was rated as being out of compliance with this provision item.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and	According to SGSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. This was consistent with the requirements of the Settlement Agreement.	Noncompliance

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	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.	With regard to serious incidents, the facility policy entitled Incident Management required that all serious incidents be reported to the facility director immediately, reported to DFPS immediately if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. It further specified requirements for reporting certain types of incidents to other outside agencies. This policy was consistent with the requirements of the Settlement Agreement. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 415 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 10/1/10 through 4/1/11. From these 415 cases, there were: • 13 confirmed allegations of abuse, • 31 confirmed allegations of neglect, and • 1 confirmed allegation of exploitation. • Confirmed allegations involved 20 different individuals. The facility investigators conducted investigations for 60 additional serious incidents during the same time period. The incidents included: • Serious Injuries – 21 • Choking Incidents – 4 • Deaths – 7 • Sexual Incidents – 23 • Encounter with law enforcement– 1 • Unauthorized departure - 4 Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. Two samples of investigations were selected for review. These included: • Sample #D.1 which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 and Sample #D.3 which included a sample of facility investigations. Some of these were investigations that had been referred to the facility by DFPS, while others were investigations the facility completed related to serious incidents. See the list of documents reviewed for investigations included in this sample. Based on a review of the 30 investigative reports included in Sample #D.1:	

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		• 29 (97%) of reports in the sample indicated that DFPS was notified within one hour. o UIR #3684 indicated that the IMC was not notified of the incident occurring on 11/21/10 at 11:45 am until 11/22/10 at 11:45 am. Consequently, DFPS was not notified until 11/22/10 at 2:40 pm after the IMC completed a preliminary investigation. • Twenty-eight (93%) indicated, the facility director or designee was notified within one hour. o UIR #3684 was an investigation of a serious injury. The individual was transported to the hospital where she received sutures for a head injury resulting from a fall. The injury occurred at 11:45 am on 11/21/10. According to the UIR, the facility director was not notified of the injury until 11/22/10 at 11:45 am. o The documentation for UIR #3930 indicated that DFPS received the report at 11:03 am and notified the facility at 1:15 pm. • Twenty eight of 28 (100%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. • Thirty (100%) investigation reports in the sample indicated that the state office was notified of the incident. 0% documented notification of the state office by 9:00 am the following working day as required by state policy. Twenty-nine indicated notification of the state office at 9:30 am the following day and one (UIR #3678) indicated notification at 10:05 am the following day. • DADS Regulatory was notified in nine of nine (100%) cases within 24 hours as required. • Based on a review of 9 incident reports included in Sample #D.2: o Nine (100%) showed evidence that serious incidents were reported to DFPS when abuse or neglect was suspected. o Nine (100%) indicated, the facility director or designee was notified within one hour. o Two (100%) investigation reports in the sample indicated DADS regulatory was notified when required. o Nine (100%) indicated the state office was notified. All nine reports indicated that the state office was notified at 9:30 am. The state policy requires notification by 9:00 am the following working day. It seems unlikely that notifications would be made at the exact same time for every incident in the sample. This leads to questions of whether or not the facility was accurately reporting notifications. Injury reports for Individual #384 dated 3/24/11, Individual #186 dated 4/3/11 and	

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		4/19/11, Individual #345 dated 3/8/11, and Individual #304 dated 4/19/11 were designated as serious injuries. The facility director was not notified within one hour in the following incidents: • Individual #345 was seen in the emergency room following a fall down a staircase. The incident occurred on 3/8/11 at 4:20 pm. According to the UIR, the director was not notified until 4:35 pm the following day. • Individual #384 sustained a serious injury when he fell over a curb on 3/24/11 at 6:05 pm. The director was not notified of the injury until 11:00 am the following day. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form designated by DADS for reporting unusual incidents other than serious injuries. Serious injuries were documented on the SGSSLC Client Injury Report. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 15 incident reports included in Sample #D.2 and Sample #D.3: • Fifteen (100%) utilized the standardized reporting format. The monitoring team found examples of cases where employees failed to report suspected abuse or neglect. See section D.2.d for a summary of these findings. The facility needs to ensure that all serious incidents are reported to the facility director and outside entities as required.	
	(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	According to SGSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy the facility was mandated to assure the safety and protection of individuals by immediately removing alleged perpetrators. Based on a review of 30 investigative reports with known alleged perpetrators (AP) included in Sample #D.1, 30 (100%) alleged perpetrators were removed from direct contact with individuals immediately following the facility being informed of the allegation when the AP was known. Based on a review of 30 investigation files in which the AP was identified and the facility Abuse and Neglect Employee Reassignment Log, • Thirty (100%) indicated that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation or the conclusion of the investigation allowed their return to direct contact duties, or the employee was not disciplined due to the outcome of the	Substantial compliance

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	the investigation.	case. • In five cases, the employee was returned to a position that allowed contact with individuals under continuous monitoring as outlined in the facility's spurious allegation policy following a preliminary investigation. • Twenty-five employees remained in "no client contact" positions until the investigation was completed. The facility did have a system in place for assuring that alleged perpetrators were not returned to regular duty until notification was made by the facility investigator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Twelve individuals at the facility were on the DFPS chronic caller list, allowing for streamlined investigations. The facility policy titled Spurious Allegations of Abuse/Neglect/Exploitation dated 3/30/11 addressed individuals who made frequent false allegations of abuse and neglect to DFPS. It required that the director would determine if criteria were met to identify individuals as "chronic callers" according to specific criteria included in the policy. For investigations involving individuals on this list, APs were always to be removed from contact with individuals until a preliminary investigation was completed by the facility. Based on the preliminary investigation and criteria listed in the policy, the AP under continuous monitoring could be placed in a position of contact with individuals. • In cases involving individuals on the chronic caller list in the sample reviewed, APs were removed from client contact until at least a preliminary investigation was completed. • During the monitoring visit, an AP placed on continuous monitoring was observed working in one of the homes. He was being directly monitored by another employee in the home and had no engagement with individuals in the home that was not observed by the assigned monitor. A review of the 15 UIRs in sample D.2 was completed to determine if adequate action was taken to protect individuals involved in serious incidents. In 15 out of 15 (100%) indicated that appropriate immediate action was taken to protect the individual following the incident. • Section 10 of the UII is the portion of the UII designated to describe correction action taken immediately following the incident. Examples of appropriate action taken immediately following the incident include: o The report for UII #3734 indicated that a nursing and emotional assessment was completed, level of supervision was increased for the two individuals involved in a sexual incident, and APs were removed	

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		from client contact. o The report for UIR #3983 indicated that the individual was placed on one-to-one supervision and self-harm protocols were implemented, nursing and emotional assessments were completed, and the AP was placed on non client contact upon identification. o Documentation for UIR #4011 indicated that medical intervention was provided and staff deployment following the DFPS report, however, it was found that staff did not immediately implement neurological checks and notify the doctor as required following a fall with a head injury. The individual was later found unresponsive and taken to the emergency room. The report did not include the outcomes of the emergency room visit and any follow-up monitoring that should have been completed as a result. • In all cases where appropriate, a medical assessment was completed immediately to assess for further injury. The facility is in substantial compliance with this provision of the settlement agreement.	
	(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 state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. It further mandated that all supervisors must ensure that required training is appropriately documented by certification and date of completion as directed by the Health and Human Services Commission's Facility Support Services' Competency Training and Development Department. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. The state training compliance report indicated that the facility was in compliance with training requirements. This was not the finding of the monitoring team. Not all training had been completed as required, though there had been an increase in the percentage of adequately trained staff since the last monitoring visit. A review of the training curricula related to abuse and neglect and incident management was reviewed for: (a) new employee orientation and (b) annual refresher training. The results of this review were as follows: Review of 24 staff records (Sample #C.2), showed that; • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months.	Substantial Compliance

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		• 18 (100%) employees with current training completed this training within 12 months of the date of previous training if not hired in the past year. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 3 (17%) of the 18 employees with current training completed this training within 12 months of the date of previous training. Based on interviews with 10 staff: • Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility needs to ensure that all employees receive annual retraining as required by the state policies on abuse and neglect and incident management. According to the Incident Management Coordinator, employees are now required to complete training on unusual incidents annually.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was requested for 24 current employees at the facility and all staff hired within the past two months. • The facility did not provide signed acknowledgement forms for the 24 current employees as requested by the monitoring team. • Seventy-eight of 85 (92%) new staff hired in the past two months had signed a form acknowledging their obligation to report. Forms were not submitted for seven employees listed as newly hired in March 2011. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was asked for a list of staff identified as having failed to report abuse and/or neglect. This generated a list of zero staff, however, as noted below, staff had failed to report abuse and neglect immediately as required by policy. • In investigation #3680, a staff person that was interviewed as a collateral witness stated when the individual described an incident of sexual abuse to her, she brought another staff person in the room and made the individual repeat her story to be sure that she did not change the allegation before reporting the incident to the OD on call. The facility did not address this error in reporting	Noncompliance

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		procedures in the recommendations in the investigation. Staff persons should be trained to report allegations of abuse directly to DFPS. • In investigation #4084, a case involving confirmed physical abuse, the DFPS investigator noted a concern that "a report was not made to DFPS concerning this matter. Evidence revealed several staff were aware of this incident, but did not notify the APS hotline." The facility was not in substantial compliance with this item as evidenced by the above examples.	
	(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.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. In interviewing a sample of eight individuals, all eight (100%) said that they would call the DFPS hotline if someone hurt them or they saw someone being hurt. Three of the individuals pointed out the poster with the #800 on it at the home. There were numerous cases of alleged abuse or neglect reported to DFPS by individuals at the facility since 9/1/10. Based on a review of 10 individuals' PSPs (Sample #D.4), three (30%) indicated the individual, or his or her LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. • The PSPs for Individual #32, Individual #94, and Individual #12 indicated that the state developed resource guide was shared with the individual and their LAR. • The PSPs for Individual #59, Individual #313, Individual #331, Individual #247, Individual #232, Individual #287, and Individual #44 did not include documentation that this information had been shared with the individual or the LAR. QMRPs will need to be reminded to include this information in the new PSP plan development process. The facility was in compliance with this provision during the last monitoring visit. This was not maintained in the new PSP process. Documentation that information on identifying and reporting unusual incidents was shared with the	Noncompliance

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		individual and/or their LAR will need to be maintained by the facility and provided to the monitoring team in order to verify substantial compliance in future reviews.	
	(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.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all but one of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. An assistant independent ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer and ombudsman. The rights officer was well known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. OIG provided the facility with an email notifying the facility of the conclusion to their investigation. Based on a review of 30 allegation investigations completed by DFPS (Sample #D.1), in 28 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 28 (100%). OIG investigated 12 of the 28 cases (49%) referred in the sample. OIG did not find evidence of criminal activity in any of the cases in the sample. The facility investigator reported that the facility had a cooperative working relationship with both OIG and local law enforcement. The facility is in substantial compliance with this item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including	According to SGSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated:	Substantial compliance

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	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.	• SGSSLC policy addressed this mandate. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation. The facility reported that there had been no staff who had alleged that they were retaliated against for in good faith reporting an allegation since the last monitoring visit. The facility was in substantial compliance with this item.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The state developed an audit tool to look at whether or not injuries were reported for investigation. Implementation of this audit process will be reviewed at the next monitoring visit. Sample #D.2 included investigations completed on a sample of injuries. As noted throughout section D, these investigations appeared to be routine for significant injuries. Additionally, a sample of injury reports and supporting documentation was reviewed for the past four months for Individual #186, Individual #365, Individual #382, and Individual #34. Uniform Client Injury Reports were completed routinely on injuries of unknown cause. A sample of investigations for discovered injuries of unknown cause was reviewed for four individuals. Investigations were completed for all four injuries. The investigations were signed off on by the Risk Manager and the Director. A sample of Daily Incident Management Meeting (DIMM) minutes since the last monitoring review were reviewed and indicated that injuries of both known and unknown cause were routinely reviewed by the committees. Observation of both the Daily Unit Meeting and Daily Incident Management Meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow-up recommendations were made when warranted. A small sample of injuries of unknown cause was reviewed for documentation and tracking. The sample included eight injuries for Individual #76 (1/5/11), Individual #294 (1/6/11 and 1/16/11), Individual #316 (2/3/11 and 3/4/11), Individual #346 (2/4/11), Individual #60 (1/8/11) and Individual #385 (2/13/11). • Five of eight (63%) injuries were reviewed during the Daily Unit Meeting and the Daily Incident Management Meeting as evidenced by meeting minutes.	Noncompliance

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		• For two of discovered injuries of unknown cause for Individual #294 on 1/6/11 and 1/16/11 and one discovered injury for Individual #385 on 2/13/11, there was no indication in the unit meeting minutes or the DIMM minutes that either injury had been reviewed by either committee. As evidenced above, injury reports were not being routinely reviewed to ensure reportable injuries had been reported. The facility was not in compliance with this provision.	
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 SGSSLC Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • addressed training requirements for investigators including training in working with people with developmental disabilities; and • and required that investigators be outside of the direct line of supervision of the alleged perpetrator. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on working with people with developmental disabilities. Thirteen DFPS investigators were assigned to complete investigations at SGSSLC. The training records for DFPS investigators were reviewed with the following results: • Thirteen investigators (100%) had completed the requirements for investigations training. • Thirteen DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SGSSLC had 11 designated facility investigators. The training records for facility	Noncompliance

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		investigators were reviewed with the following results: • Nine (82%) facility investigators had completed CIT0100 Comprehensive Investigator Training;. One newly hired investigator had not yet completed this training and had not begun investigating incidents at the facility. • Eleven (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Zero (0%) had completed Root Cause Analysis according to training transcripts reviewed; and • Eleven (100%) had completed the requirements for training regarding individuals with developmental disabilities. The facility was found out of compliance for Root Cause Analysis training based on a review of training transcripts during the last review. Following the issuance of the draft report for the last review, the facility stated that all facility investigators had completed this training. Documentation was still not provided to the monitoring team for verification of Root Cause Analysis training during the May 2011 review. None of the staff designated as investigators had supervisory responsibilities and, therefore, were not in the direct line of supervision of anyone subject to investigation. Investigators need to complete Root Cause Analysis training and training needs to be documented in training transcripts. The facility remained out of compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Review of the investigation files in Sample #D.1 showed that in 30 out of 30 investigations (100%), facility staff cooperated with DFPS investigators. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. OIG was routinely informed of investigations and provided with information as requested. Jalown McCleery, Incident Management Coordinator, reported that the facility had a cooperative relationship with both DFPS and OIG. Interagency meetings with SGSSLC, OIG, and DFPS were being held quarterly. Both OIG and DFPS had designated offices at the facility. Clerical staff were assigned to outside investigators to ensure request for documentation and other information needed to complete investigations were readily available. The facility is in substantial compliance with this item.	Substantial Compliance
	(c) Ensure that investigations are	The Memorandum of Understanding, dated 5/28/10, provided for interagency	Substantial

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	coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 30 the investigation completed by DFPS (Sample #D.1), 28 had been referred to law enforcement agencies. OIG completed investigations in 14 of the cases referred. For 14 out of these 14 (100%), it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • OIG found evidence of criminal activity in 0 of the 14 cases investigated. • There was no indication that the facility had interfered with any of the investigations by OIG. The facility was found to be in substantial compliance with this provision.	Compliance
	(d) Provide for the safeguarding of evidence.	The SGSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video monitoring footage was provided to DFPS as requested and reviewed by facility investigators and photographs were taken of injuries as necessary. The facility was in substantial compliance with this item.	Substantial compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within	The facility Incident Management policy mandated investigations of serious incidents: • were to commence begin immediately for all unusual incidents; • were to be completed within five working days of the incident; • did require a written extension request from the facility director or Adult Protective Services Supervisor to be completed outside of the 10-day period;	Substantial Compliance

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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.	and • Were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • 30 out of 30 (100%) commenced within 24 hours or sooner. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. • 27 of 30 (90%) were completed within 10 calendar days of the incident. o The investigations for UIR #3678 and UIR #3680 were completed in 19 days. Both allegations occurred on the same day. DFPS filed extensions in both cases because large portions of video surveillance were requested by the facility. The facility needed extra time to process the video. o The investigation for UIR #3928 was completed in 18 days. An extension was filed on the tenth day to allow investigators to complete additional investigative activities. • All 30 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In five (17%) of the 30 investigations reviewed, concerns or recommendations for corrective action were included. The following are examples of investigations that included appropriate recommendations and/or concerns noted: o For UIR #3966, the investigator documented concerns regarding documentation of supervision checks verifying the correct LOS was maintained. o For UIR #4027, the investigator recommended retraining of staff on appropriate interactions after viewing video footage of staff interactions. o For UIR #3964, the investigator noted several concerns regarding lack	

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		of appropriate documentation, which resulted in an inconclusive finding in a case of physical abuse. The investigator also referred concerns regarding care for individuals back to the facility for administrative review. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2 and #D.3: • Fifteen out of 15 (100%) of the UIRs reviewed indicated that the investigation commenced within 24 hours of the incident. • Thirteen of 15 (87%) indicated that the investigator completed in report within 10 days of notification of the incident or following referral back to the facility by DFPS. o UIR #3927 and UIR #3929 both indicated that the report was completed 14 days from the initial report to DFPS. DFPS completed its report in three days and referred the case back to the facility. There was no evidence that an extension had been submitted to the IMC or director. • Fifteen (100%) of the investigations completed in the sample indicated that the facility director and incident management coordinator had reviewed the report upon completion. Three (20%) of the reports did not indicate that this review was completed in a timely manner. The exceptions were UIR #3922 (reviewed 21 days after the incident), UIR #3927 (reviewed 16 days after the incident), and UIR #3929 (reviewed 16 days after the incident). • All 15 (100%) investigations resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In 15 investigations reviewed, recommendations for corrective action were included in 11 of the investigations (73%). Examples of documentation that appropriate recommendations were made included: o UIR #3776 was completed for an unauthorized departure. Appropriate recommendations in the UIR included retraining staff, reminding maintenance staff to keep a gate lock, updating the individual's BSP and a review of the individual's level of supervision. o UIR #4055 included recommendations to refer the individual to the Psychology Internal Peer Review Committee and staff retraining on her token plan. The facility was in substantial compliance with this provision. The facility had a system	

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		in place to ensure investigations would commence quickly and could be completed in a timely manner.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Based on a review of SGSSLC Incident Management Policy, it did require that a UIR be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations for sample #D.1: • In 29 out of 30 (97%) investigations reviewed, the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o In investigation #3684, DFPS originally substantiated neglect against the AP because the AP was not following the individuals PNMP resulting in a serious injury to the individual. The facility requested a methodological review following the final report. DFPS changed their finding to inconclusive based on the fact that the AP was not trained on the individual's PNMP. There is no clear connection between this additional information and the resulting inconclusive finding. If in fact the AP was not trained on the PNMP, the facility was neglectful in not providing the training. • The report utilized a standardized format that set forth explicitly and separately, the following: o In 30 (100%), each serious incident or allegations of wrongdoing; o In 0 (0%), the name(s) of all witnesses; ▪ There was no list of witnesses documented in any of the reports. Names of witnesses interviewed in the investigation were included, but it was not known if this included all witnesses in each case. DFPS reported that only the names of witnesses interviewed were included. The monitoring teams will need to discuss this particular item and the criterion for scoring. o In 30 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 30 (100%), the names of all persons interviewed during the investigation;	Noncompliance

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		o In 30 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 30 (100%), all documents reviewed during the investigation; o In 0 (0%), 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 DFPS investigative reports did not include a list of previous investigations considered as evidence, although in many cases reviewed involved victims and perpetrators that had been named in other similar cases. This is a repeat finding from the last monitoring visit. o In 30 (100%), the investigator's findings; and o In 30 (100%), the investigator's reasons for his/her conclusions. According to DADS, DFPS was preparing to implement policy and procedure that will instruct investigators to document the results of the prior case history review in the investigative report whether it was used or not. Currently, this information was stored in the IMPACT case management system, but did not translate to the written report. DFPS reported that it was making arrangements to modify the IMPACT case management system to include information about prior case history in the printed report that is mailed to the facility. This change was scheduled to occur May 2011. <u>Facility Investigations</u> The following summarizes the results of the review of nine facility investigations included in sample #D.2 • The report utilized a standardized format that set forth explicitly and separately, the following: o In nine (100%), each serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators when known; o In nine (100%), the names of all persons interviewed during the investigation; o In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In nine (100%), all documents reviewed during the investigation; o In nine (100%), all sources of evidence considered, including previous	

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		investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. Facility investigations included historical information on previous incidents that might be relevant to the investigation including o In nine (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions. DFPS investigations did not include the allegation history relevant to the current case for the victim or perpetrator. According to information provided by DFPS, beginning in May 2011 this information will be added to all DFPS investigative reports. Facility investigations were consistently formatted and well organized. The facility was still not in compliance with this provision, but it is expected that the change in DFPS procedure will bring the facility into substantial compliance at the next review.	
	(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.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 17 DFPS investigations included in Sample #D.1: • There was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission in 100% of the files reviewed. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC), Director of Facility, and reviewed by the Incident Management Committee. Thirty (100%) DFPS investigations were reviewed for by the facility director, and IMC following completion. o Fifteen (50%) were reviewed by the Facility Director and Incident Management Coordinator within five days of completion. The following cases were not reviewed within 5 days by either the IMC or Facility Director: UIR #3903 (21 days), #3906 (13 days), #3930 (27 days), #3926 (6 days), #3935 (6 days), #3945 (30 days), #3960 (20 days), #3966 (10 days), #3964 (15 days), #3986 (12 days), #3972 (8 days), #3976 (27 days), #3979 (12 days), #3987 (9 days), and #4004 (13 days). • DFPS noted concerns or made recommendations in five (17%) of the cases in sample #D.1. The facility documented follow-up to recommendations made by	Noncompliance

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		DFPS in all five cases. It was not evident that concerns were always adequately addressed by the investigator. For example: o The DFPS investigator noted a concern over the number of unfounded allegations reported by the individual involved in UIR #3948. There was no concern noted regarding staffing shortages. Witnesses indicated that the individual was upset because she could not take a scheduled walk due to staff shortages. The following are examples of where deficiencies or areas of further inquiry were not adequately addressed. o For UIR #4004, the investigator confirmed allegations of neglect due inadequate staffing levels in the home. The facility addressed the concern by noting that the shift coordinator "had no other choice as he could not get any other staff to come in." A plan for addressing critical staff shortages in the future was not developed. o In UIR #3966, the DFPS investigator noted concern that required 15 minute checks were not completed. An email was sent to staff regarding the need for retraining the AP. Evidence of completed training was not documented in the investigation file. o For UIR #3964, the DFPS investigator noted several concerns regarding documentation. The case resulted in an inconclusive finding of physical abuse because documentation was not available to confirm or disprove information in the allegation. Recommendations were made to retrain three staff members involved in the incident in documenting procedures. There was evidence that two of the staff members had been retrained, but no documentation of retraining for the third staff member. Cases where deficiencies are areas of further inquiry was adequately addressed the following cases: o For UIR #3948, the DFPS investigator noted a concern in regards to the significant number of unfounded allegations called in by the individual. The facility UIR indicated that the facility reviewed her allegation history and the number of unfounded allegations had significantly decreased in the past six months. Therefore, it was felt that he BSP was adequate to address this behavior. o For UIR #4027, the DFPS investigator recommended that the AP be retrained in appropriate conduct after reviewing a display of inappropriate conduct with individuals in the home. The recommendation was addressed in documentation included in the investigation file.	

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		Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In 15 out of 15 (100%) UIRs from sample #D.2 and #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. In all cases, this review occurred within five days of the completion of the investigation. • Recommendations for follow-up were made in 10 of the 15 investigations completed by the facility. As evidenced above, injury reports are not being routinely reviewed to ensure reportable injuries have been reported.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A UIR was completed for each unusual incident in the sample.	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.	In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1, Sample #D.2, and #D.3 was selected for review. This subsample, Sample #D.4, included the following investigations: UIR#3734, UIR #3903, UIR #3927, UIR #4055, UIR #3701, UIR #3864, UIR #3928, and UIR #3945. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review: • All (100%) of the investigations in the sample included documentation of disciplinary action for confirmed allegations. Other investigations in the sample included retraining of staff when warranted. For example, the following disciplinary actions had been taken and documented: o For UIR #3903, documentation indicated that disciplinary action was taken in regards to a confirmed allegation of physical abuse. The investigation concluded on 2/17/11. The employee was dismissed on 3/8/11. o For UIR #3945, an allegation of physical abuse was confirmed. DFPS completed their investigation on 3/4/11. Documentation indicated that the perpetrator was released from NCC on that same day. On 3/9/11	Noncompliance

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		the IMC reviewed the case and recommended termination. On 4/4/11 a letter addressed to the AP indicated that she would be suspended for seven days. It is not clear whether or not the employee returned to work following her release from NCC prior to her suspension. o UIR #3734 was an investigation of a sexual incident that occurred when the hall monitor was distracted while reading the newspaper. Recommendations included retraining staff on hall monitoring duties and developing a system to document assignment of hall monitors. A memo was addressed to all staff on the home reminding them of what their duties entail when monitoring the hall. It further notes that any further instances of failure to follow procedures would result in corrective action. There was no documentation indicating that staff received or read the memo. There was also no documentation regarding the recommendation to document hall monitor shifts. o UIR #3927 included a recommendation for the Unit Director to review the AP's suitability for working at her current position. The investigation file included documentation of the AP's resignation following the outcome of the case. • Examples found where recommendations were made for programmatic action, but follow-up was not documented in the investigation file include: o Information from UIR #3903 indicated that one staff person was left in the home responsible for five individuals, two on one side of a locked hallway and three on the other side. The ombudsman made several other recommendations in the case regarding appropriate staffing ratios in the homes. There was no evidence that the ombudsman's concerns were addressed or follow-up was completed. ▪ For UIR #3734, the investigator recommended changes in the level of supervision for the two individuals involved in a sexual incident. The investigation file included a revised level of supervision training guide for each of the individuals. ▪ UIR #4055 included recommendations regarding referral to the Psychology Internal Peer Review Team. There was no documentation included in the investigation file to confirm that this recommendation had been followed up on. ▪ The UIR for case #3701 documented actions taken in response to a serious injury sustained in an incident of peer to peer aggression. All three women involved were moved to other homes and placed on home restriction. There was no indication when the home restriction would be removed or if the PST had	

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		met to review the incident and implement other behavioral strategies to prevent repeat incidents. • Examples where follow-up action was completed and documented in the sample reviewed included: o For UIR #3734, the investigator recommended changes in the level of supervision for the two individuals involved in a sexual incident. The investigation file included a revised level of supervision training guide for each of the individuals. o The DFPS investigator did not make any recommendations or note concerns for UIR #3928. The facility investigator recommended a visit with the psychologist for the two individuals involved in peer to peer aggression. There was documentation in the investigation file that the psychologist did meet with the individuals. o UIR #3684 was an investigation of a serious injury which occurred as a result of staff not following the individual's PNMP. Staff were retrained on the plan and documentation was included in the investigation file. The facility needs to ensure that follow-up action is taken and documented when appropriate. It was evident that the facility had attempted to follow-up on recommendations in investigative reports by sending those recommendations out to appropriate team members via email. A system will need to be developed to track outstanding recommendations and ensure documentation of follow-up action is included in the investigation file. The facility was 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.	At the facility, investigation files were maintained in the investigator's office. Files requested during the monitoring visit were readily available for review at the time of request. All facility investigations in the review included information about past allegations for both the individual involved and the alleged perpetrators. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	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	The facility had a system in place to track data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • Type of incident, • Staff involved in the incident, • Individuals directly involved,	Substantial Compliance

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	unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	• Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The facility compiled quarterly reports that focused on all unusual incidents, all allegations of abuse and neglect, and all injuries. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress. The facility was 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.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility director had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. According to Sarah Roder, Management Specialist at the facility, all SGSSLC employees were required to complete HR0202 Notice of Criminal Offense Self Report Requirement for Employees when hired. These forms were forwarded to the Records Management	Substantial Compliance

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		Division at HHS Human Resources Office. The facility did not keep a copy of the form at the facility. The monitoring team requested any documentation of instances where employees self reported criminal activity for a sample of 24 employees. Information received from the facility indicated that 15 of the 24 employees (63%) had self reported criminal activity. According to information provided to the monitoring team, • No employees had been terminated since the last monitoring visit based on background checks. • For FYI 11, criminal background checks were submitted for 214 applicants, • Four had employees had been terminated as a result of fingerprint or name-based failures. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self report criminal activity forms. The facility provided examples of where employees had submitted a form reporting criminal activity. The facility was in compliance with this provision of the Settlement Agreement.	

Recommendations:

1. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.

2. The facility needs to ensure notification is made to all parties required within required timeframes in regards to investigations and documented in the UII.

3. Ensure DFPS 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.

4. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs.

5. The facility needs to ensure that all serious injuries are investigated and reviewed by the facility.

6. The facility needs to ensure that completed DFPS investigations are reviewed by the IMC and Facility Director in a timely manner and concerns raised during investigations are adequately documented and promptly addressed.

7. The facility needs to ensure that follow-up action is taken and documented when appropriate. A system will need to be developed to track outstanding recommendations and ensure documentation of follow-up action is included in the investigation file.

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

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o DADS Draft revised policy on Quality Enhancement, undated o SGSSLC Organizational chart, undated o SGSSLC policy lists, 4/8/11 o List of typical meetings that occurred at SGSSLC o SGSSLC POI, 5/9/11 o SGSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 5/23/11 o SGSSLC DADS regulatory review reports o Documents related to recent federal CMS survey, 4/29/11 o SGSSLC policy procedure "Quality Assurance Process," dated 4/14/11, by Angela Kissko, QAD o SGSSLC policy procedure "Quality Improvement Council," dated 10/6/10, by Penny Bivens, SAC o QA Plan table, 4/18/11 o Variety of documents, emails, spreadsheets and notes showing activity around the development of the QA plan and matrix from 11/15/10 through 4/18/11 o Set of blank forms used by the QA department staff at SGSSLC for the following topics: unusual incidents, abuse neglect, mealtimes, the active record, the environment, individual to individual aggression, PSP meetings, and a variety of engagement and programming topics in a six page tool called Individual Support Observation and Interview o Set of completed monitoring tools done by the QA department o Set of completed self-monitoring tools done by the service departments o SGSSLC trend analysis report: only one of the typical four data sets was submitted (injuries) o SGSSLC QA report, 2/11, 3/11, 4/11 o QI Council meeting minutes since 12/10 (10 meetings) o List of Performance Improvement Teams, their purpose, and why/how they were initiated o Monthly status summaries for each PIT, 12/10 through 3/11 o Various minutes, action plans, and other documents for each of the PITs o DADS SGSSLC family satisfaction survey online summary, 15 respondents o SGSSLC Enlightener facility staff newsletter, three most recent issues, through 6/11 o Self-advocacy meeting minutes and notes, 12/10, 2/11, 4/11, 5/11 Interviews and Meetings Held: o Angela Kissko, Director of Quality Assurance o Dr. Philip Baugh, Facility Director o Penny Bivens, Settlement Agreement Coordinator o Michelle Martin, DADS Central Office Quality Assurance Coordinator

	o David Daniel, Program Compliance Coordinator o Linda Lothringer, Director DADS Settlement Agreement Compliance Unit o Roy Smith, Human Rights Officer, and Melissa Deere, Assistant Independent Ombudsman o Natalie Montalvo, Residential Director o Unit Directors: Melinda Gentry, Cedric Woodruff, Vicki Hinojos <u>Observations Conducted</u>: o QI Council Meeting, 5/23/11 o QI Council data review meeting, 5/25/11 o Self-advocacy meeting, 5/24/11 o Many residences, day program, and vocational program
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI had been extensively revised since the last monitoring review. The facility rated itself as being in noncompliance with all five items of this provision. The monitoring team concurred with the facility's self-ratings for all of these provision items. The monitoring team learned that an even newer, updated and improved POI format had been recently created. Its goal is to more adequately describe actions taken and actions planned, directly in line with each provision item. This sounds like it will be a good improvement. As the QA director completes her section of this new POI, the monitoring team recommends that the information provided in this section of the report be used. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the QA director to use this report to guide her in setting forth a set of actions to work towards achieving substantial compliance with this provision. The QA director appeared to take the previous monitoring report as a guide for her activities. The narrative portions of the POI provided a lot of detail regarding the many QA-related activities that the facility, its management, its QA director, and its QA department engaged in since the time of the previous onsite review. For example, training had been provided to the QI Council and a SGSSLC QA policy was developed, a monitoring matrix was developed, statewide self-monitoring tools were being used, a special QI Council meeting was initiated to review the master data list, and discipline section leads were asked to identify information they recommended be reviewed by QI Council. The POI noted that the QI Council formed a number of PITs, and that the QA director had begun a regular QA report. The POI also indicated that a system for corrective action plans was still to be developed. In addition, the presentation book prepared by the facility for this section of the Settlement Agreement was reviewed. Although not a requirement of the Settlement Agreement or the monitoring team, the facility's intention was for the presentation books to be an easy way for the monitoring team to learn about progress and activities of the department in relation to this provision. The presentation book contained a lot of information that was useful to the monitoring team.

	The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. SGSSLC should update its POI based upon the information presented by the monitoring team during the onsite review, at the exit conference, and in this report.
	Summary of Monitor's Assessment: SGSSLC demonstrated continued progress regarding the items in this provision. Since the last onsite review, the facility had taken numerous steps, including responding to the many recommendations made in the previous monitoring report. For example, the QA director, with the support of the facility director, had written a facility-specific policy on QA, made progress on developing a listing of all data collected at the facility, and created a number of evolving drafts of a QA table/matrix that detailed the types of data to be managed by the QA department. In addition, the QI Council was meeting regularly and had formed a secondary meeting to focus more specifically on data at the facility. The QI Council had set up eight performance improvement teams in a variety of important areas based on previous monitoring reports, external reviews, the facility's own internal monitoring, and discussions at QI Council meetings. A QA report was completed for the previous three months. The monitoring team and the QA director talked at length about ways to ensure the report is relevant, useful, and manageable. It represented a very good first attempt at doing so. QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, conducted a variety of audits. The QA director worked collaboratively with the facility's Settlement Agreement Coordinator. This state policy was being revised. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding a number of areas, such as the format and content of the QA plan and QA report, and the use of PITs. During the week of the onsite review, the monitoring team had the opportunity to meet with the DADS central office quality assurance coordinator to discuss revisions to the DADS state policy for QA. Family satisfaction measures were recently initiated. Data results needed to be reviewed and incorporated into the QA program. Satisfaction measures for staff, individuals, and from the community still needed to be implemented. The self-advocacy group continued to meet regularly and had progressed in its incorporation of problem solving, decision making, and individual involvement. Home meetings were occurring each week and presented other opportunities for individual participation in advocacy, education, and decision making. The facility had used a set of self-monitoring tools that were designed to be used at all of the SSLCs. The

	monitoring team, however, recommends that the facility and state work to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. A system for the management of corrective actions as per provisions E2, E3, E4, and E5 was not yet in place.

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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.	SGSSLC made continued progress towards achieving substantial compliance. The QA director, with support from the facility director, oversaw the continued improvement in the key areas of this provision: QA policy, QA plan, QA data collection, QI Council, and the management of corrective actions. <u>Policies and QA Planning</u> The DADS statewide policy #003: Quality Enhancement, dated 11/13/09, was adopted by the facility. This state policy, however, was being extensively revised and was likely to be disseminated some time in the next few months. The facility will likely benefit from receiving additional direction via this new policy. The monitoring team hopes that the new statewide policy will provide specific direction to all of the SSLCs so that there is consistency in expectation regarding: • Facility-specific policies • Format and contents of the QA plan o Minimum required types of data • Utilization of statewide self-monitoring tools • Facility-specific self-monitoring tools • Formation and utilization of PETs • QAQI Council responsibilities • QA reports • Corrective Action Plans During the week of this onsite review, the monitoring team was fortunate to have the opportunity to meet with the DADS central office quality assurance coordinator. The primary reason for this meeting was to discuss the draft of the proposed revised QA policy. The monitoring teams had done an initial review of the policy and this meeting was used to provide some of this feedback and for the monitoring team to present a number of suggestions to the coordinator. This meeting allowed for more discussion and questions than would have occurred if the feedback was provided in only a written format or via emails. The monitoring team greatly appreciated this discussion and looks forward to the completion of policy and procedures for this important provision. Also sitting in on this discussion were the DADS Director of the Settlement Agreement Compliance Unit, the facility's assigned Program Compliance Coordinator, and two	Noncompliance

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		SGSSLC managers who were currently in a leadership development program called "Building the Bench." SGSSLC had two relevant policies and procedures: Quality Assurance Process, dated 4/14/11, and Quality Improvement Council, dated 10/6/10. The QA Process policy and procedure appeared to be based on the proposed draft of a revised state policy that was described in the paragraph directly above. Since this draft policy is going to be extensively changed, SGSSLC will need to update (perhaps totally change) its facility-specific policy again at that time. The QI Council policy and procedure, however, appeared to remain relevant. Overall, the SGSSLC QA department had made progress on these tasks: • Create a listing of all data collected at the facility that includes the following (also, a number of suggested types of data were detailed in the previous monitoring report and, therefore, are not repeated here): o Data collected by each discipline service department; this includes two categories of data: ▪ Data the discipline service department uses for its own service and operational purposes ▪ Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the facility service department (if any) o Data collected by the QA department staff: ▪ Data they collect themselves ▪ Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring o Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, and the FSPI. Status: SGSSLC had made good progress on creating this listing and was continuing to work on completing it. More work (and time) was needed to do so and to incorporate all of the types of data listed above. • Determine which of these data are to be submitted to the QA department for tracking and trending. Status: The QA department had made progress on this activity by developing the detailed table/matrix of measures and tools.	

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		• Determine which of these data are to be o Included in the QA report. o Presented regularly to the QI Council. QI Council should make this determination, that is, it should not be a decision made by the service department head, though their suggestions might be welcomed by the QI Council. Status: The QA report was new and although much work was needed, it was a good start. The QI Council was reviewing some data, discussing the data, and making recommendations. The new state policy will likely provide guidance in this area. • Create and manage corrective actions based upon the data collected and direction from the QAQI Council. Status: The QI Council was forming PITs (see below) and moving forward on this activity, however, a system of managing corrective actions (of which the formation of a PIT might be one) was not yet in place. QA Department Angela Kissko remained as QA director. The other members of the QA department had also not changed since the previous onsite review. Overall, the monitoring team found the QA staff to be competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. Penny Bivens, the Settlement Agreement Coordinator, played a lead role in the collection and organization of data and documents at SGSSLC so that the monitoring team could conduct its review. Ms. Bivens was extremely responsive to the monitoring team's requests and she worked tirelessly during the weeks before, during, and following the onsite review. She was competent, well organized, and professional. The SAC and the QA director appeared to have a good working relationship. This was important because these two departments needed to work together if the facility is to achieve substantial compliance across all provisions of the Settlement Agreement. Quality Assurance Plan The QA director oversaw a great deal of activity since the last onsite review towards the development of a QA plan. She completed and submitted a QA plan that was in table format, was nine pages long, was dated 4/18/11, and showed the responsible staff, the tool to be used, the sample size and frequency, and staff responsible for inter-rater reliability for each of the provisions of the Settlement Agreement as well as 18 other areas. These 18 other areas were determined by the QI Council. A variety of documents, emails, spreadsheets and notes demonstrated some of the activity that occurred at the facility around the development of the QA plan and matrix from 11/15/10 through	

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		4/18/11. For example, the current QA plan appeared to have evolved from a combination of a previous chart called "Data Elements," the state's standardized trend analysis of four types of data (e.g., restraint usage), and the topics/data requested in the monitoring team's document request for each onsite monitoring review. Thus, it was a long and comprehensive list developing in the direction describe above (i.e., create a listing of all data collected at the facility, have QI Council choose which data to review, create a QA report, manage corrective actions, and so forth). The new state policy will provide guidance to the facility regarding the content of a QA plan. A QA plan will be a description of the overall QA program at the facility. Therefore, the table/matrix that was created will be a piece of this broader QA plan. The table/matrix should include all of the items that will be managed/reviewed by the QA department. It will include all of the data and activities conducted by the QA department as well as the facility's service and operational department self-monitoring data and other relevant data. The data that are managed/reviewed by the QA department (i.e., what is listed in the table/matrix) should be incorporated into the QA report and presented to the QI Council. <u>QA Activities and Indicators</u> The activities of the QA staff were primarily • Collection of data/audits (same data and measures as at the time of the previous onsite review) • Completion of service department self-monitoring tools for the purpose of assessing interobserver agreement • Participation on various committees and attendance at various meetings The QA director reported that the same measures were being used by the QA department as were being used during the previous onsite review. Therefore, the full listing and description will not be repeated here. The QA department submitted documentation of: • Results of QA department audits of individual records and staff interviews related to activities to reduce and address abuse/neglect, unusual incidents, and level of supervision; along with needed follow-up and whether the follow-up occurred; 11/10 through 3/11. • Results of QA department audits of content and quality of individual records; one to two per month; along with needed follow-up and whether the follow-up occurred; 11/10 through 3/11.	

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		• Results of QA department implementation of its own Individual Support Observation and Interview tool; one per month; 11/10 through 3/11. • Results of QA department active treatment observations before and after meals (this may be a new observation tool); two to three observations per month; 3/11 through 4/11. • Variety of other data received from other departments, such as mock medical drills, FSPI, administrator environmental inspections, fire drills, and weather drills. These indicated that the QA staff were quite busy. All of these items were included in the QA plan table. As noted above, how they were to be summarized and reported (both in a QA report and to the QI Council) still needed to be determined. The QA department, and the service departments throughout the facility, were using a set of self-monitoring tools that corresponded to many of the provisions of the Settlement Agreement. Each tool consisted of a set of checklist-type items and had an attached set of instructions for completing each item of the tool. These tools were designed to be used at all of the SSLCs, were generated by DADS central office, and were based upon a set of tools originally used by the monitoring teams and developed in 2009. It was good to see that tools had been standardized for use by all the SSLCs and that they were based on the monitoring team's original tools. The monitoring team, however, recommends that the facility and state work to review and update the state-created tools so that they are based upon the most recent findings and activities of the monitoring teams. Further, the quality of the self-assessment tools would likely be improved if DADS obtained feedback and suggestions from QA staff at all of the SSLCs. The facility staff were taking their responsibility to implement these tools very seriously. This was good to see because the system of self-monitoring that includes inter-rater reliability checks, review of the self-monitoring findings by QIC, and review of the self-monitoring results by DADS central office will help the facility achieve substantial compliance across all of the provisions of the Settlement Agreement and contribute to the ongoing maintenance of appropriate and quality supports and services to individuals. The facility submitted completed self-monitoring tools for the many provision items for which tools existed (almost all) for January 2011, February 2011, and March 2011. This was a lot of information demonstrating the facility's extensive activity towards quality improvement. For some of these, inter-rater reliability was assessed. The facility should compare the findings of the self-raters to the findings in the monitoring report. In this way, the content of the self-monitoring tools might be modified and/or the criterion used by the self-raters might be made more in line with the monitoring report. The QA	

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		director and the QI Council should, at this point, be suspect of overly high ratings. In the baseline report and in the last monitoring review report, the monitoring team recommended that a variety of satisfaction measures be obtained, summarized, and included as part of the QA system at SGSSLC. One suggested target was staff satisfaction. The facility had not addressed this yet. Another suggested target was family satisfaction. SGSSLC families and LARs had the opportunity to participate in the new statewide online (or paper) questionnaire. Over the past four months, 15 families had completed the survey. The facility did not yet appear to be doing anything with this information. A third suggested target area was satisfaction of individuals. This was not being done in any type of standardized or formal manner, however, the facility's self-advocacy group and home meetings (every home had a weekly meeting) were active and making progress. In particular, the self-advocacy group's facilitators (primarily the human rights officer and the residential director) moved to a more problem solving focus. That is, rather than finding out about individual dissatisfaction and then fixing it, the facilitators were supporting the individuals to come up with solutions to the problems they raised and to develop and implement actions to do so. Out of this, for example, came the new set of activities for days, evenings, and weekends. The monitoring team had some suggestions for the self-advocacy group: (a) create an agenda that pre determines what topics will be discussed so that individuals can prepare, and (b) consider breaking up into small groups of about four individuals to do some of the work and discussion that is too difficult to do with the large group. Perhaps information from the self-advocacy group and the weekly home meetings can somehow be summarized in a way that can be part of the QA table/matrix and possibly QA report and QI Council review. A fourth suggested target was others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. This had not been addressed yet.	
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	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. SGSSLC made continued progress in this area. <u>QA Data Management and Analysis</u> SGSSLC not only focused on improving their QA data systems, but also began implementing processes to address this provision item. As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the table/matrix). These data will need to be	Noncompliance

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	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.	summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Not all of these graphs need to be created by the QA department. It is possible that the facility sets an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QI Council. The statewide trend analysis document deserves special mention. For the past few years, every SSLC created an almost identical monthly report on four sets of data: restraint usage, abuse and neglect allegations, injuries, and unusual incidents. These are important topics and the report provided a lot of valuable information. Each facility now had data for three or so years. The document, however, was cumbersome and lengthy. The QA director will need to take the most important parts of this trend analysis document and incorporate them into the facility's QA program (e.g., table/grid, QA report, report to QI Council) rather than including the entire trend analysis document within the QA report. <u>QA Report</u> The monitoring team was pleased to see that a QA report was initiated since the last onsite review. The first two reports were, as would be expected, were rough first attempts. The April 2011 report showed improvement in data presentation and organization. Each report should include the current month's self-monitoring detail (i.e., results on each of the provision items) as well as a second graph showing month to month overall self-monitoring results (i.e., a single data point for the month). Other data, as per the QA table/matrix, the QI Council's preferences, and any other data deemed noteworthy by the QA director should be included. Clinicians, physicians, and others should not be identified by name in the QA report. As the QA report develops, it may become apparent that a monthly report is not necessary and that the needs of the QA department, QI Council, and facility can be met with a bi-monthly or perhaps quarterly QA report. If so, data should still be reviewed, trended, and graphed each month. <u>QI Council</u> The QI Council met regularly and was another improvement since the last onsite review.	

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		The QI Council appeared to take their responsibility seriously. To that end, they formed a second meeting so that they could have a more in depth review of data. This was an excellent way to proceed, especially during these early stages of the development of the QA program, and the QI Council. The facility's plan was for each QI Council meeting to have a standard agenda of regular topics (e.g., status of regulatory deficiencies) and a rotating agenda of a set of Settlement Agreement provisions. The rationale was to allow for a more meaningful discussion of a smaller set of provisions and their related data. This appeared to the monitoring team to be a reasonable way to proceed (though it was not yet being implemented). <u>Performance Improvement Teams</u> The SGSSLC QI Council, as designed, formed Performance Improvement Teams (PIT) to focus on areas where corrective actions were needed. PITs had become a well-known and typical part of facility operations at SGSSLC. At the time of the onsite review, there were eight PITs in operation. They are listed below. Of these eight, four were formed as a result of previous monitoring reviews, one was formed in response to the new mock ICFMR survey process, and three were formed in response to the facility's own internal monitoring and/or discussion at QI Council meetings. The eight are: • Physical and nutritional management during mealtimes • Restraint reduction • Medication variance/errors • Active treatment • Spurious allegations • Mock ICFMR survey • EMPACT (staff recognition) • Pain management Each of these PITs met regularly, kept minutes, created actions, implemented actions, and evaluated the outcome. Each PIT gave an update report at each QI Council meeting. The QI Council was charged with reviewing each PIT and, if its goals were met, ending its actions. This had not yet occurred for any of these PITs. Further, the monitoring team recommends that the QI Council have input into the activities of each PIT rather than solely appointing the PIT. <u>Corrective Actions</u> The formation and actions of the PITs were one type of corrective action. The facility had not yet implemented an overall plan to address the management of all corrective actions as required by provision items E2, E3, E4, and E5 was not being done as required. This	

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		was also acknowledged in the facility's POI. The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements of this provision item. These considerations could be included in SGSSLC's facility-specific policies regarding QA and the QI Council. • How to determine whether or not corrective action is required (e.g., based on scoring of a monitoring tool, based on a level of data submitted, based on discussion at QI Council). • If there is a determination that corrective action is required, describe what that action will be. A formal Corrective Action Plan (CAP) is one possibility, but there are other types of corrective actions that might be more appropriate (e.g., development of a new policy, decision by facility director). • Create a method for tracking all corrective actions, not only corrective actions that require a CAP. • A corrective action, whether it be a CAP or not, may involve the formation of a Performance Improvement Team (PIT). A PIT, once formed, might also delegate certain activities to a Performance Evaluation Team (PET). As noted above, SGSSLC was doing a great job with PITs. • Specify how the facility's practices for implementing corrective actions will meet the requirements of the items of this provision, that is: o E2: 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 o E3: disseminate corrective action plans o E4: monitor and document implementation and outcomes of the corrective action o E5: modify corrective actions when needed.	
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	SGSSLC was not in compliance with this provision item.	Noncompliance

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	necessary, to ensure their effectiveness.	See comments above in section E2.	

Recommendations:

1. Implement new DADS policy once it is disseminated.
2. Revise and implement facility-specific policies based upon the new DADS policy, once it is disseminated.
3. Complete the task of listing all types of data that are collected at the facility.
4. Finalize the set of data to be managed/reviewed by the QA department (i.e., the QA table/matrix).
5. Write a QA plan. State policy should help guide the format and content. The table/matrix that was created should be part of the QA plan. In addition, it should include a narrative description of the overall QA program at the facility.
6. Update all statewide self-monitoring tools content and criteria
    a. look closely at consistently high scoring of self-monitoring to ensure it is being done accurately, reliably, and without unintentional bias.
7. Conduct satisfaction assessments of staff, individuals, and related community agencies.
8. Summarize satisfaction data and include it in the QA program.
9. QA director should regularly review and ensure summarization of all data from the QA table/matrix.
10. Develop a finalized version of the QA report; do not include the names of specific clinicians or staff in the report.
11. QI Council should have input into the activities of each PIT.
12. Develop a comprehensive system to generate, implement, manage, and track corrective actions, as per E2 through E5, and as described above.

The following are offered as additional suggestions to the facility:

13. For the self-advocacy group, consider creating and disseminating an agenda prior to the meeting, and consider breaking up into small work groups during the meeting, when appropriate to do so.

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>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum o SGSSLC List of PSP development dates and admission dates o SGSSLC Plan of Improvement o SGSSLC Draft QMRP Monthly Oversight Form o PSP Quarterly Review Form #6630 Revised May 2011 o Draft PSP for Individual #302 with QMRP Coordinator comments and corrections o The following documents for a sample of individuals: • Individual #232 – PSP dated 3/1/11, Assessments, SPOs, Quarterly Reviews • Individual #186 – PSP dated 7/27/10, Assessments, SPOs, Quarterly Reviews • Individual #295 – PSP dated 4/6/11, Assessments, SPOs, Quarterly Reviews • Individual #34 – PSP dated 4/22/10, Assessments, SPOs, Quarterly Reviews • Individual #327 – PSP dated 11/17/10, Assessments, SPOs, Quarterly Reviews o PSP, PSP Addendums, Assessments, SAPs for the following Individuals • Individual #365 – PSP dated 4/13/11 • Individual #389– PSP dated 2/10/11 • Individual #236 – PSP dated 1/12/11 • Individual #90 – PSP dated 2/23/11 • Individual #313 – PSP dated 2/23/11 • Individual #59 – PSP dated 2/23/11 • Individual #12 – PSP dated 3/3/11 • Individual #126 – PSP dated 3/3/11 • Individual #247 – PSP dated 3/3/11 • Individual #287 – PSP dated 3/4/11 • Individual #367 – PSP dated 3/9/11 • Individual #151 – PSP dated 3/9/11 • Individual #44 – PSP dated 3/15/11 • Individual #94 – PSP dated 3/17/11 <u>Observations Conducted:</u> o Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; o John Church, Associate Psychologist

	o Jalown McCleery, Incident Management Coordinator o Natalie Montalvo, Director of Residential Services o Mary Holmes, Lead Investigator o Michael Davila, QMRP Coordinator o Roy Smith, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 5/24/11 o Daily Incident Management Meeting 5/24/11 and 5/26/11 o Human Rights Committee Meeting o Annual PSP meetings for Individual #169 and Individual #134
	Facility Self-Assessment: The facility's POI for this section detailed the many new processes that had been put in place to address the requirement of this provision. The facility had provided new training to QMRPs and other PST members on assessments, integrated treatment, the new risk identification process, and meeting facilitation. New forms had been implemented to monitor PST meetings, PSPs, active treatment, and plan implementation. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts were in the beginning stages, therefore, the facility is still not in compliance with most of the items in Section F.
	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. At the PSP meetings observed, team members discussed supports needed in relation to the individual's preferences and interests. Teams were attempting to identify risks of individuals and encourage integrated discussions of those risks and supports needed to safeguard individuals, however, as noted in Section I, this discussion was still not leading the identification of true risks and necessary supports to minimize those

	risks. The QMRP Coordinator and the Director of Residential Services shared a number of new processes that had been implemented since the last monitoring visit in terms of PSP development and implementation. Both acknowledged that the facility was in the beginning stages of compliance with this provision. It was evident from conversations with the monitoring team that the facility was carefully considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. A number of new monitoring procedures had been implemented in regards to PSP development and monitoring. Staff had been retrained on the assessment process and participation at PSP meetings. All staff had also been trained on the new risk identification procedure. Four annual PSP meetings were observed by the monitoring team. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. QMRPs had recently completed facilitation training and most were still adapting the meeting process to try to capture all information needed to develop a comprehensive plan. QMRPs were working with all disciplines at the facility to ensure that necessary assessments were being completed and recommendations were included that could be used in PSP development. As noted throughout section F, active treatment and vocational staff were struggling with consistent plan implementation. 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 and then, ensuring that plans are accessible to support staff. Throughout section F, the monitoring team has 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 fully implement these changes. The PSPs that were reviewed were chosen from among the list of individuals for whom the new format/process for PSPs had been used. The monitoring team reviewed a sample of 17 of the new plans to assess compliance with section F. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans.

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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 were responsible for facilitating PST meetings at the facility. The QMRPs were also responsible for developing, monitoring, and revising treatments, services, and supports. All PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings. A sample of 12 PST attendance sheets was reviewed for presence of the QMRP at the annual PST meeting. At all annual meetings, there was a QMRP present. In the annual PST meetings attended by the monitoring team, the QMRP facilitated the meeting and did a nice job of encouraging input from all team members. The QMRPs appeared to be familiar with the individuals and contributed to the team meetings. Although the QMRP coordinator indicated that a monitoring process had been put in place to ensure updated plans were accessible to support staff, it was again found that current plans were not always available to staff providing support to individuals. QMRPs should ensure that direct care staff have current information needed to support each individual safely and consistently, and that all plans are being implemented as written. The facility had taken a number of steps addressed at achieving compliance with this provision including: o Retraining of all disciplines on completing identified assessments at least 10 days prior to the annual PSP date and filing in the facility's shared drive for all team members to review. o A new quarterly review process was implemented by a pilot group of QMRPs to identify gaps in current services and supports. The QMRPs will need to coordinate corrective action plans with all disciplines, as well as the quality assurance department to ensure findings are appropriately addressed regarding gaps in services and supports. o QMRPs were completing a monthly oversight sheet to assist with the monitoring of implementation and progress towards action steps in the PSP. This process was in the initial stages, but should be effective in identifying deficiencies in consistent implementation and lead to more frequent plan revision when progress is not being made. o The QMRP Coordinator and one of the QMRPs had attended facilitation training in Austin on 4/8/11. They had provided facilitation training to the other QMRPs	Noncompliance

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		at the facility on 5/5/11. While it was too soon to evaluate the effectiveness of this training, the QMRP Coordinator was attending annual PST meetings and continuing to mentor QMRPs with regards to meeting facilitation. At the recent Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QMRP to facilitate the PST in a way that meets this provision item.	
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.	A sample of attendance sheets was reviewed for compliance with this provision with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the following individuals: Individual #295, Individual #247, Individual #59, Individual #313, Individual #94, Individual #151, Individual #287, Individual #126, Individual #12, Individual #44, Individual #365, and Individual #389. • 10 (83%) of 12 indicated that the individual attended the meeting; o Individual #59 refused to attend his annual PST meeting. o Individual #287did not sign the attendance sheet for his annual PST meeting. The PSP did not indicate whether he participated in the meeting. • Three (25%) of 12 individuals had a LAR; one (33%) participated at the annual PST. Staff present by discipline where relevant at the annual PST meeting included: • In 12 (100%), the QMRP attended the meeting, • In 10 (83%), residential staff attended, • In seven (58%), day habilitation staff attended, • In one (14%) of seven, vocational staff attended, • In 12 (100%), nursing staff attended, • In 12 (100%), psychology staff attended, • In six (86%) of seven, the psychiatrist assistant attended, and • In five (56%) of nine, appropriate PNM staff attended. The following are examples of comments regarding participation in PST meetings for a sample of individuals reviewed. • Representation from all relevant disciplines was in attendance at the annual PST meeting for Individual #295. • For Individual #313, full representation from relevant disciplines attended her annual PST meeting. • For Individual #59, he refused to attend his meeting. PNM did not attend his meeting. He had been previously rated at risk for choking and aspiration. He utilized modified dining equipment and was on a modified diet for choking and	Noncompliance

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		aspiration risk. The team agreed to "remove aspiration from the dining focus due to no incidents reported." The QMRP had requested an evaluation in the past year due to "unsafe mealtime behaviors." He also had been diagnosed with GERD. Therapy staff needed to be included in this discussion regarding his true risk level for aspiration. • For Individual #247, his guardian did not attend the meeting. Vocational staff did not attend the meeting, though he had been referred for community placement and working in the community was a priority identified by the team. • Residential and vocational staff did not attend the annual PST meeting for Individual #94. • Vocational staff were not in attendance at the PST annual meeting for Individual #151. There was not a clear discussion in his PST regarding work, although, it appeared that he was working at the workshop at the time of his annual meeting. • The annual PST meeting for Individual #287 did not include participation by the SLP. His PSP indicated that he had limited communication skills. Supports needed in this area were not clearly defined in his annual PSP. Residential staff did not attend the meeting. • Day staff and therapy staff were not in attendance at the annual PST meeting for Individual #126. According to her PSP, she attended the Susie Crawford Center during the day. She was at risk for falls, choking, and aspiration and used adaptive equipment for mobility and dining. The risk ratings conflicted in her PSP. The full team needs to meet and determine her true risk levels. • All relevant team members were present for the annual PST meeting for Individual #12 except for vocational staff. He was currently working at the sheltered workshop and the team agreed that supported employment was a priority for him. • All relevant team members were also present for the annual PST meeting for Individual #44 except for the day services staff. • Vocational Staff did not attend the annual PSP meeting for Individual #365. He was working at the greenhouse and workshop. Work was listed as a priority for him and he hoped to work in the community one day. • Day habilitation staff did not attend the annual PSP meeting for Individual #389. It was found that day habilitation and/or vocational staff (when applicable) were often not present at meetings. These team members can provide critical input into how the individual likes to spend his or her day. A majority of the active treatment at the facility was provided during daytime hours. The facility had invested a lot of time and effort into revamping day programming at the facility to try to address active treatment and engagement issues. In order to continue to develop meaningful programming, it will be essential for day habilitation and vocational staff to be an integral part of the PST and	

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		planning process. The QMRP Coordinator and lead QMRPs for each unit had begun to monitor selected PSP meetings each month to provide oversight. When key team members were not present at meetings, the QMRP Coordinator notified the department head for the appropriate discipline. This should be an effective means for achieving better attendance at PSP meetings. 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 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, section R regarding communication assessments, and section T regarding most integrated setting practices. 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. The Personal Focus Assessment (PFA) 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. In the plans reviewed, this list was individualized and offered a good starting point for plan development. Information gathered from the PFA was discussed in the PST meetings observed. Each QMRP reviewed the individual's list of preferences and members of the team contributed information on how this might be supported. Attempts were made to integrate these preferences into outcomes developed by the team. 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. Vocational assessments were not adequate to address job placement preferences and skills. Vocational assessments should include situational assessment based on the individual's known skills and interests to determine if the individual is truly interested in possible work in an alternative setting regardless of whether or not the preferred job is available at SGSSLC. Some examples where adequate assessments were not completed for the individual	Noncompliance

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		included: • The vocational assessment for Individual #287 rated him with a "D" (physical disability prevents) in all areas. The evaluator commented "nonverbal" in all sections of the assessment. This conflicted with information from his OT/PT assessment that noted that he was able to complete tasks that were asked of him with prompting and redirection to stay on task. His assessments did not indicate what activities may have been presented to him in the past that he might enjoy. The leisure/recreation and behavioral section of the assessment stated that he likes to walk around and lick objects. There were notes throughout his assessments regarding licking objects and putting his fingers in his throat until he gags. There was no indication that he had been assessed for GERD or any other medical concerns that might be causing this behavior. • Individual #365 had a vocational assessment that was completed prior to his annual PST meeting. It included a checklist of work skills that he was able to complete and a list of employment preferences. It did not describe supports that he needed to maintain employment or include recommendations to move him closer to supported employment. • The Annual Rehabilitation Therapy Review for Individual #389 noted that his annual SLP assessment was pending at the time of his annual PST meeting. His PSP summarized his communication needs with the following statements: "meaningful speech is absent or limited to a few simple words. Priority code for communication – 1; has no effective means of communication independent of other's assistance. Needs are predicted by familiar and/or trained listeners and 100% interpretation is required. He has no other option than to follow inherent prompts of environmental activity or routine events." His PSP did not include a description of communication supports that he needed throughout his day or outcomes to address his communication needs.	
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. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. A sample of the newer style PSPs indicated QMRPs were at various stages in integrating information into a meaningful plan that identified needed supports in relation to the individual's preferences and needs. Information regarding significant diagnosis, risks, and supports was not included in all plans. Some QMRPs were including more information in the primary narrative section of the plan, but in some cases this information was just "cut and pasted" from assessments without any additional discussion of how direct care staff should support the person throughout his or her day. The use of clinical terms throughout some PSP narratives would make it difficult for	Noncompliance

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		direct support staff to understand how assessment recommendations should be implemented. PSPs should be a guide to providing supports that all staff can understand and follow. For example: • The PSP for Individual #136 stated: "Per speech, the individual demonstrates a communication disorder consistent with decreased cognition and she does not speak to communicate. She is able to communicate by gestures and facial expressions to gain attention, accept or deny, greet, show interest, imply basic need and express some emotions. However, due to deficits of receptive and expressive language and reduced attention to tasks she experiences barriers to expression of basic needs, social interaction, requesting help, clarifying information for/from caregivers, advocating for herself, controlling her environment, and asking questions. She has been provided with a communication dictionary to assist with communication with staff." • A more meaningful guide to providing services might state: Being able to make decisions and having control over her day is important to this individual. Staff can support her to do this by: o Offering her the opportunity to choose which clothes she would like to wear in the morning by pointing to her preference of clothing when two outfits are presented to her by staff. o Offering pictures of food available for each meal and letting her point to her choice. o Providing simple information and asking questions in a yes/no format, so that she may indicate her preferences by nodding her head. o Ensuring that she always has access to her communication book with pictures of her preferred activities so that she can indicate which activity she would rather participate in at any given time. • Her healthcare section noted: "Constipation r/t decreased peristaltic action secondary decreased metabolic rate and decreased physical activity. • A more meaningful guide for staff providing support would be to state this in a way that would ensure all staff can understand the risk and monitor her health status. For example: o She occasionally experiences constipation. Staff can minimize this risk by ensuring that fluids are offered throughout her day and she remains active and mobile. When she is not feeling well, she is less active and frequently cries out or grimaces, sometimes holding her stomach when she is constipated. If staff observe these behaviors, a nurse should be notified for assessment.	

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		Some good examples of where integrated information regarding protections, services and supports was included in PSPs were: • The annual PSP for Individual #365 was the most recently developed plan in the sample. It was the best example of a plan that included an integrated discussion of the individual's preferences and needed supports. The plan included a good description of supports that he would need to insure his interest and preferences were an integrated part of his day. The plan discussed areas of risk and how staff could minimize those risks. The plan discussed his employment history and current employment. As noted in F1c, vocational staff did not attend his meeting and his vocational assessment did not include recommendations for outcomes or supports. The team could have developed more appropriate outcomes to move him towards his goal of supported employment if these had been in place. • The PSP for Individual #126 included a good discussion regarding the findings from her rights assessment, her ability to make decisions, and her need for guardianship. The section on leisure and recreation described some of her preferences and how those were integrated into her day. • Individual #44's PSP included a summary of relevant assessments and described supports that were needed throughout her day. There was a description of how she liked to spend her day, preferred activities, and important relationships. Her PSP included her chronic medical issues and gave a brief description of how she should be supported to minimize her risks. Again, it would be more useful to staff if QMRPs would minimize the use of clinical language in the PSP narrative. • For Individual #236, her PSP included how staff could support her with the description: "If the environment is too noisy or active, offer her an environmental change by taking her to a quieter part of the room, her bedroom, or outside (weather permitting). When she is in her bedroom, turn off or dim the lights and play country/western music or other soft music to help her relax." This offered staff clear direction on how she might be supported to avoid exhibiting behaviors targeted in her PBSP. 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 appeared that this information was not used to develop and implement protections, services, and supports for the individual. ▪ Individual #94's personal focus assessment indicated that she was bored with her job tearing paper at the workshop and would like a more interesting job. Vocational staff did not attend her meeting, nor was a change in employment discussed. Her PSP included her risk levels but did not include a discussion of her diagnosis or medications that contributed to the risk level. The PSP did not	

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		indicate how these risks should be monitored or what supports may be needed to minimize her risks. ▪ Individual #287's PSP did not clearly describe assessment results or supports needed as recommended by assessments. His PSP indicated that he did not have the communication skills to fully express himself, but offered no clear description of how he prefers to communicate. His PSP stated that he "does present a significant communicative deficit, related to his hearing acuity." The next paragraph stated that he "does not present a significant communicative deficit." His psychological stated, "communication is limited (no expressive talk, responding to some simple words and phrases)." His risk assessment indicated that he was at medium risk for choking. His PSP narrative did not address his risk for choking. His rights assessment indicated that he was unable to make informed decisions and guardianship had lapsed. His need for guardianship was not addressed in his PSP other than to state that his team determined he did not need guardianship. His psychological assessment indicated that he was diagnosed with autism. This diagnosis is not noted in his PSP. ▪ The PSP for Individual #126 contained conflicting information regarding her risk for aspiration. The physical nutritional management section stated that she was at low risk for aspiration. The medical/risk section stated that she was at medium risk for aspiration. The team needs to discuss all factors that place her at risk and agree upon a risk rating. ▪ The personal focus assessment for Individual #12 indicated that he liked to work, but did not like his assigned job at the sheltered workshop. The team agreed that piece work was not the best type of employment for him. No employment outcomes were developed to address supporting him in a job that he prefers. ▪ The Annual Nutritional Services Evaluation for Individual #367 noted that staff needed to ensure adequate hydration, encourage two to three liters of fluids every day with the use of Lithium, and encourage consistent sodium intake. This information was not included in his PSP. His vocational assessment stated "his mental capability prevents him from staying on task." There was no indication what types of task he was presented with or how many task were attempted. Attempts should be made to evaluate individuals on task that they are interested in. It was not clear that this was done with this individual. His audiological evaluations dated 2/10/11 and 2/11/10 were identical, other than a change in date. It did not appear that his hearing was actually reevaluated. ▪ Individual #90's PSP stated there had been no rehabilitation therapy consults since her last annual PSP. Her Rehabilitation Therapy Assessment (RTA) dated 2/8/11 indicated that there had been three consults since her last annual PSP meeting. These consults were all in response to concerns by her physician. Each	

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		consult resulted in a change in her PNMP plan. The PSP should have summarized the results of these consultations. The PSP indicated that she was at low risk for injury, though her RTA indicated that she had osteoporosis with a history of fractures. The PSP also indicated that there were no reported issues with skin breakdown and she was at low risk for skin integrity. Her RTA indicated that she was at high risk for skin breakdown. Her adaptive equipment was reevaluated during the past year due to incidents of skin breakdown on her hand, heel, and head over the past year. Her PSP stated that she was a low risk for aspiration due to supports that are in place. The next paragraph stated, "we agreed that aspiration is a high risk, as she is PEG tube fed." There was no discussion in her PSP regarding her significant healthcare needs and diagnosis. She had a history of multi-drug resistant infections, skin cancer, deep vein thrombosis, and was being treated for chronic pain. She had also been hospitalized with pneumonia since her previous PSP. The facility was in the beginning stages of ensuring assessment information is used to develop plans that outline all supports and services. The QMRP Coordinator recognized the challenges in achieving compliance with this provision and was working with QMRPs to ensure progress in this area. The facility is not yet in substantial compliance with this provision.	
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. Seventeen of 17 PSPs (100%) reviewed for Section F (listed in the documents reviewed) indicated that individuals and/or their LARs were offered information regarding community placement as required. In 15 (88%) instances, the teams concluded that the individual should continue to reside at SGSSLC. • Individual #247's PSP indicated that he had already been referred for community placement. • The PSP for Individual #389 stated that he "would be referred for community placement in the next two weeks." The community living discussion indicated that the individual had expressed a desire to remain at SGSSLC, but had little understanding of community placement. Justification for a referral was not included in the discussion. The PST annual meeting was observed for Individual #169. The team engaged in a good	Noncompliance

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		discussion around living options and appropriate placement in the least restrictive environment. The individual wanted to move into the community. The team agreed that it would be appropriate in the future, but was unsure how his court order for placement and restrictions placed on him by the court would impact his placement in the community. The team had many unanswered questions around this issue. He had gone to the HRC last year to appeal the team's decision that he should remain at SGSSLC. A meeting held during the monitoring visit with the HRC raised similar questions regarding rights and placement. The facility needs to consult with the state office to provide clarification on these issues in order to hold an informed discussion during PST meetings regarding proceeding with community placement. Plans included limited opportunities for community based training. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. The Active Treatment Coordinator was creating a form for staff to use during scheduled community trips to document observations and training efforts in the community. This is a good first step to begin capture training that could be occurring in the community. The facility was undergoing some major changes in the way that programming was offered to individuals at SGSSLC. A college-type format (e.g., using the term "semester") had been set up based on interest and needs of the individuals residing there. Classes had been developed to provide training in a wide area of daily living skills including, reading, math, cooking, fitness, money management, anger management, and job skills. The hope was that this would offer individuals day programming of interest where skill deficits needed for more independent living could be addressed. The monitoring team agrees that this is a good start towards providing functional training to individuals. As the facility proceeds with this process, they will need to keep in mind some of the following: • Consideration needs to be given towards ensuring that progress is competently measured towards completing outcomes. • Individuals should have the opportunity to progress through a continuum of training that helps them to learn new skills and support their becoming more independent. Without the opportunity to use skills learned for functional living in the community, these classes will eventually become meaningless for the individuals, resulting in the same refusals to attend class, boredom, and behavioral problems that the facility has previously fostered. For example: o Cooking classes should lead to individuals progressing towards the next step of menu planning, shopping in the community for food items, participating in cooking meals in the home, or possibly employment in	

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		food services. o Money management classes should lead to individuals having the opportunity to set up their own checking accounts in the community and manage their money more independently with appropriate supports. Although many individuals had participated in money management outcomes for years, there was no evidence that training ever led to independent banking in the community, opportunities to write checks and pay bills, or acquiring a debit card to shop in the community. o Reading classes should lead towards opportunities such as using the community library, acquiring a GED, attending community college classes, or community employment. • Functional training should be offered in the community in conjunction with training provided in the classroom. • Participation and scheduling will need to be coordinated with each discipline to insure individual's days are structured and all needed supports are received. Although the facility reported that training was occurring in the community, it was not evident in PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. Interviews with the vocational staff indicated that a lot of thought was going into how vocational services could provide more meaningful job training and employment opportunities. Efforts to expand vocational opportunities included: • Vocational staff were making attempts to educate community employment providers regarding services that the facility's vocational services could offer to employers. • The workshop was establishing mobile work crews to go into the community to complete work in order to give individuals experience working in the community. • Individuals were going out and meeting with employers to learn more about job skills requirements and employment opportunities. Efforts to this point had not been successful in opening doors to community employment. One barrier noted by vocational staff was competition from community based employment service providers. The facility will have to take a more aggressive, creative approach to secure employment opportunities in the community. In order to move forward with these efforts, it might be beneficial for vocational staff to receive additional training on supported employment and be provided with the opportunity to visit successful supported employment programs to learn new approaches that might lead to	

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		supported employment. This provision is discussed in detail later in this report with respect to the facility's progress in implementing the provisions included in Section T of the Settlement Agreement. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. The facility needs to provide additional training to teams in this area. This is a repeat need also noted in the previous monitoring report.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The PSPs reviewed included a list of "What's most important to the person?" For individuals in the sample, this list was used as the basis for outcome development. As noted in F1e, outcomes were not functionally implemented in the community. There was very little focus on priority skills such as communication, socialization, and community integration. The facility had made considerable progress on implementing training opportunities at the facility that would be more meaningful to individuals at the facility. This should lead to more willing engagement in activities and fewer behavioral incidents. Many more activities were being offered based on interests of the individuals at the facility. The facility, however, had not yet developed a system to effectively measure progress towards outcomes in the new classes offered at the facility. This will be the next step necessary to ensure individuals are receiving appropriate supports and needs are being met. The PSTs should have developed action steps that would facilitate community participation while learning valuable skills needed in the community for most individuals	Noncompliance

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		in the sample. Currently, little structured training was occurring in the community. As noted above, the Active Treatment Coordinator was working on capturing information regarding training that is occurring in the community in hopes to increase those efforts. The facility had few options to address vocational services. Vocational staff were often not included in planning and vocational services were not considered a priority for individuals at the facility. During discussions with the Vocational Director, it was shared that with the new change in schedules for individuals, work was often not a consideration. Individuals were scheduled to attend classes throughout the day, which meant that they may come to work for an hour, leave to go to class, then come back and work another hour between classes. This schedule made it difficult for vocational staff to consistently provide vocational training. Individuals at the workshop should have been learning work skills that would transfer into employment skills for the community with the opportunity to make real wages in an integrated setting. Progress made on each vocational outcome should move the individual closer to community employment. It did not appear that was a real consideration for the individuals in the vocational program. As noted in F1e, the Vocational Director was exploring opportunities to expand the facility's employment program and address this provision. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community.	
	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;	Strategies included limited generic supports needed for implementation. Adequate supports were not always identified in assessments or, if they were identified, they were not included in planning. Examples of outcomes and goals that were not measurable and/or did not include supports needed to accomplish the goal included: • Individual #389 had five SPOs for outcomes included with his PSP. Three of the five (60%) were not measurable. He had a training objective for money management. He was working on an action step that stated, "Individual #389 will choose items he wishes to purchase." There were no teaching strategies and no indication of what criteria would be used to determine when the action step was completed. He had a training objective for choosing his clothing for the day. The action step that was being implemented stated "points to all available	Noncompliance

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		clothes. " Again, there was no criterion to measure completion of this action step. He had an outcome for learning to self medicate independently. The action step being implemented stated "nurse holds up a medication and states name of the medication." There was no indication what his response should to be to successfully complete this step. It appeared that there was no action required on his part. • Individual #90 had an SPO for socialization. It listed three action steps: (a) will be assisted to the lobby area to enjoy television, (b) will interact with peers by smiling at them, and (c) will be assisted to sit among her peers in the lobby area. The first and third action steps were not steps that needed her participation to complete. They were instructions for staff. The second action step was not measurable would be difficult to assign completion to her actions. This individual needed many supports throughout her day. None of the many supports listed in her assessments was included in staff instructions. For example, staff should have had specific instructions for positioning her appropriately to facilitate interact with her peers. Additional examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. As noted in F1e, PSPs indicated that community placement was discussed at PST meetings and in most instances the teams concluded that current placement was optimal for each individual. Plans did not include strategies and supports to be provided in a more integrated setting. Other than going on community outings, plans did not designate that services would be provided outside of the facility, even though a lack of exposure to the community was noted as being a barrier to community placement in some of the plans reviewed. Outcomes to go on community outings did not have corresponding SPOs for learning to take place while in the community. Although an SPO is not required for every outing, the lacks of SPOs in this area were missed opportunities for instruction to have occurred.	
	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. PSPs developed using the new person centered training, however, showed progress in this area. The newer plans were much more comprehensive in identifying and addressing risk for individuals and including supports that were needed by each individual. See section I of this report for specific examples of how risks were being identified and addressed in plans. When developing the PSP for an individual, the team should consider all	Noncompliance

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		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. Then the facility must ensure that plans are developed and implemented in a timely manner. As noted throughout section F, the planning process did not always result in a plan being developed and distributed to staff responsible for implementing plans. This process will be further reviewed when the facility has had an opportunity to fully implement the new person centered planning process.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	In the 17 PSPs reviewed, it was noted that not all training objectives identified in PSPs had corresponding skill acquisition plans to ensure consistent training. During observation of day training programs at the facility, it was also noted that most individuals spent much of the day in training where implementation and progress were not recorded. Training curriculum had been developed for the newly implemented classes at the facility, but that training was not individual specific. The Director of Residential Services reported that the facility was looking at ways to measure individual progress in classes. PSPs and skill acquisition plans (SPOs) for four individuals (Individual #389, Individual #90, Individual #367, Individual #287) were reviewed. The following is a summary of what was found in regards to the: • Five outcomes with SPOs were reviewed for Individual #389. o Two (40%) of the five included methods for implementation; o Zero (0%) included timeframes for completion; and o Five (100%) named staff responsible for implementation. All specified direct care staff as the staff responsible. According to the action steps listed for his self medication outcome, the nurse was responsible. • Individual #90 had two SPOs in place. SPOs had not been developed for two of her training objectives. o One (50%) of two included methods that would allow for consistent implementation of outcomes. o Zero (0%) included a time frame for completion; and o Two (100%) named staff responsible for implementation. • Individual #367 had six SPOs in place. They were not consistent with training objectives listed in the PSP document. o Five (83%) of six included methods that would allow for consistent implementation of outcomes. His SPO for self-medication, just stated, "state the name of medication." It was not clear if he had to ask for his medication by name, identify medication when it was handed to him, or	Noncompliance

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		know the names of all of his medications. Instructions were not related to this action step. o Zero (0%) had a time frame for completion; and o All (100%) named staff responsible for implementation. • Individual #287 had SPOs to address five outcomes. o Five (100%) of five identified methods to be used for implementation. None included individualized supports that he would need for implementation. o Zero (0%) had a time frame for completion; and o All (100%) named staff responsible for implementation. PSPs did not identify the methods for implementation of outcomes. All SPOs included generic methodology for implementation. None incorporated individualized strategies from assessments into implementation strategies. See section S for additional findings regarding the adequacy of skill acquisition plans.	
	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 throughout this section of the report, outcomes in the PSPs reviewed did not always adequately address supports needed by the individual to achieve outcomes and strategies to support functional learning in the community were not included in the PSPs in the sample. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare issues, PNM needs, and behavioral support needs. The facility was not in compliance 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.	Skill acquisition plans for four individuals (Individual #389, Individual #90, Individual #367, and Individual #287) were reviewed. It was found that training objectives were not individualized and did not contain information necessary to permit objective analysis of progress. See section K for additional comments regarding data collection. The following is a summary of what was found: • Data to be collected were not specific to the outcome. All data collection sheets were identical grids that required the staff to initial when implemented and note the level of assistance necessary. Data codes listed were: I for did the task independently, VP for verbal prompts required, G for gestural prompts, D for demonstration, and PS for physical support. Information was not included that would let staff know what successful completion criteria was required before moving to the next action step. • All (100%) identified the frequency of data collection • All (100%) identified the person responsible for data collection • All skill acquisition plans had a place for the QMRP's signature. It was assumed	Noncompliance

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		that the QMRP was assigned to review the plan, but did not indicate how often this review was to take place.	
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. As noted in F2g, the facility did not have a fully developed quality assurance system in place to effectively monitor the quality of PSPs. While the monitoring team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. The facility did not have a process to ensure coordination of all components of the PSP.	Noncompliance
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.	A sample of 30 individual records was reviewed in various homes at the facility. It was found that individual records were often locked in offices rather than being freely accessible to support staff assigned to implement the PSP. Current PSPs were not available in seven (23%) of the 30 records, indicating that support staff did not have information necessary to fully implement PSPs. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. The PSP is a document that is integral to overall service provision, and ensuring it is available in the record seems to be a relatively easy clerical task. 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 individual would remain safe and healthy.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that,	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 teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate outside of schedule quarterly review	Noncompliance

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	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.	meetings. The three lead QMRPs were piloting a new quarterly review process. The process included a monthly review of implementation of action steps. All PST members involved were trained on the new process and instructed how to record monthly information into the new quarterly review form. The QMRPs were then responsible for reviewing all data. The QMRP coordinator was working closely with the lead QMRPs in implementing the new process. All QMRPs were currently reviewing progress towards outcomes; changes in health and behavioral status; therapy recommendations; level of supervision; injuries and restraints; family; participation in community, social, and religious activities. While this was not occurring monthly, this was a good start to achieving compliance with this provision. The facility will need to implement a system to monitor services and supports monthly and ensure that plans are revised and updated as necessary. When plans are revised, there needs to be a system in place to ensure that all support staff are aware of changes and new plans are being implemented as written. A sample of the new monthly review documentation was provided to the monitoring team for Individual #232. The form included a section to note progress or regression on all service and training objectives monthly and along with a place for QMRPs to comment quarterly on the progress or lack of progress. There was also a monthly oversight form that the QMRP completed noting any PST meetings needed and whether staff responsible for monthly reviews had completed those. The QMRP Coordinator will need to review this process to see if it results in a better system for QMRPs to monitor implementation of plans. A sample of quarterly reviews completed by the QMRP was reviewed for compliance with this provision. • The 7/16/10 quarterly review for Individual #295 indicated that the QMRP looked at monthly progress notes for each outcome listed in the PSP. It was not clear that action was taken when problems were noted. For example, comments regarding his outcome to attend programming indicated that "he comes to class most of the time, but a lot of the time he will come two hours early and they have to send him home." There was no indication that this had been addressed with appropriate support staff. There was also a note that his STACS class had been suspended. There was no indication that this was addressed through alternate programming. A comment regarding his BSP noted that his BSP needed to be reviewed and progress notes needed to be completed. There was no indication that this information was shared with the psychologist. The quarterly review	

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		noted changes in his health and risk status, contact with his family, community outings, and restrictions. Overall, it was a good summary of events throughout the quarter. • The quarterly review for Individual #186 dated 4/4/11 noted that her outcome to take off campus trips was not implemented during the quarter. There was no explanation for why this was not implemented. There was no documentation that her outcome to call her family had been implemented throughout the quarter. The QMRP noted that the PST agreed to discontinue the outcome. No reason was given for discontinuing. Other outcomes were marked as "progress," "no change," or "regression." The QMRP just noted "continue program." There was no indication what progress had been made or in the case of regression, if changes needed to be implemented to the program. The review did include a good summary of medical issues and follow-up throughout the quarter. • The quarterly review for Individual #327 dated 2/20/11 included a brief summary of specific progress made on each outcome included in the PSP. The review indicated that outcomes were revised when progress was not being made. The QMRP noted when documentation on outcomes was not appropriate. There was a summary of all supports and services provided throughout the quarter. • The quarterly review for Individual #34 dated 1/31/11 gave a brief summary of progress towards outcomes for each month in the quarter. The QMRP discontinued outcomes when the individual showed no interest and moved to the next step when a criterion was met for completion. For healthcare and behavioral outcomes, the QMRP noted any changes in status. Services and supports provided throughout the quarter were summarized in the quarterly review. 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. QMRPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals'	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 the development of a comprehensive PSP document.	Noncompliance

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	ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	A review of training transcripts for 24 employees indicated that 24 (100%) of the 24 had completed the new training on PSP process entitled Supporting Visions. As noted in F2f, QMRPs were not ensuring that current plans were developed and distributed to staff responsible for providing supports indicating that support staff had not been trained on plan implementation when plans were updated or 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.	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility provided the monitoring team will a list of all PSP date, previous PSP dates, and admission dates • 205 (91%) of 226 were revised within 365 of the previous PSP • 15 (88%) out of 17 PSPs for new admissions and had been developed within 30 days of admission. Individual #147 did not have a PSP in place in her home. She had been admitted to the facility 45 days prior to the monitoring visit. Support staff had very little information in the home to guide supports or allow them to appropriately monitor any risks for her. The only information available to support staff was a brief profile on a 3"x5" card. As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 29% of the plans in the sample were not current in the homes and available to staff. Some plans were over a year old indicating that in some cases, PSPs may never have been distributed if developed. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff do not have the tools that they need to safely	Substantial Compliance

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		and consistently support individuals.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. 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. The QMRP Coordinator and lead QMRPs reviewed draft PSPs prior to distribution to ensure completeness. The draft plan with comments and corrections by the QMRP Coordinator for Individual #302 was provided to the monitoring team. The QMRP had thoroughly reviewed the draft plan and made comments throughout the report where additional information was needed. Many of the issues noted throughout Section F were addressed and the QMRP was prompted to revise information in the draft plan. Some examples of appropriate comments by the QMRP Coordinator included: • Family contact is something that is important to Individual #302. There needs to be an action plan to show how the PST is supporting this. • One of the outcomes included in the draft plan stated, "will identify community activities that he enjoys." The QMRP noted that specific steps on what types of activities he likes to participate in will give more direction to planning activities to meet his action plan. • Another outcomes stated, "will continue to attend workshop." The QMRP Coordinator prompted, "how does this focus on training at the workshop?" • In regards to referral for community placement, the QMRP Coordinator noted that there needs to be an action plan to keep track of the referral process and ensure objectives are being carried out in a timely manner. • The QMRP Coordinator noted that any assessments not turned in by PST members should have an action plan for follow-up. There were many additional appropriate prompts and comments throughout the draft report. This type of monitoring may be needed for all plans until the QMRP Coordinator determines that QMRPs are competent at writing plans in compliance with this provision. QMRPs should be held responsible for not distributing plans in a timely manner and support staff should be trained to notify supervisors when they do not have the tools necessary to safely and consistently provide supports. An effective quality assurance system for monitoring PSPs was not in place at the facility.	Noncompliance

Recommendations:

1. Develop a system to ensure that PSPs are in individual records and updated as necessary.

2. When key members of the PST are unable to attend meetings, document any attempts to get input prior to the meeting and include recommendations from each team member not present.

3. Provide additional training to PST members on developing and implementing plans that focus on community integration.

4. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.

5. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

6. The facility needs to consult with the state office to provide clarification on issues surrounding community placement for individuals placed at the facility in order to hold an informed discussion during PST meetings regarding proceeding with community placement.

7. All action steps should include individualized supports based on assessment for each individual.

8. The team should assign completion dates that correspond with the individual's rate of learning.

9. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.

10. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o SGSSLC Organizational chart, undated o SGSSLC policy lists, 4/8/11 o List of typical meetings that occurred at SGSSLC o SGSSLC POI, 5/9/11 o SGSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 5/23/11 o QI Council meeting minutes listed in section E above o Review of records listed in other sections of this report o Notes from psychology regarding plans for integrating with other disciplines, three pages, 1/11 o SGSSLC policy on consultation process, revised 4/7/11, Dr. Rebecca McKown o Clinical integration POI/interdisciplinary meeting notes, nine meetings, 2/11 through 5/11 o Notes from medical-nursing meetings, seven meetings, 2/11 through 5/11 o Examples of IPNs showing responses to outside consultations for one SGSSLC physician o Four record reviews done by Dr. James Goodman, M.D., 4/1/11 o Documents from training attended by psychology and psychiatry o Continuing education documentation for some medical staff Interviews and Meetings Held: o Dr. Philip Baugh, Facility Director o Dr. Rebecca McKown, M.D., Medical Director o Angela Garner, Chief Nurse Executive o Charles Njemanze, Assistant Director of Programs o Residential Director and Unit Directors: Natalie Montalvo, Melinda Gentry, Cedric Woodruff, Vicki Hinojos o Penny Bivens, Settlement Agreement Coordinator 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 Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o POI Interdisciplinary Meeting, 5/26/11 o QI Council Meeting, 5/23/11 o QI Council data review meeting, 5/25/11

	Facility Self-Assessment: The SGSSLC POI rated G1 and G2 as in being in noncompliance. The monitoring team agreed with these self-ratings. Determination of a set of activities that are required to demonstrate the provision of integrated clinical care will likely be required if the facility is to meet the requirements of G1. The self-assessment narrative properly indicated many of the activities the facility had taken, however, these were primarily, if not solely, related to medical department activities.
	Summary of Monitor's Assessment: SGSSLC was not in compliance with this important provision, however, continued progress was evident. First, the medical director had taken actions towards integration of the medical and psychiatry departments with other clinical disciplines. Second, senior administration (the assistant director of programs) headed a regularly occurring meeting of all clinical department heads with the primary, if not sole, purpose of working towards the provision of integrated clinical services. This involved sharing of information, and addressing challenges and barriers. Below, the monitoring team makes some comments for the ADOP to consider as this group moves forwards. A number of specific examples were provided to, or observed by, the monitoring team that showed some ways in which SGSSLC was making service provision more integrated across clinical service departments. These examples are provided below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided. A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech	SGSSLC was not in compliance with this important provision, however, the facility management was taking steps towards improving the integration of clinical services. The medical director was the facility's lead manager for this provision. The facility was responsive to the monitoring team's comments and recommendations during the previous onsite review and in the previous monitoring report. Thus, SGSSLC had made continued progress towards substantial compliance. In general, continued progress was evident in the way the integration of clinical services	Noncompliance

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	therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	was a topic throughout the facility, especially at the senior management level; the specific activities taken by the medical director; and the initiation of a monthly meeting of clinical directors solely devoted to the issues and challenges of integration. Moreover, the monitoring teams recently presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility. This list might also become part of the self-monitoring of section G compliance. At the time of this onsite review, the facility was not engaging in any self-monitoring of sections G or H. It will be important for SGSSLC to do self-monitoring of these two important provisions if substantial compliance is to be achieved and maintained. <u>Clinical integration committee meetings</u>: SGSSLC administration initiated a regular meeting of all clinical department heads. The group was called the POI/Interdisciplinary committee, however, the purpose was to promote the integration of clinical services. Apparently, this began earlier this year as a smaller group between medical, psychiatry, and nursing, but it had grown to include all clinical disciplines and was headed by the facility's Assistant Director of Programs. It was great to see that the facility had formed this group, that attendance was good at all meetings, and that it was led by senior administration. The monitoring team reviewed the minutes since the group's formation in February 2011 and attended a meeting during the week of the onsite review. The minutes and the observation indicated that some very appropriate topics were discussed. Examples included the implementation of suction toothbrushes, pretreatment sedation, graphing for psychology and psychiatry, risk discussion portion of the PSP meetings, and the signing out of records. It did appear, however, that a good part of the meeting was devoted to announcements and information sharing rather than discussion of the status and challenges of integrating clinical services at SGSSLC. To that end, the monitoring team recommends that the ADOP consider piloting changing the meeting format so that during each meeting, two disciplines present (for 30 minutes each) how their discipline integrates with other disciplines, challenges their discipline faces in integrating with other disciplines, and suggestions for improvement. Then, every other discipline head in attendance would need to comment, respond, reply, and/or add to the presenter's comments. It may be that this type of approach will be more efficient and effective for	

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		the discipline heads, especially given their limited time and busy schedules. This may help achieve that ADOP's goal, as stated in the meeting observed by the monitoring team: "this meeting is to take away barriers that prevent us from accomplishing this task." Policy: A facility policy did not exist, however, a draft DADS statewide policy was available. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. Monitoring team examples: Examples of integration of clinical services that were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • Medical department reported meeting weekly with other department heads in October 2010. • Nursing and medical met regularly since February 2011 • A three page document from psychiatry indicated the psychiatry department's plan to integrate psychology, medical, nursing, pharmacy, and dental. • PSP meeting times were changed to the afternoon so as to not conflict with medical rounds and psychiatric clinics so that physicians and psychiatrists could attend PSP meetings. • Medical coordinated and attended continuing education trainings with psychiatry and psychology. • The more recent PST reviews of individuals' health status and needs were more complete and thoughtful analyses of their health needs and risks. • One time interdisciplinary meetings were held by o Medical, nursing, QA, residential regarding new consultation policy o Medical, psychology, and OT/PT regarding programming for individuals living in the 516 homes. • Residential unit directors reported that they participated in the massive facility wide project to restructure the day programming activities and classes at the facility. • Residential unit directors reported that psychology was more involved in setting expectations for what psychology expected from direct care staff. • A daily facility management meeting to review incidents and other important information occurred daily at 11:00. The meeting was led by the facility	

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		director. • Progress was observed in regards to the at risk processes. • Integrated progress notes were being used. • There was inconsistent evidence that individuals' physicians participated in their PST meetings, which was especially relevant when individuals' risk assessments and plans were reviewed and evaluated. • The nursing sections of the PSPs referred the reader to "See Nursing Assessment." This did not provide an adequate recapitulation of the individual's health status over the past year. • Improved collaboration between psychology and psychiatry was observed at psychiatry clinic. • The OTs and PTs had conducted position and alignment assessments in conjunction with dental to ensure proper support in the dental chair for examinations and to minimize risk of aspiration. • The PITs established to address mealtime issues were an excellent example of integration and collaboration. Other examples indicated that more work needed to be done: • There was no daily clinical meeting with the medical staff (PCPs, APRNs, psychiatrists and dentist), nursing, and the hospital liaison. • There was no true integration of medical and psychiatry and this resulted in several instances where medication changes occurred (or perhaps did not occur) related to the use of AEDs and psychotropics. • There also appeared to be problems with successful integration of medical and pharmacy. • Although there was great discussion of integration between dental clinic, psychology, and psychiatry, the pretreatment sedation notification form had not been implemented. Email exchanges dated in April 2011 implied that the dental clinic was kept updated on development of desensitization plans • There was very poor collaboration among departments in the developments of SPOs. For example, (a) psychology only wrote four desensitization plans, however, the dental department indicated many more individuals would benefit from these types of plans, and (b) SLPs and the language department were not involved in communication SPOs. • OT, PT, and SLP worked in a collaborative manner, however, they did not conduct co-assessment via observation in the homes and day programs to identify potentials for skill acquisition plans and methods to enhance existing programs developed by day program staff. • Integration of clinical services was not evident in the written annual PSP document. The narrative should document the team's discussion and illustrate	

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		(a) how integration had occurred over the previous year and (b) plans to ensure integration of clinical care was to occur during the upcoming year. In addition, there will continue to be separate plans (e.g., PNMPs, BSPs, nursing care plans), however, the PSPs should identify (in action plans) the objectives of these separate plans, identify who is responsible for implementation, identify who will review data, any modifications of plans, and integration of these plans with other disciplines as appropriate.	
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.	As noted in the previous monitoring report, the facility appeared to be responsive to recommendations from non-facility clinicians. SGSSLC had developed a facility policy to address this provision item. This provision item requires documentation of the PCPs' agreement or disagreement with each of these recommendations, and the requirement to refer relevant information to the PST. The facility's process was to do so by an explicit statement, in the integrated progress notes. The medical director provided some examples of IPNs that indicated that this process was followed, however, the explicit statement as required was not evident in each one of these. More direct review of documentation (see section L) indicated problems related to the routing of outside consults. The records reviewed provided several examples of delays of three to six weeks in receipt of QDRRs and outside consults. This problem was recognized, and processes were adjusted. At the time of the onsite review, a routing stamp had been purchased but not yet implemented. The medical staff signed and dated consults but summaries of the consults were frequently lacking in the records. Responses were frequently late when done due to routing issues (as noted immediately above). The medical department should maintain a report log that lists all non-facility consultations and tracked them from the date received until the final report was obtained. This listing might be useful to the recordkeeping department for their conduct of quality assurance reviews of the active record (see section V3 below). The Hospital Liaison nurse was directly involved in the daily process of reviewing non-facility clinician's recommendations. She ensured that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at SGSSLC. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via daily written reports, which were sent to the individuals' nurse case managers, physician,	Noncompliance

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		and DCS supervisor, and were also filed in the individuals' records. The Hospital Liaison's activities and reports were complete, comprehensive, and informative. There was no evidence across 20 of the 24 sample records reviewed (see section M), however, that their nurses consistently reviewed non-facility clinician's reports and recommendations and ensure that the clinician's recommendations were addressed/implemented in a timely manner. As a result, there were many recommendations without evidence of follow-up. This was especially significant for women diagnosed with gynecological problems, individuals whose hearing could not be evaluated due to impacted wax in their ears, individuals with abnormal blood test results, etc.	

Recommendations:

1. Develop and implement policy.
2. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.
3. Develop a system to assess whether or not integration of clinical services is occurring (i.e., self-monitoring). This will require creating measurable actions and outcomes.
4. Review and consider addressing the many items above in G1 under "Other examples indicated that more work needed to be done."
5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document.
6. Develop and maintain a list of all non-facility consultations, per individual.
7. Consider the recommendation above in G1 regarding changing the format of the Integrated Clinical Services interdisciplinary meeting.
8. Take steps to ensure that nurses document their review of individuals' lab tests, diagnostic reports, consultations, etc. and their plan to address the findings/recommendations, as applicable.

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 DADS draft policy #005: Minimum and Integrated Clinical Services o SGSSLC Organizational chart, undated o SGSSLC policy lists, 4/8/11 o List of typical meetings that occurred at SGSSLC o SGSSLC POI, 5/9/11 o SGSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 5/23/11 o QI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Dr. Philip Baugh, Facility Director o Dr. Rebecca McKown, M.D., Medical Director o Angela Garner, Chief Nurse Executive o Charles Njemanze, Assistant Director of Programs o Residential Director and Unit Directors: Natalie Montalvo, Melinda Gentry, Cedric Woodruff, Vicki Hinojos o Penny Bivens, Settlement Agreement Coordinator 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 Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o POI Interdisciplinary Meeting, 5/26/11 o QI Council Meeting, 5/23/11 o QI Council data review meeting, 5/25/11
	Facility Self-Assessment: The SGSSLC POI indicated that all seven provision items were not in compliance, and noted some comments regarding activities that were occurring towards meeting each provision item. The monitoring team concurred with these ratings as indicated below.

	Summary of Monitor's Assessment: Some progress was observed in regards to this provision item, however, over the past six months, little specific attention was paid to this provision. A draft state policy was disseminated. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H (but not for provision G as noted above). It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision. It is recommended that the facility's QA department play a role in addressing this provision.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, 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 across all areas of clinical service. The CNE was responsible for this provision and little had been done to specifically address each of the provision items H1-H7. The monitoring expects that more will be done by the next onsite review. When addressing provision H, the CNE will need to ensure that all clinical services are addressed, not only nursing and medical. For this provision item, H1, the state policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). The medical staff conducted sick call daily based on the assigned caseload. Assessments were usually in response to acute changes or hospital returns. The primary care providers did not complete quarterly assessments of individuals in their caseload. There was improved documentation to reflect that the psychiatrists had been evaluating individuals, however, due to problems with the dictation service, there was a noted	Noncompliance

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		overall deficiency, per review of records. The psychiatric assistant was instrumental in working with the lead psychiatrist to develop a schedule to prompt the psychiatry team about regularly attending to follow-up evaluations and comprehensive assessments (see section J). Quarterly and annual nursing assessments were not complete and/or accurate for 20 of the 24 sample records reviewed. In addition, despite numerous changes in individuals' health status and needs during the quarterly review periods, assessments were not reviewed/revised to ensure timely evaluation of and response to individuals' needs (see section M). Psychological assessments were not consistently complete and functional assessments were not completed for individuals with a PBSP (see section K). There were only three part time speech clinicians to complete communication assessments for all individuals. At their current rate they will not comply with their own Master Plan (assessment priorities and schedule). A number of these individuals had not had a previous assessment in many years (see section R).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	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. Even so, record reviews by the monitoring team indicated that appropriate ICD 9 nomenclature was used. Outlined throughout section J, the diagnostic formulation and psychiatric target symptoms selected for treatment recommendations were not well addressed. Aberrant behaviors, such as aggression to self and others were the focus of the treatment recommendations. Clinicians should determine psychiatric target symptoms that established the reasons for the assigned diagnosis and then select psychopharmacology accordingly in accordance with DSM. The overwhelming majority of nursing assessments failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA.	Noncompliance
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	SGSSLC did not have a plan or procedure in place to ensure or monitor 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 across all clinical service areas. Facility self-monitoring might include an item indicating whether there were any examples of interventions being clinically inappropriate and/or	Noncompliance

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	appropriate based upon assessments and diagnoses.	provided later than clinically appropriate. The CNE noted that nursing services had begun to use the statewide revised self-monitoring tools and that the facility had received its first external medical review (see L2 below). The draft state policy listed eight areas of treatment that were to follow various national and/or state guidelines. A ninth area referred to the federal government's guidelines website. The medical staff responded to a change in status very often with verbal orders for medications or transfer to the local hospital. Documentation of actual assessments for routine, acute, and emergency problems was very often lacking. Documentation of pre-hospital transfers appeared to be lacking, in many instances, even when the transfer occurred during normal business hours. SGSSLC was in dire need of an effective system in place to ensure that individuals acute and/or chronic health needs were addressed by complete, individualized health plans that referenced adequate and appropriate treatments and interventions based upon the individuals' assessments and diagnoses. The majority of intellectual assessments reviewed were more than five years old .	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The draft state policy included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start to assist the facility in meeting this, as well as the other, items of provision H. 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. The facility had not implemented any clinical guidelines at the time of the review. Several had been developed and were being reviewed by state office. Documentation in records referred to an individual being "stable," but did not define what was being monitored to determine this conclusion. Other terminology used was ''behavior was either improved (or not)." This type of terminology would not indicate if an agent was effective, especially if someone was administered polypharmacy without a detailed rationale for each medication chosen.	Noncompliance

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		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 were few intervention plans and the establishment of functional and measurable goals was inconsistent and, as such, hindered the clinicians' ability to effectively track progress and make appropriate clinical judgment to continue, terminate or modify existing intervention plans.	
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. Recently, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process (see section I below). Development of state policy may help guide the facility in the determination of a system to effectively monitor the overall health status of individuals, not just their levels of risk. This might include a combination of a variety of information already collected by medical, nursing, pharmacy, and other departments at SGSSLC, such as the annual and quarterly medical assessments, nursing assessments, and pharmacy reviews. The activities noted in the draft state policy commented on above in section H4 also apply to this provision item. Determining how the medical staff responded to changes in status was at times difficult. Physician orders were frequently given verbally, but in most instances, there was no documentation of an assessment or rationalization for the orders. The lead psychiatrist has begun to orchestrate the design of psychiatric delivery of services at SGSSLC. Development of new policy and procedures were underway.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	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 response to clinical indicators. A comprehensive set of clinical indicators had not been established. Numerous clinical guidelines were being reviewed at the state level.	Noncompliance

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		During the monitoring review, however, several examples of the psychiatric team modifying treatment regimen in response to clinical indicators were cited. For example, an individual was experiencing an adverse drug reaction and the psychiatrist altered the medication regimen. Unfortunately, the team was not certain about how to proceed for reporting of the ADR. Additionally, an interim meeting was held during the monitoring visit to review the plan for an individual who required a chemical restraint. Across all 20 of the 24 individuals reviewed, the HMPs did not consistently address all of the health care needs of the individuals; and, despite the development of acute/emergent health needs and risks, ACPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care problems and risks. The "stock" care plans were not specific enough for caregivers to be able to pick it up and effectively continue the care. 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. There was some evidence that functional assessments and PBSPs were beginning to be modified in response to clinical indicators (i.e., data-based decisions).	
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. State policy was in draft and incomplete format.	Noncompliance

Recommendations:

1. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H.
2. Ensure that all clinical services are addressed by the facility, not only medical activities.
3. 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.
4. 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 Policy #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o SGSSLC POI for Section I o List of individuals seen in the ER or hospitalized since 10/1/10 o List of individuals with fractures since 1/1/010 o List of individuals with pneumonia incidents in the past 12 months o List of 10 individuals with the most injuries o List of all individuals residing at SGSSLC and their risk rating levels o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals at high risk for GI concerns o List of individuals at high risk for aspiration o List of individuals that have contractures o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals with poor oral hygiene o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months. o List of Infirmary admissions 10/1/10 o List of Incidents and Injuries since 10/1/10 o List of expired individuals since 10/1/10 o List of individuals who receive nutrition enterally o List of all individuals residing at SGSSLC and their risk rating level in the o PSPs, Health Risk Assessment, and relevant assessments for determining risk: • Individual #186, Individual #295, Individual #90, Individual #313, Individual #126, Individual #247, Individual #287, Individual #94, Individual #382, Individual #32, and Individual #276, Individual #210

	Interviews and Meetings Held: • Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; • John Church, Associate Psychologist • Natalie Montalvo, Director of Residential Services • Michael Davila, QMRP Coordinator • Roy Smith, Human Rights Officer Observations Conducted: • Observations at residences and day programs • Morning Unit Meeting 5/24/11 • Daily Incident Management Meeting 5/24/11 and 5/26/11 • Human Rights Committee Meeting • Annual PSP meetings for Individual #169 and Individual #134 • PST Integrated Risk Rating demonstrations/discussions for Individual #66 and for Individual #247
	Facility Self-Assessment: The facility POI indicated that the facility was not yet in compliance with the provisions of section I. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I. The POI indicated that teams continued to meet, discuss risks, and develop plans to reduce risk. The facility had just begun a self-monitoring process. The monitoring team was in agreement with these self-ratings.
	Summary of Monitor's Assessment: The state had taken a number of steps to support positive results in the area of risk management. This included: • The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at SGSSLC. The new policy included changes in evaluating and addressing risks identified for individuals. • Forms had been revised for identifying risk, and a risk action plan had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative had been implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration. Risk categories included Seizures, Challenging Behaviors, Fluid Imbalance, Osteopenia/Osteoporosis, Skin Integrity, Weight, Respiratory compromise, Constipation/Bowel obstruction, Falls, Fractures, Aspiration, UTIs, Polypharmacy/Side effects, GI Concerns, Cardiac Disease, Circulatory, Diabetes, Choking, Hypothermia, Infections, and Dental. The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and

	addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance. SGSSLC had taken steps towards compliance with this provision including: • Implementation of the revised process began in January 2011. Training on the new process was provided to all PST members by 12/28/10. • Staff physician had traveled to Lubbock as part of the first team to participate in internal facility to facility record audits to monitor the new risk process. • Staff physician had begun auditing records of individuals at high risk for compliance using the newly developed state audit tool. Twelve records had been audited over the past three months. • Aspiration trigger data sheets were initiated for all individuals determined to be at risk for aspiration. The hope is that this new process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. SGSSLC had some challenges unique to the facility in terms of risk factors due to the forensic population being supported at the facility. The number of individuals at risk for challenging behaviors put a large number of individuals at risk for injury. There were a total of 2385 injuries reported for individuals at the facility since 9/1/10. Of these injuries, 17 were serious injuries resulting in fractures or sutures. As evidenced by the example in section I3 below, prevention plans were not adequate to safeguard individuals from injury. There had been 137 incidents of peer to peer aggression from 1/1/11 through 3/30/11. There was an additional concern due to the high number of active investigations at the facility at any given time. Due to the removal of direct support staff from contact with individuals during investigations, it appeared to be routine for staff to be assigned to homes where they were not familiar with the individuals in the homes. During the monitoring visit, the monitoring team encountered support staff who were not routinely assigned to the home in which they were working. They were not aware of some of the risk factors for those individuals they were assigned to support. It will be important for the facility to address these issues systemically in order to protect individuals at the facility from harm.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The new state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The facility was mandated to have its risk assessments/risk ratings using the new At Risk Process completed at each of the regularly scheduled next quarterly PST meeting held between 1/1/11 and 5/31/11. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee. A list of indicators for each of 21 risk areas had been identified by the new state policy. Each was to be rated according to how many risk indicators applied to the individual's case. The new policy had expanded the number of risk areas being addressed by this process to include choking, aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, diabetes, gastrointestinal problems, osteoporosis, seizures, skin integrity, infections, polypharmacy, challenging behaviors, falls, fractures, fluid imbalance, hypothermia, urinary tract infections, and dental status. A risk level of high, moderate, or low was to be assigned for each category. The facility had identified a target list of individuals with a history of pneumonia and/or aspiration pneumonia and/or received enteral nutrition as priority individuals for identification of aspiration risk. There were 243 individuals rated for risk of aspiration. Of the 243 individuals rated for risk, 13 (5%) were identified as being at high risk (Level 1), 21 (9%) at moderate risk (Level 2), and 209 (86%) at low risk (Level 3). A list of all individuals diagnosed with pneumonia in the past year indicated that 22 individuals had been hospitalized due to pneumonia/aspiration pneumonia since 3/1/10. It was not always evident that teams were engaging in adequate discussions with all relevant team members present to make accurate determinations regarding risks. For example, • The PST for Individual #59 had determined that he was at low risk for aspiration at his annual PST meeting on 2/23/11. PNM staff did not attend the meeting. He was on a modified diet reportedly due to his risk for choking and aspiration. The QMRP had requested an updated evaluation in the past year due to "unsafe mealtime behaviors." This behavior included taking large bite sizes, not finishing one bite before taking another, and becoming angry when staff prompted him in safe eating. Additionally, he had been diagnosed with GERD. The PSP did not include recommendations, if there were any, following the updated evaluation.	Noncompliance

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		The monitoring team met with the PSTs for Individual #66 and Individual #247 during the review week to observe and discuss how the teams assigned risk ratings. The monitoring team appreciated the PSTs' willingness to conduct this type of discussion with the monitoring team. In both meetings, the teams reviewed the list of risk areas that had been developed by the state office. Comments from the monitoring team are summarized below: • The reading of pre-determined risk ratings from previous meetings appeared to result in the lessening of active participation by attendees. For example, the risk rating form brought to the PSP meeting for Individual #158 was already completely filled out, that is, prior to any discussion at the PSP meeting. • The teams struggled with the determination of high versus medium risk ratings. • The interrelatedness of risk factors should be considered and discussed in an interdisciplinary fashion. • Consider that important risk issues for a particular issue can be classified in the "other" category to highlight its importance, especially for challenging behaviors, such as flight/running away. Observation of annual PSP meetings scheduled the week of the review showed that PSTs had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. This was a fairly smooth process for most of the meetings observed. QMRPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the monitoring team observed some meaningful multidisciplinary discussion occurring during most of the PSP meetings observed. Teams were attempting to identify risk and weave that information into the discussion regarding supports needed for the individual to achieve his or her desired outcomes. Teams, however, were not accurately identifying risks for most individuals and adequate plans were not in place to minimize those risks. During the onsite review, the monitoring team had the opportunity to observe the annual PSP meeting for Individual #169. All relevant disciplines were represented at the meeting. Team members knew the individual well and were able to contribute to the discussion regarding his risk and needed supports. The team determined that he was low risk in all health related areas and moderate risk for challenging behaviors. There was some discussion regarding whether his rating for challenging behaviors should be rated as high or moderate risk. The team agreed on a moderate rating. He had a number of restrictions due to his behaviors, which probably meant that he should have been considered high risk. Even so, the team did discuss supports needed to minimize his risks. He had a diagnosis of osteoporosis and had recently had a fracture. The nurse reported that this was a stable condition, so suggested that he was low risk for	

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		osteoporosis and fractures. Again, this probably should have been given a higher risk rating, but even so, the team discussed appropriate supports to prevent injury. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following is a summary of findings from this review. • PNM staff were not in attendance at the annual PST meeting for Individual #126 on 3/3/11. Her PSP noted that there had been no rehabilitation therapy consults in the past year. The narrative portion of her PSP indicated that she was at medium risk for falls, choking, aspiration, and dental hygiene in the risk identification section. The risk ratings were not consistent throughout her PSP. The physical nutritional management section stated that she was at low risk for aspiration. The medical/risk section stated that she was at medium risk for aspiration. The dental section indicated that she had good oral hygiene. Her physical exam included many active medical problems that were not discussed in her PSP, including hypothyroidism, hyperlipidemia, cardiomegaly, constipation, and kyphosis. The full team needs to meet and determine her true risk levels and develop a plan to address all risks. • Individual #94's PSP included her risk levels, but did not include a discussion of her diagnosis or medications that contributed to the risk level. The PSP did not indicate how these risks should be monitored or what supports may be needed to minimize her risks. • Individual #287's risk assessment indicated that he was at medium risk for choking. His PSP narrative did not address his risk for choking. His risk assessment indicated that he had no GI symptoms or problems. His physical indicated that he had chronic constipation which was currently under control with medication. Assessments note continual mouthing of objects and hands which possibly could have been related to reflux. There was no indication that he had been assessed for GERD though his dental assessment noted excessive wear to his teeth due to bruxism. • Individual #295 was rated as moderate risk for bowel impaction, pain, and challenging behaviors. He was high risk for cardiac issues. His PSP did not clearly describe symptoms and supports that direct support staff should monitor to ensure he remained healthy. He was listed as moderate risk for pain, but his PSP did not indicate that this had been discussed by the team or that adequate assessments had been completed to determine the source of pain. • Individual #90's risk rating form indicated that she was high risk for aspiration, osteoporosis, skin integrity, infections, falls, fractures, contractures, and dental health. She was moderate risk for GI problems, constipation, circulatory issues, weight, and respiratory compromise. Her PSP indicated that she had been	

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		hospitalized in the past year with a UTI and pneumonia. She did not appear on the list of individuals hospitalized in the past year. Her PSP indicated that she was low risk for skin integrity. Much of the risk information was repeated several times in the PSP in different sections, but did not clearly give staff directions for supporting her and monitoring her health status. • Individual #325's risk rating assessment indicated that she was high risk for skin integrity, urinary tract infections, and dehydration. She was rated as moderate risk for dental and osteoporosis. The facility produced a list of individuals at risk in each category, for example, there was a list of all individuals at risk for skin integrity. She showed up as low risk on the lists for skin integrity, urinary tract infections, dehydration, dental, and osteoporosis. • The risk rating assessment for Individual #313 indicated she was high risk for dental hygiene, moderate risk for choking and challenging behaviors, and low risk in all other areas. Her physical exam noted that due to chronically abnormal labs, her home staff and nursing staff should be diligent to report signs and/or symptoms of infection. This information was not in her PSP. She was rated as low risk for polypharmacy, but "continued to need frequent monitoring due to bizarre movements and EPS due to medications." She had over 30 psychiatric medication changes in the past year. She had an abnormal EKG in the past year that was attributed to her use of Geodon. This individual had many complex, interrelated risks. The team needs to meet, determine her true risk areas, and offer guidelines to staff supporting her to minimize her risks. • Individual #66 was rated as high risk for dehydration, urinary tract infections, and dental health. He was moderate risk for skin breakdown. The facility list for each of these areas indicated that he was low risk. • Individual #382's PSP indicated that she was at moderate risk of challenging behaviors and injuries. Her PSP stated that her health risk is low. She was diagnosed with asthma, insomnia, hypothyroid, GERD, allergic rhinitis, constipation, and glaucoma. She was hospitalized on 1/2/11 with pancreatitis. The PST needs have an integrated discussion regarding her true risk levels and train staff on how to provide safe supports and monitor her health. • Individual #32 was rated as moderate risk for GI concerns and challenging behaviors. Her PSP described interventions and supports needed for both of these risks. • Individual #276 was rated as low or no risk in all areas except challenging behaviors. His PSP included supports that he would need to remain safe stay healthy. Numerous additional examples are listed in section M5.	

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		The facility was not yet in compliance with this provision of the Settlement Agreement, but it was noted that they were making continued progress in attempting to address this provision and put safeguards in place for individuals at the facility. It is expected that all individuals at SGSSLC will have gone through the new risk identification process by the time of the next monitoring visit. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks.	
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 new At Risk policy required that when an individual was identified at high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. In addition, health risk ratings were not consistently documented. 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. The facility was not yet 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 interdisciplinary assessment, including preventive interventions to minimize the condition of risk,	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The new policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the PST in response to risk categories identified by the team. Throughout the monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were generally able to accurately identify some risks, but not all. Staff could identify some	Noncompliance

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	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.	supports, but not all, needed to monitor those risks. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. It was not evident that adequate protections were always put into place in a timely manner to prevent further incidents when risks were identified. • Individual #186 was identified as being at high risk for injury on 3/3/10 by the Health Status Team due to aggression by peers. She had 55 documented injuries between 3/1/10 and 3/31/10. Of these injuries, three were serious injuries requiring sutures and/or hospitalization. o On 9/1/10, the PST met to discuss her health risk status. It was determined that she remained at high risk for challenging behaviors and injuries. It was noted that she attempted to cause injury to herself 21 times in the past year and attempted to harm others 40 times. The team did not discuss how many times she had been the victim of peer to peer aggression. Recommendations were to continue enhanced supervision off the home, continue her current BSP, and reinforce her for participating in programming. o On 9/14/10, the PST met after she cut her arm with a light bulb requiring staples to close the wound. The team determined that she should only get one trip to the token store by herself in the afternoons. o The PST met on 10/12/10 after three more incidents of aggression by peers. Again, the PST noted that protections and interventions were adequate to protect her from harm. o On 10/15/10, she jumped over the railing at the home and broke two vertebrae in her neck, one rib on her right side, and had a laceration on her scalp that required 25 staples to close after staff told her she would not be able to participate in a reinforcement activity due to her behavior. At that point, the team determined that she should be moved to a home with less aggressive individuals. The team also recommended that all PSTs should identify individuals who may react negatively when positive reinforcers are not earned. o On 10/20/10, the PST met and agreed that she should have one-to-one supervision and transition to a new home. o On 12/27/10, the PST met following several significant incidents between 12/12/10 and 12/24/10. On 12/12/10 she ran in front of a moving car. On 12/13/10, she attacked a staff member, stabbing her with scissors and kicking her in the stomach. On 12/15/10, she attacked another resident with a telephone receiver. On 12/24/10, she attacked a staff member with a telephone receiver causing serious	

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		injury. She also attempted suicide several times during that time period by attempting to remove light bulbs from the bathroom to use to cut herself. She was the victim of aggression by other residents in the home six times. The PSPA noted that several work orders were submitted to change the type of lights in the bathroom. There had been no response to this request. The PST determined that she should be moved back to a locked environment. The team acknowledged that this carried the risk of putting her back in a situation where she was the victim of aggression. This recommendation was justified by the statement the "risk of hurting herself is much greater than the risk of her getting hurt by her peers. Black eyes, bruises, and scratches that will eventually heal versus not being able to recover from paralysis or death if she were to break her neck." The team determined that the best environment for her was at SGSSLC even though the facility had not been able to protect her from significant harm over the past year. o The PST met at least five more times between 1/3/11 and 4/4/1 to review at least 17 additional injuries. She was placed on enhanced supervision to assist in protecting her from her peers but continued to sustain multiple injuries. o On 4/4/1, the PST met to review four more incidents of aggression by peers and determined that she should temporarily be transferred to another home for her safety. She had been the victim of aggression 25 times since moving back to 511B. The team agreed that it would be in her best interest to move to an environment where she was not fearful of her staff and peers. Although PSPs included a number of plans to address risk identified by the PST, during observations of homes by the monitoring team, it was noted that PSPs were often missing from individual records or not accessible, so direct support staff did not have current information regarding risks available to them. As noted in section F of this report, a sample of individual records was reviewed in various homes at the facility. Current PSPs were not available in 23% of the records. If there is not a current PSP in the home, staff do not have the information that they need to provide safe supports and services to individuals in the home. Staff cannot be held responsible for implementing a plan that they do not have. The facility needs to implement a monitoring system to ensure that staff have information readily available at all times to provide necessary supports to each individual in the home.	

Recommendations:

1. 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 and when to seek medical support.

2. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.

3. Ensure that risk rating accurately reflect risks identified through the assessment process.

4. Update facility risk list to include ratings assigned by each PST.

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk.

6. Implement a monitoring system to ensure that direct support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home.

7. Address facility wide trends that increase risk for individuals with a plan of correction.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Curriculum vitae of facility psychiatrists and family nurse practitioner • Jimmy Randall Mercer, M.D., William Earl Bazzell, M.D., and Donna Fay Yates, A.P.R.N. o Plan of Improvement dated 5/09/11 o SGSSLC Presentation Manual for the monitoring team o Policies, procedures, and/or other documents addressing the use of pretreatment sedation medication o Informed Consent Policy/Procedure o All policies, protocols, procedures, and guidance that related to the role of psychiatrists o For the past six months, list of individuals who received pretreatment sedation medication for medical or dental procedures that included date the pretreatment sedation was administered, the name dosage, and route of the medication, and an indication of whether a plan was in place to minimize the need for the use of pretreatment sedation medication o For the past six months, any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication o A description of any current process by which individuals receiving pretreatment sedation were evaluated for any needed mental health services beyond desensitization protocols o Dental desensitization plans for the following: • Individual #7, Individual #217, Individual #130, Individual #198, and Individual #18 o A spreadsheet of individuals (listed alphabetically) prescribed psychotropic/psychiatric medication, listing name of individual, residence/home, psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III, and medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration) o List of all individuals age 18 or younger, including date of birth, who were receiving psychotropic medication o List of individuals prescribed benzodiazepines, including the name of medication prescribed and duration of use o List of individuals administered emergency psychotropic medication 11/20/10-3/31/11 o A list of individuals prescribed anticholinergic medication, including the name of medication prescribed and duration of use o A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed, and the start date of each medication o Facility-wide data regarding polypharmacy o Spreadsheet for all individuals administered a Reiss screen inclusive of date completed o A list of new admissions since 1/1/10 and date of Reiss screen

	o List of individuals who (in the past six months) were referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen o A list of individuals with tardive dyskinesia o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o A list of families/LARs who refused to authorize psychiatric treatment and/or medication recommendations o A list and copy of all forms used by the psychiatrist o Examples of forms used to document side effects, e.g., MOSES, DISCUS o Overview of psychiatric practitioners' weekly schedule o Description of administrative support offered to the psychiatrists o For the past six months, minutes from the committee that addresses polypharmacy o Lab Matrix o Records reviewed included: • Individual #128, Individual #130, Individual #236, Individual #198, Individual #7, Individual #217, Individual #196, Individual #376, Individual #123, Individual #124, and Individual #298 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, Physician's Orders, Interdisciplinary progress notes, Nursing Annual Assessment and last Quarterly Assessment, Dental section o For the following individuals: • Individual #239, Individual #233, Individual #99, Individual #18, Individual #116, Individual #186, Individual #19, Individual #312, Individual #197, Individual #205, Individual #381, Individual #243, Individual #288, Individual #166, Individual #218, Individual #359, Individual #385, Individual #178, Individual #247 <u>Interviews and Meetings Held</u>: o Jimmy Randall Mercer, M.D., lead psychiatrist o William Earl Bazzell, M.D., facility psychiatrist o Donna Yates, A.P.R.N., family nurse practitioner o Misty Mendez, psychiatry assistant o Robb Weiss, Psy.D., chief psychologist o Don Conoly, R.Ph., pharmacy director o Rebecca McKown, M.D., medical director o Angela Garner, chief nurse executive (CNE)

	Observations Conducted: o Risk Management Meeting for Individual #66 and Individual #247 o Medication Review Committee Meeting o Psychiatric Clinic with Donna Yates, A.P.R.N. for Individual #18 and Individual #328 o Psychiatric Clinic with Dr. Bazzell for Individual #197, Individual #205, and Individual #359 o Psychiatry Interim Review meeting with Dr. Mercer regarding Individual #186 o STEPP Group Therapy conducted by Jane Bajaj, MA, LPC, LSOTP, and Robbie Potter, psychology assistant o PSP for Individual #312 o Internal Peer Review meeting with chief psychologist regarding Individual #186 o Integrated Process Meeting/Medical Plan of Improvement (POI) Interdisciplinary meeting
	Facility Self-Assessment: The self-assessment outlined in the Plan of Improvement (POI) for section J, dated 5/09/11, noted a self-rating of noncompliance in all 15 provisions. Even, so, there were accomplishments and continued progress since last review, including the hiring of a full-time, board certified, lead psychiatrist who had begun to address systematic issues for the delivery of psychiatric services at SGSSLC. Based on interviews with staff, observations, attendance at facility meetings, review of documents and policies and procedures, the monitoring team's findings were congruent with the facility's self-assessment and rated noncompliance with all the provision items for section J. It is hoped that a reading of section J of the report below will provide detail regarding the monitoring team's conclusion to support these ratings and the types of actions that the facility needs to take in order to meet substantial compliance with the provision items.
	Summary of Monitor's Assessment: At the time of the onsite visit, the facility had three full-time equivalent (FTE) psychiatric practitioners, two of whom, were recently employed to provide psychiatric services for the individuals at SGSSLC. The lead psychiatrist and new family nurse practitioner were both learning the system and meeting the individuals assigned to their caseloads. There was, however, no child and adolescent psychiatrist, forensic psychiatrist, and/or board-eligible forensic child and adolescent psychiatrist providing services at SGSSLC for the minors at the facility. Minors were admitted for assessment and secondary to court commitment. Upon meeting with the facility psychiatry staff, the monitoring team reviewed their understanding of the psychiatric issues outlined in the Settlement Agreement. The psychiatric practitioners were encouraged to meet together routinely to implement the provisions outlined in the Settlement Agreement in order to establish a psychiatric system of care that met generally accepted professional standards of care. While psychiatry was interacting with psychology on some levels, there were marked deficits in the delivery of integrated care. It was apparent that some of the duties that should fall in the realm of psychiatry had been provided by psychology (e.g., risk/benefit analysis for psychotropic medications) and was in the process of being turned over to the department of psychiatry. 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 psychiatric clinic was organized due to psychiatric assistant functioning in this role. The director of psychology, medical director, CNE, lead psychiatrist and the psychiatrists were receptive to working together to establish revisions to the delivery of psychiatric services for the individuals at SGSSLC.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Since last review, SGSSLC hired a full-time board-certified general psychiatrist in December 2010 that was designated the lead psychiatrist. Additionally, SGSSLC had a full-time board-eligible general psychiatrist who had been employed since December 2009. The previously employed advance practice registered nurse resigned recently. SGSSLC hired a new full-time family nurse practitioner, with a post-masters in adult psychiatric mental health, one month ago. There were, however, no psychiatrists who were board-eligible or board-certified in child and adolescent psychiatry, forensic psychiatry, and/or forensic and child psychiatry. There were three individuals who were younger than 18 years of age who were not receiving psychiatric services from a child and adolescent psychiatrist. One individual was 14 years of age. Per American Academy of Child and Adolescent Psychiatry (AACAP) Policy Statements regarding Criteria for Clinical Privileges for Physician Members of Medical Staffs, the inpatient admission and treatment of adolescents and children should be done only by those psychiatrists who have specific clinical privileges to admit and treat individuals in this developmental age group. • "For patients under 14 years of age, a qualified psychiatrist is a child and adolescent psychiatrist who is board certified in child and adolescent psychiatry or a psychiatrist who in addition to general psychiatry training has successfully completed a training program in child and adolescent psychiatry accredited by the Accreditation Council on Graduate Medical Education." • "For patients 14-17 years of age or older, a qualified psychiatrist is a child and adolescent psychiatrist as noted above or general psychiatrist who has documented sufficient, specialized training and experience in working with adolescents and their families on an inpatient treatment program, and has demonstrated competence to examine and treat adolescents comprehensively." • AACAP notes for those individuals 14 and above, the expertise of the general psychiatrist with special training in working with hospitalized adolescents should be supplemented by consultation with a qualified child and adolescent psychiatrist. This should be done within seven days of admission for patients	Noncompliance

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		age 14 and 15 and every 30 days thereafter or within 21 days for patients age 16 or 17 and thereafter within 45 days. 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 by contract, consultation, or consultative supervision of current psychiatry staff. The facility psychiatrist that was board-eligible in general psychiatry was clear that he did not feel comfortable treating younger individuals. The lead psychiatrist that was board-certified in general psychiatrist provided information to the monitoring team that he had prior experience in treating adolescents, individuals with developmental disabilities, and individuals in a forensic hospital. The nurse practitioner also had prior experience in providing care for younger individuals, individuals with forensic issues, as well as individuals with developmental disabilities. The monitoring team was informed that SGSSLC would continue to provide services for minors. In summary, this provision was found to be in noncompliance because of (a) the absence of a qualified psychiatrist for those individuals admitted who were under 14, and (b) appropriate consultation/supervision for the psychiatrist treating those who were 14-17 years olds. Please also see the discussion in J5 below.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per staff interviews with the two psychiatrists, nurse practitioner, and the psychiatry assistant, it was reported the individuals receiving psychotropic medication were being scheduled to receive quarterly psychiatric examinations, interim evaluations as clinically necessary, and comprehensive psychiatric assessment as outlined in Appendix B. The lead psychiatrist and psychiatry assistant were in the process of establishing a clinic schedule and implementation of a policy and procedure for the psychiatric clinic at SGSSLC. Documentation in the medical record per the psychiatric practitioners improved since the last monitoring review. The psychiatry assistant informed the monitoring team that eight comprehensive psychiatric assessments have been completed as described in Appendix B. At the last onsite review, there was only one assessment completed however, this represented a continued deficiency since only 4% of individuals who were prescribed psychotropic medication had received a comprehensive psychiatric examination as described in Appendix B.	Noncompliance

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		Below are examples summarizing areas of the evaluation that either met the standard of care or required further review. <u>Individual #239</u> Individual #239 was admitted to the facility when she was younger than 18 years of age secondary to a commitment to "attend competency restoration classes." • This individual was charged with aggravated assault and had an Axis I diagnosis of Pervasive Developmental Disorder, however, the target symptoms that were being monitored included "auditory hallucinations." This information was outlined in the psychiatric quarterly review dated 3/21/11. At the time of the quarterly review, the team was not ruling out or considering a diagnosis that was consistent with presenting symptomatology being monitored (i.e., psychotic disorder). Axis III indicated the individual had a seizure disorder. Medications included intra-class polypharmacy (e.g., two antipsychotic medications) for an individual with Pervasive Developmental Disorder. Additionally, this individual received numerous emergency administrations of an antipsychotic medication for agitation on 12/8/10 (e.g., Geodon), 12/13/10, 12/17/10, 12/31/10, 1/17/11, 2/13/11, 3/7/11, and 3/21/11 (e.g., Thorazine) that altered her mental status exam with resultant sedation. • This practice pattern did not meet generally accepted professional standards of care since psychotic symptomatology was not appropriate to justify a diagnosis of PDD according to DSM-IV-TR criteria in a clinically justifiable manner. If assessment and diagnosis were not appropriately determined then evidence-based selection of medication regimen would not be accurately selected. • This individual would not become competent to proceed to stand trial if target symptoms were not appropriately addressed and if medication regimen resulted in the individual experiencing altered mental status such as sedation. The individual must have sufficient present ability to consult with their lawyer with a reasonable degree of rational understanding or a rational, as well as factual, understanding of the proceedings. Thus, this young individual may remain incompetent to stand trial and/or be subjected to a more restrictive setting due to inadequate integrated care delivered per the PST. • On a positive note, the psychiatrist documented that the MOSES and DISCUS were obtained in regards to monitoring of side effects; this will be further outlined in provision J12. The facility psychiatrist also included documentation that the individual was scheduled to have a neurology consult follow-up and summarized the normal findings of the EEG and the MRI of the brain. The coordination of care between the neurologist and psychiatrist will be reviewed in provision J15.	

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		Individual #233 Individual #233 had numerous summaries per psychiatry in the integrated progress note (5/10/11), psychiatric evaluation/consultation interim report (4/26/11), and quarterly review transcribed 2/2/11 (date dictated not noted). Axis I diagnosis included "Organic Brain Syndrome Due to HIV" in addition to "Bipolar Disorder with Mood Swings, Anger, Agitation." Organic Brain Syndrome is not a diagnosis listed in the DSM-IV-TR. The psychiatrist must establish if the individual's presenting symptoms were reflective of a disorder secondary to a general medical condition and/or superimposed on a Bipolar Disorder. This individual noted that some of her medications made "her dizzy." • Treatment plan had limited instruction: "We will continue with current medications and see her back in one month." There was no direction provided to the PST to rule out possible drug-drug interactions for this individual who received a polypharmacy regimen inclusive of a benzodiazepine (e.g., Ativan), anti-depressant medication (e.g., Celexa), and an anti-psychotic medication (e.g., Seroquel). • The medication regimen was further complicated due to the individual receiving numerous medications for her medical condition. The consultation did not consistently outline a medical section, such as review of orthostatic vital signs, EKG findings, or laboratory information for this individual who complained of dizziness and had HIV. • The target symptoms applicable to the diagnosis were not identified to determine medication efficacy. • There was not consideration to simplify medication regimen such as utilization of an antidepressant agent to target documented features of anxiety. Anxiety Disorder was not a formal diagnosis listed on Axis I for this individual. The pervasive practice pattern at SGSSLC was prescription of long-term utilization of benzodiazepines. These drugs may impair memory, other cognitive functions, and affect motor skills for impacting individuals who already have intellectual or motoric disabilities. Adverse effects of benzodiazepines may include dis-inhibition, sedation, aggressiveness, irritability, and subjection to abuse and dependence. Withdrawal symptoms may also occur inclusive of seizures, insomnia, tremor, and anxiety. It is hoped that, since the facility recruited a new full time lead psychiatrist, 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.	

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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.	During this review, an interview was held with the director of psychology. He informed the monitoring team that psychology and the lead psychiatrist had begun to address provisions as outlined in the Settlement Agreement. The departments were working together to incorporate psychiatry into the treatment team meetings and had designed a proposal for psychology to provide pertinent data to the psychiatrist prior to the psychiatric clinic. The facility was in the beginning stages of developing an integrated diagnostic and treatment planning system regarding the psychiatric care of the individuals at SGSSLC. While all individuals prescribed medication had diagnosis noted in the record, there were concerns regarding the justification and case formulation for specific diagnosis, and documentation of the clinical review of psychotropic medications by the psychiatric staff. Below is an example summarizing areas of the evaluation that either met the standard of care or required further attention. <u>Individual #99</u> Individual #99 received a comprehensive psychiatric evaluation on date of admission. She was a 14 year old admitted to SGSSLC on a commitment to determine if she "was fit to proceed and her commitment" was "not to exceed 90 days." • Individual #99 was admitted on a polypharmacy regimen consisting of three medications. Since the psychiatrist concluded that this individual had no diagnosis on Axis I, the psychiatrist appropriately initiated a "slow taper study." It was summarized that this individual experienced an anoxic event during delivery and her mother took numerous medications during the pregnancy (e.g., Xanax, Prozac, Inderal, and Flexeril). • The individual also experienced a high fever in 2008. Records provided did not reveal any consultation with a neurologist or ordering of a neuroimaging study such as an MRI of the brain. MRI would be an imaging modality obtained for those individuals who may have experienced a hypoxic-ischemic encephalopathic event to determine pattern of injury (i.e., injury to the deep gray matter of the brain, brainstem, basal ganglia). This individual's case formulation would be an example of the need to rule out a neuropsychiatric diagnosis, such as a mood disorder secondary to a general medical condition for an individual with a noted anoxic event during delivery. Family history was obtained per psychiatry that supported family history of mental illness and this section was well documented. • The care of Individual #99 was then transferred to another psychiatrist due to a change in staffing. Per interim review 4/11/11, the psychiatrist summarized that the individual experienced a medication induced mood variation with the	Noncompliance

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		addition of antidepressant medication, therefore, the medication was appropriately discontinued. Unfortunately, recommendations included numerous medication changes at one time that did not allow for adequate tracking of target symptoms. For example, if the addition of the antidepressant medication, Lexapro, resulted in the increase in mood swings, then the taper to discontinuation of the Lexapro should have resulted in improvement of the individual's mental status. Instead, the psychiatrist also elected to increase the antipsychotic Seroquel and the Lithium at the same time that the Lexapro was tapered. The individual experienced an increase in "the tremor that she had before" that was "probably due to the increase" in the Lithium. • This individual was given a diagnosis of Bipolar Disorder without consideration of involvement of a medical etiology to the presenting symptoms. Recommendations again did not outline detailed description of target symptoms to be monitored by the team to determine medication efficacy. There was no indication that psychotropic medication was being prescribed as a punishment at SGSSLC. Review of the list of emergency psychotropic medications utilized at the facility 11/20/10-3/31/11 revealed there were 76 instances of "Emergency Psychotropic Medication" (intramuscular or oral medication) for aggression towards staff and/or peer(s), property destruction, agitation, and self-injurious behavior. In order to reduce the practice pattern of resorting to emergency psychotropic medication, it is essential for collaboration to occur between psychology and psychiatry in the joint determination of target symptoms, and the descriptors or definitions of the target symptoms, consistency within the case formulation, as well as the use of the objective rating scales normed for the developmentally disabled population. This will allow the team to generate a hypothesis regarding the behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. For example, Individual #186's social history and evaluation date (of update) 9/24/2009 noted this individual had "Malta fever." Additionally, at the age of 5 years, individual #186 hit her head on a concrete floor, had a seizure, and was hospitalized for 15 days. It was noted that the "behavior problems either began or became worse following the head injury. These included "restlessness, disobedience, running away, low frustration tolerance, uninhibited sexuality, tendency to be promiscuous, poor judgment, and verbal/physical aggression." Past abuse history summarized her family member "locked her in her room or tied her to a chair," and "seven unknown males sexually abused her." In March 1999, she was in jail for 29 days for allegedly sexually assaulting a 17- year- old female at school. On 6/12/00, she was admitted to North Texas State Hospital-Vernon Multiple Disabilities Program on a Section 5 for the charge of Aggravated Sexual Assault	

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		of a child and injury to a child. On 2/25/02, she was found "incompetent to stand trial with no probability to attain, mentally retarded, a risk to self/others." • Chemical restraint was given to Individual #186 on 3/30/11 "due to extreme aggression," yet a psychiatrist was not in attendance for the team meeting as reflected per the PST signature sheet. PSP Addendum 4/1/11 was held for this individual receiving another chemical restraint secondary to extreme agitation on 3/31/11, yet there was no psychiatric practitioner's signature indicating participation by psychiatry. • Personal Support Team signature sheet dated 4/4/11 did not include the signature of a psychiatrist. The meeting was held to plan a transfer to a different home for this individual who was injured by other individuals living in the home setting. PSP Addendum summary noted that the PST met to discuss this individual who received a chemical restraint "due to extreme agitation" on 4/2/11. Addendum summation noted "behaviors have continued for the previous 2 hours and the reason for the behaviors" (i.e., attacking staff and peers by pulling hair, hitting, and kicking) was unknown. There were numerous examples of chemical restraints being administered and psychiatry not being present for the PSP meeting including, but not limited to, a 3/28/11 meeting for the 3/25/11 administration of chemical restraint due to "extreme aggression." • Behavior Support Committee dated 2/23/11 did not include the signature of a psychiatrist, however, there were two signatures that were not legible. It would be helpful to list the discipline represented next to the signature. Psychiatry must be involved in directing the team, especially for those individuals who have received restrictive intervention.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment 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 pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical	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, the monitoring team received "no data to present." In another document request, information regarding the use of restraints for medical or dental clinic at the facility was provided for the past six months (10/10-3/11). A review of the data revealed that since 10/10, there were 48 incidents of restraint for medical/dental procedures. This number of restraint episodes occurred for a total of 26 individuals, with seven of the restraint episodes documented as occurring during dental clinic. The monitoring team reviewed this provision with the lead psychiatrist and also had a separate meeting with the chief psychologist who both explained to the monitoring team that the two departments were working together to coordinate the development of a desensitization plan if clinically indicated. As of 4/06/11, per POI, a new pretreatment sedation notification form was noted to be "on hold" until clarification was received from unified record coordinator. This form would allow for communication and documentation between disciplines for those individuals who require pretreatment	Noncompliance

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	services, and shall be monitored and assessed, including for side effects.	sedation. Interestingly, a review of the listing of all individuals requiring restraints of any type for either medical or dental clinic revealed that of the 26 individuals, 88% were also receiving psychotropic medication management. Most notably, seven individuals who received pretreatment sedation were also prescribed a routine dosage of benzodiazepines. These included Individual #18, Individual #116, Individual #128, Individual #130, Individual #236, and Individual #198. Individuals who were routinely prescribed benzodiazepines (41 individuals per document review) were subjected to potential drug-drug interactions when they received similar medications for medical or dental procedures. For example, Individual #18 was prescribed the benzodiazepine Clonazepam up to 1.25 mg/day since the year 2000. This individual also received three administrations of a benzodiazepine for pretreatment sedation, Ativan (2 mg), on 10/14/10, 2/22/11, and 3/4/11. Per record review, physician's orders dated 10/14/10 noted, "start Klonopin 0.75 mg po q bedtime for agitation and aggression" per nurse practitioner. This individual also received the pretreatment sedation of Ativan on same date (10/14/10). A note was prepared by the psychiatric practitioner on 10/14/10 noting "we are hoping that more Klonopin might improve his situation even more-whether it is affecting akathisia or anxiety or something else…will follow-up with team in a month if not sooner." The pretreatment sedation was not addressed in the psychiatric practitioner's documentation dated 10/14/10. The team did not know what this medication was targeting specifically and, per documentation, the team was not aware this individual was also going to be administered a separate and additional dose of a benzodiazepine in addition to the increased benzodiazepine prescribed by psychiatry. Improved documentation as per the 2/24/11 "Psychoactive Medication Review Quarterly" was illustrated per the APRN. There was notation in this document that Individual #18 had received Ativan 2 mg IM for "foot clinic." The BSP dated 2/09/11 noted to begin desensitization program with an objective to "receive dental care without becoming overly upset and without having to receive sedation for the procedure." He had a dental desensitization plan dated 1/7/11. Documentation since the last onsite review had improved. For example, for Individual #186, there was documentation in the PSP dated 7/27/10 that there was no pretreatment sedation, restraint, and desensitization strategies needed at this time. A request to review medical and dental desensitization plans revealed that the facility did not employ medical desensitization plans. Last review, the monitoring team noted	

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		that the facility dental director, the dental clinic staff, and the dental hygienist had developed a list of individuals whom the dental clinic proposed as being in need of a desensitization plan. There was a total of five completed desensitization plans at SGSSLC. These included plans for Individual #7, Individual #217, Individual #130, Individual #198, and Individual #18. With regard to the inclusion of the treating psychiatrist in the informational loop for pretreatment sedation for dental clinic, the monitoring team suggested pertinent information to be provided to the psychiatrist to review for any potential contraindications and interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. Medications utilized for pretreatment sedation could result in a mental status change, unwanted challenging behaviors or sedation that could be mistaken as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen (e.g., disinhibiting effect of benzodiazepines, such as Ativan). Additionally, an individual administered pretreatment sedation superimposed on a polypharmacy psychotropic regimen, may experience alteration of their vital signs, increased lethargy, respiratory depression, and lowering of the seizure threshold, among other medical complications. With such a great percentage (88%) of the individuals who required pretreatment sedation also being prescribed psychotropic medications, communication and documentation regarding the utilization of pretreatment sedation is of utmost importance. In future monitoring reviews, the extent of pretreatment sedation will be further reviewed because the facility was in the beginning phase of implementing the new pretreatment sedation notification system at the time of this onsite review.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The psychiatry assistant informed the monitoring team 196 individuals (80% of the census) received psychiatric services at SGSSLC as of 5/23/11. The lead psychiatrist provided an overview of the psychiatric coverage. The two psychiatrists were available Monday-Friday from 9-5. The nurse practitioner was available Tuesday-Thursday. The nurse practitioner was under the supervision of the facility psychiatric physicians as a physician extender. After hours, a psychiatrist was available via telephone consultation. Individuals receiving psychotropic medications were reviewed by psychiatric practitioners a minimum of quarterly. Individuals were reportedly seen more frequently if they were experiencing increased psychiatric symptoms or behavioral challenges.	Noncompliance

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		The monitoring team was informed there had been discussions with a child and adolescent psychiatrist to obtain "contract of services" because SGSSLC would continue to provide services for minors. 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 psychiatric practitioners were necessary to ensure the provision of services. If the caseload were evenly distributed, each psychiatric practitioner would be assigned to 65 individuals; that would be a sufficient number of FTEs to manage the care for this number of individuals for routine assessment and medication management in collaboration with the primary care physician and PST. Now that the lead psychiatrist had been hired, work-load indicators need to be developed to determine optimal staffing, taking into account not only clinical responsibility, but also documentation of clinical care, and required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency PSP, supervision of the physician extender, call responsibility). In order to ensure the provision of services for the younger individuals at SGSSLC the facility must secure the services of a board certified or board eligible child and adolescent psychiatrist. Further, due to court orders involving forensic assessment and intervention, mandated by the judicial system, a board eligible or board certified forensic child psychiatrist would be best suited to meet the needs of these individuals.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The monitoring team was given a policy/procedure named "Psychiatry Clinic Process" prepared by the psychiatric assistant, dated 4/07/11, that did not yet have an approval date. The purpose of the procedure was to establish standards for documentation and organization of the psychiatric clinic. Required documentation included a psychologist report, nurse report, and QMRP report for every psychoactive medication review, quarterly. The psychiatrist will dictate a draft of the quarterly review. The lead psychiatrist arranged for utilization of a dictation service to improve documentation of clinical services delivered per psychiatric practitioners. As outlined in the plan of improvement, updated 5/9/11, the Appendix B document was to be divided into sections and updated by various team members instead of being the sole responsibility of the psychiatric practitioners. This process was new as the Appendix B annual schedule (e.g., outlining when evaluations were to be completed) was sent to the psychologist, psychological assistants, and nurses, along with a "rollout" plan. Improved documentation was reflected in the initial psychiatric evaluation of Individual #166. This individual was evaluated initially 2/9/11 with interim reports dated 3/1/11,	Noncompliance

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		3/15/11, and 4/12/11, clearly an improvement in documentation since the last onsite review. The initial psychiatric evaluation was inclusive of the majority of categories described in Appendix B, inclusive of identifying information, history of present illness, family history, substance use history, past medical history, social history, lab evaluation, psychiatric history, diagnosis inclusive of Axis I, II, III, IV, and V, and case formulation. There was not, however, a detailed discussion in the treatment plan outlining each medication selected with the necessary target symptoms associated with the individual's psychiatric diagnosis to be monitored by the team in order to determine medication efficacy. This issue was reviewed onsite with the lead psychiatrist (i.e., that it was a frequent occurrence that the psychiatric diagnosis of record was not supported with psychiatric symptomatology, but rather highlighted aberrant behavioral presentation of the individual such as aggression or self-injurious behavior). The coordination of monitoring presenting symptoms with the PST would be required to reduce the use of psychotropic medications that were not necessary. Another example of improved documentation for an individual recently admitted to SGSSLC was Individual #19. The initial psychiatric assessment addressed the majority of categories included in Appendix B, such as identifying information, past psychiatric history inclusive of substance use, legal history, diagnosis inclusive of Axis I, II, III, IV, and V, and case formulation. Unfortunately, the treatment practice pattern at SGSSLC for this individual and others was of concern due to utilization of long -term benzodiazepines. Here, the benzodiazepine, Lorazepam, was prescribed for "anxiety" according to the physician's orders yet the Axis I diagnosis did not include an anxiety diagnosis. The mental status examination upon admission noted that individual #19 was "very calm." The monitoring team reviewed the physician's orders dated from admission 4/20/11-5/23/11. The psychiatrist noted a different diagnosis than the primary care physician. For example, upon admission, the individual was assigned a diagnosis of polysubstance abuse, however, the psychiatrist did not note an Axis I diagnosis of substance abuse for this individual who has a "history of cocaine dependence." Establishing accurate diagnostics is critical to set the stage for the treatment recommendations. The treatment plan for this individual did not address the need for intervention regarding the substance use history. This individual had a history that portrayed extremely poor judgment resulting in being placed on "46B for burglary of a habitation." Psychiatric practitioners must guide the treatment team in selection of target symptoms to be monitored and attempt to utilize the least restrictive psychotropic regimen possible. This was particularly applicable for this individual with a substance dependence history and prescribed an agent, such as a benzodiazepine, which can be addictive. For example, if an individual was prescribed an antidepressant medication that may be beneficial in targeting symptoms of anxiety, then prescription of the antidepressant would be preferential, over the long term use of a benzodiazepine and an antidepressant. One	

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		medication dosage change at a time would be warranted for the team to gather data after the change in dosage of the one medication (i.e., decreased or increased) to determine the impact on psychiatric symptomatology. Hopefully this type of assessment would occur for Individual #19 and others who received a polypharmacy regimen inclusive of Lorazepam, Mirtazapine, Olanzapine, and Cogentin.	
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, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SGSSLC, only for those who did not have a psychiatric assessment. The Reiss screen was not sufficient to replace a comprehensive psychiatric assessment. 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 24 admissions since 1/1/10. Of these 24, there were six documented as having undergone a Reiss Screen. Unfortunately, the documentation did not include why the screen was not performed for the other 18. In an effort to assist in the data reporting, it was suggested that if a screen was 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 10 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, was not known. Further, there were eight individuals who were recently admitted, not currently prescribed medication, who were not administered a Reiss 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. A different list was provided to the monitoring team dated 5/23/11 to 5/27/11 and listed the names of 21 individuals who were administered the Reiss screen. Some of the individuals listed were new to the facility, yet the monitoring team was unaware of how the rest of these individuals were chosen to receive the screen. Given the need for additional information in order to determine compliance with this provision item, the monitoring team will request preparation of this detailed additional information in one spreadsheet, as outlined in this provision, to be available for next review.	Noncompliance

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		Seven individuals were referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen (Individual #196, Individual #376, Individual #123, Individual #124, Individual #99, Individual #298, and Individual #239). This provision also required that all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner. As summarized in J2, comprehensive psychiatric evaluations were in the beginning stage of being scheduled for the psychiatric practitioners to complete, as was also required by this provision item.	
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.	Due to the recruitment of a lead psychiatrist and the efforts of the lead psychologist to work together to integrate pharmacological treatments with behavioral and other interventions, the facility was designing a system to address this area of service. For example, the psychiatric clinic schedule had been changed to morning clinics to allow the psychiatric practitioners to attend the PSP meetings that were scheduled in the afternoon. There were also opportunities for interaction during psychiatry clinic and a PSP forum. Three clinic observations and the PSP meeting observed during this monitoring review highlighted a base upon which to build integration between the PST members. One area of integration that required attention was regarding the use of data. The monitoring team noted last review that both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the choice of individual target behaviors. This continued to be problematic as outlined in several examples in this report whereby the target symptoms identified were not applicable to the assigned diagnosis. Information presented to the psychiatrist must also 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. The lead psychiatrist informed the monitoring team that he had begun to attend the BSP committee meetings for the review of other interventions through combined assessment and case formulation. This psychiatrist, however, was not necessarily the prescribing psychiatrist for the individuals reviewed. As a result, limited information was provided	Noncompliance

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		to the BSP committee by the psychiatrist. This lack of integration negatively affects the decision making process in regards to diagnostics, indications for utilization of psychotropic medication, and/or recommendations of other less intrusive measures. Perhaps some measures can be put in place to prepare the psychiatrist for the upcoming BSP committee, such as a listing of the individuals to be reviewed, along with each individual's most recent psychiatric note and psychology review. Medication decisions made during clinic observations conducted during this onsite monitoring review were based on a minimum 20 to 30 minute observations/interactions with the individuals as well as the review of information provided during the time of the clinic. In the clinics observed 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, QMRP, direct care staff, home manager, nursing, and the individual) the team spent an adequate amount of time discussing the individual's status. Regrettably consistent throughout the clinics observed, the staff presented information, such as "behaviors were increased" or "bit staff recently," instead of initiating conversation about the psychiatric diagnosis. The psychiatrist and the monitoring team were present during a PSP meeting for individual #312. This was an improvement in attendance by psychiatry since a psychiatrist did not participate in this individual's last PSP. The monitoring team initiated a discussion about the psychiatric diagnosis because the team remained overly focused on aberrant behaviors, such as "verbal/physical aggression, SIB, and inappropriate social behavior." After prompting by the monitoring team, the psychiatrist stated the assigned psychiatric diagnosis was probably not accurate because the individual had not displayed symptoms consistent with the assigned diagnosis. The individual's diagnosis was initially given in 2006. This 28–year-old individual was receiving an antipsychotic medication that subjected her to potential side effects, especially if continued on a long- term basis. In fact, it was noted that she had a "short PR interval" on a previous EKG. Antipsychotic agents may affect the cardiac function and result in arrhythmias and myocardial infarction and, therefore, should be utilized with caution. The psychiatrist had excellent rapport with the individual and the individual remained engaged and receptive to staff feedback. The monitoring team provided positive feedback to the psychiatrist regarding the respectful communication style with the individual. There was no indication observed during the psychiatric clinics that objective	

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		assessment instruments were 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. This issue was discussed with the lead psychologist that informed the monitoring team about the time spent in training the psychology staff regarding the utilization of such scales. The lead psychologist and lead psychiatrist were in agreement regarding addressing these issues together to establish an effective monitoring system at the facility.	
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 symptoms for 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. The collaboration with regard to the identification and definition of target symptoms for monitoring may also serve to decrease the reliance on psychotropic medication. As noted in the POI for section J, the lead psychiatrist had been attending the PBSP meetings and prompted the team to discuss information (on the form), though more work, and time were needed before this became a typical, integrated part of the meeting and discussion. The POI further outlined that the PBSP had had a "fast track" that did not allow for adequate discussion thus the lead psychiatrist's presence was not serving the function intended. Therefore, the psychology department was requested to communicate with the lead psychiatrist prior to the meeting so that he could prepare for a thorough review of a PBSP and would use the new form developed. It was understandable that the lead psychiatrist was working on system issues, that is, to evaluate what would work best for a team approach in determining the least intrusive and most positive interventions to treat the behavioral or psychiatric condition. Ultimately, however, the participation of the individual's actual treating psychiatrist would need to occur in order to meet the generally accepted professional standard of care. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors of focus of the positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications.	Noncompliance

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		It was difficult to discern, from the data reported, the benefits of 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 notation referencing "psychiatric consult" in the section regarding an individual's reason, such as behavior change, or clinical observation." 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. For example, as noted in the record review of Individual #116 (an individual with a diagnosis of schizophrenia), the monitoring of challenging behaviors, such as physical aggression, verbal aggression, property destruction, and self-injurious behaviors were the established target symptoms. Throughout the numerous pages available for review in the BSP, there was limited discussion in regards to the psychotic symptoms that would be of concern. In fact on page 5 of the BSP, it was noted that staff "should not ask her if she is having hallucinations such as hearing or seeing things" or make statements, such as it's "the voices that are telling you to do that aren't they?" Instead staff should be given guidance on how to best assess if the individual has been experiencing symptoms of psychosis. From this example, it appeared that the content at the beginning of the example would be appropriate for the staff to address, such as inquiring if the individual experienced any type of hallucination. The second part of the example was clear that staff should not provide leading questions that would provide inaccurate data. Also, there were no signatures on this document. In the future, it would be helpful for the monitoring team to receive adequate documentation of individuals along with their discipline that have been participating in the various meetings such as the BSPs, and when provided, the signatures must be legible.	
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	A review of the records of individuals at the facility who were prescribed various psychotropic medications did not consistently 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. 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. They were incomplete with regard to the inclusion of specific risks, and did not generally include other alternative treatment strategies. Psychiatric practitioners had reportedly begun instituting either a conversation with the individual or a telephone call to the legally authorized representative regarding medication consent. The risk/benefit and alternatives to medication, however,	Noncompliance

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	medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	continued to be authored and presented to the individuals or their legally authorized representative by psychology staff. Now that the psychiatric practitioners had elected to lead the team to this end (i.e., in order to obtain 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), other systemic issues need to be addressed. For example: • Regarding ADRs: During psychiatric clinics that were observed during this review, the teams began to discuss how several individuals (e.g., Individual #197, and Individual #205) were experiencing what appeared to be adverse reactions to the psychotropic medication prescribed. The team participants, inclusive of the nurse case manager and the psychiatrist, appropriately responded to the individual's needs by altering their medication regimen, but were not confident on how to proceed in reporting these findings. The nurse case manager explained to the monitoring team that an ADR would not be completed for an individual unless it was definitively determined to be due to the medication. The monitoring team explained to the team and also to the CNE (in a separate meeting) that reporting was indicated when an ADR was "suspected." The nurse case manager informed the monitoring team that training on the policy had been provided and did not realize reporting was necessary with suspected ADRs. The monitoring team reviewed the "Adverse Drug Reaction" Policy/Procedure dated 1/27/11. The procedure/reporting section noted, "any staff member who witnesses a suspected adverse reaction will notify the RN/LVN on duty." The monitoring team met with the CNE and recommended further training regarding the reporting of suspected adverse drug reactions. The monitoring team also addressed this issue with the lead psychiatrist for the psychiatric practitioners to attend to possible harmful effects of psychotropic medication and implement the ADR policy/procedure. The deficiency in reporting of ADR's was further outlined in the medical section. • Regarding diagnoses, consent, and side effects: Individual #205's record was reviewed. Consent dated 2/22/11 revealed Invega was indicated for the acute treatment and maintenance treatment of schizophrenia. A description of the potential adverse side effects was limited (i.e., "fever, stiffness, confusion, sweating, and/or fast or uneven heartbeat"). The possible consequences of refusal to consent to the use of this medication stated, "could be worsening of depressive symptoms and anxiety." Yet this individual supposedly received Invega for a psychotic disorder and there was no mention of potential exacerbation of psychosis if the individual refused the medication. Conflicting	

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		information was discovered as the psychiatrist noted the Invega was for "irritability and aggression" that was not consistent with consent (e.g., Invega for schizophrenia). Further, a 5/24/11 note state that the psychiatrist recommended an additional medication Cogentin for "EPS." It was unclear what the diagnosis was for this individual as Impulse Control Disorder was also cited in the medical record. Restraint (chemical and physical) had been recently ordered due to physical aggression towards peers and staff, extreme agitation, and SIB. 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 psychiatric practitioner, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, psychologist, and nurse. It will also require providing the appropriate data regarding the individual's target symptom monitoring to the physician, that these data are presented in a manner useful to the physician, that the clinician reviews 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 being reviewed in the Medication Review Committee. As noted in the POI for this section: medical and pharmacy were e-mailed 4/12/11 "due to questionable data in polypharmacy database. Action plans updated to include monitoring of accuracy of data in new polypharmacy database." An additional pharmacist had contracted with SGSSLC since last monitoring visit and was part of the facility-level review process. Previously, the psychiatric assistant had assumed the responsibility for gathering data regarding polypharmacy and scheduled the meetings of the polypharmacy committee. The first meeting where review of an individual's regimen and discussion of the rationale for polypharmacy was held during the last monitoring review. The monitoring team attended the Medication Review Committee. The meeting time of the committee was changed to allow the monitoring team to review the process, but, unfortunately, the pharmacist was not present due to travel difficulties. While the meeting was well attended and included representatives from pharmacy, psychiatry, and medical, the discussions regarding the recommendations for medication changes were of concern. • Plans of care included two medication changes at one time made by the	Noncompliance

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		psychiatrist. The monitoring team encouraged the psychiatric practitioners to make a concerted effort to make one medication change at a time in order for the team to monitor the efficacy of the new regimen and or dosage adjustment. • The rationale for a particular medication mostly targeted aberrant behaviors and did not outline psychiatric symptomatology of a particular diagnosis. o For example, minutes dated 4/14/11 noted Individual #116 "was screaming and scratching herself inappropriately in her vaginal area. Staff continuously redirected her verbally and physically." This individual was administered Thorazine and fell asleep. The summary did not outline the reason why Thorazine was selected, other than to emphasize the impact of the medication placing the individual to sleep. Other variables were not addressed, such as medical reasons causing these type of symptoms. o Individual #186 "got upset because she didn't receive a package in the mail from her mom. She was physically aggressive to staff, pulling hair, scratching, throwing items at staff…" She was given Thorazine and became calm. Again, the rationale for the administration of a sedating antipsychotic, such as Thorazine was aberrant behaviors associated with an environmental stressor, as opposed to an exacerbation of psychiatric symptomatology. o Individual #239 was also given Thorazine due to "physical aggression toward staff…" There was no summary indicating diagnosis and exacerbation of psychiatric symptomatology, or if these aberrant behaviors were also environmentally mediated. This level of detail was essential for the PST to determine what areas of the BSP needed revision and utilization of less restrictive intervention other than potent sedating antipsychotic medication. Note that during the medication review meeting, there was robust discussion and the group was receptive to feedback from the monitoring team to enhance the quality of information gathered in this forum (e.g., rationale for the utilization of a particular regimen consistent with DSM-IV-TR terminology and evidence-based practice). This bodes well for the likelihood of SGSSLC making progress in achieving this provision item over the next six months. Polypharmacy data provided by the facility for the month of February 2011 revealed that there were 70 individuals receiving polypharmacy as opposed to 41 in November 2010. This increase was not explained. Further, some individuals were administered an unacceptably high number of	

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		medications, such as five to seven psychotropic agents. Further, there was concern that 37% of individuals also received up to four psychotropic medications. February 2011 polypharmacy percentages provided per the facility illustrated the following: • 1% of individuals received up to seven medications (regardless of class); • 1% received up to six medications (regardless of class); • 3% received up to five medications (regardless of class); • 37% received up to four medications (regardless of class); • 50% received up to three medications (regardless of class); • 7% received up to two medications (same class). In typical institutionalized populations, where 30% to 40% of individuals have epilepsy and as many as 70% may have some other medical condition of significance, drug interactions become an increasingly important consideration" (see Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Ninth (9th) Edition Volume II, Chapter 37 Intellectual Disability, 2009). The pervasive practice pattern at SGSSLC was utilization of psychotropic medication inclusive of polypharmacy for behavioral control. Targeting maladaptive behaviors (e.g., aggression and self-injurious behavior) resulted in what appeared to be the over-prescription of psychotropic medication, representing a substantial departure from generally accepted professional standards of care. Further, it was unclear, based on the facility data presented to the monitoring team, if medications were prescribed by psychiatry or neurology. For example, there was an "other" medication section that included 92 individuals, but there was no clarification if this section was inclusive of the AEDs. If not, then the AEDs were not listed in the itemized medication data dated February 2011. It would be helpful to delineate this in future polypharmacy reports. If medications were prescribed by psychiatry, then they must be counted toward polypharmacy. Medications prescribed by other practitioners (neurology, primary care) were to be reviewed by the psychiatrist in a clinical context. For example, if an individual had Bipolar Disorder and also a Seizure Disorder, and the neurologist and psychiatrist both utilized a medication, such as depakote, then this medication has to be included in calculation of polypharmacy data. 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 item, 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. Medications that were not indicated were to be tapered to discontinuation as outlined in	

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		the following: • Individual #381 did not currently receive a polypharmacy regimen. Per record review, the PST successfully tapered her from three psychotropic medications (i.e., Seroquel, Zoloft, and Depakote) prescribed 3/16/10 to monotherapy (i.e., Clozaril) as outlined in the psychiatric evaluation/consultation interim review dated 4/12/11. Clozaril was further reduced due the medication resulting in sedation that resulted in falls. The psychiatrist outlined that the individual appeared to be "functioning about the same on the lower dose of the Clozaril" and summarized that this antipsychotic medication was prescribed for her condition of schizophrenia that included hallucinations. Medical information was also gathered from the nursing staff regarding laboratory data (e.g., absolute neutrophil count) for this individual. This case represented review by psychiatry and the PST that supported the appropriate process of medication being reviewed to determine clinical justification, and medications that were not deemed necessary being tapered to discontinuation. • Individual #243's psychiatric reviews dated 4/4/11, 4/7/11, and 5/10/11 were not as informative as the example immediately above. This individual received polypharmacy inclusive of two antipsychotics (e.g., Thorazine and Haldol), a benzodiazepine (e.g., Clonazepam known as Klonopin), Depakote, and Cogentin. The psychiatrist noted that Klonopin 2 mg bid. was for "anxiety," yet this individual did not have a diagnosis of an anxiety disorder. The 4 mg dosage of Klonopin administered daily was equivalent to 40 mg of Valium. On 4/7/11, the psychiatrist recommended addition of the diagnosis "Bipolar Disorder Mixed With Rapid Cycling" and to discontinue the diagnosis of "Intermittent Explosive Disorder" because the symptoms were better defined by a Bipolar Disorder. Unfortunately, the psychiatric report the following month, dated 5/10/11, did not capture this recommendation and the individual continued to have an Axis I Diagnoses of Intermittent Explosive Disorder and Attention Deficit Disorder. o On 5/10/11, psychiatric documentation noted "she has been functioning much better since recovering from the sedation… We will continue current medications. Will look at taking her off the Haldol once she is stable." There was no formal explanation advising the team of what to monitor to establish each medication's target symptoms to understand when the individual would be "stable." This type of thorough case review, documentation, and monitoring must occur to address if such medications were clinically justified. The elements of the provision have not been met since last review. In order to ensure that the use of psychotropic medications was clinically justified, and that medications that were not clinically justified were eliminated (or were in a plan for elimination), it	

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		was imperative for the psychiatrist, psychologist, primary care physician, nurse, the interdisciplinary team, and other experts as deemed necessary (i.e., neurologist) to identify DSM-IV-TR diagnoses, and target symptoms associated with such diagnosis. In order for the facility to address polypharmacy (i.e., reduce medication burden) one needs to determine the actual target symptoms of the medication (e.g., seizure disorder, major mental illness, or both) and then make the determination if treatment with a medication is warranted.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	There were only seven individuals diagnosed with neuroleptic-induced tardive dyskinesia (TD). All seven individuals diagnosed with TD were enrolled in psychiatry clinic: Individual #127, Individual #379, Individual #288, Individual #128, Individual #118, Individual #109, and Individual #119. Additionally, there were a total of four individuals assigned a diagnosis of "subacute dyskinesia due to drugs" listed on Axis III. These individuals included Individual #40, Individual #367, Individual #128, and Individual #109. There was lack of documentation for diagnostic consistency of TD, per record review. • For example, Individual #288 had a long-term history of Tardive Dyskinesia as outlined per past psychiatric progress record dated 9/27/07. He had "pouting movements of his lips, his mouth opens and closes…consistently of tardive dyskinesia." He was prescribed numerous neuroleptics in his past and, in 2007, Zyprexa was initiated for SIB." Unfortunately, other documents did not reflect that this individual suffered from symptoms consistent with tardive dyskinesia. In the PSP dated 6/24/10, an Axis I diagnosis of Autistic Disorder was included, but nothing about TD. The PST signature sheet did not show participation by psychiatry. Further, the potential medication side effects in the BSP were generic and the identical medication list used in Individual #288's record was used in other individuals' records. Further, the physical examination dated 10/18/10 did not list TD as an Axis I disorder. His DISCUS was dated 4/11/11, was signed by psychiatrist, and included the conclusion of questionable persistent TD, with a score of 2 (grimaces) and comments noting "could be" TD or other problem. He is on no neuroleptics. This individual also received AED medications that may also suppress abnormal motor movements. The psychiatrist also signed MOSES dated 4/11/11 and noted "does have grimacing." This individual was noted to be agitated, irritable, withdrawn, had gait instability, diarrhea, and increased thirst. "No action necessary" was checked per psychiatrist.	Noncompliance

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		Individuals with TD may also experience akathetic type presentation that can lead to restlessness at all hours. Individual #288 experienced chronic insomnia as noted per record review. Additionally, there was no collaboration with neurology regarding TD diagnostics because the focus of the neurology consultation for this individual was his seizure disorder. Adjustment to AED regimen has been known to exacerbate an individual's abnormal motor movements possibly leading to further agitation and restlessness. This was an example of lack of team coordination in addressing this individual's condition consistent with TD. Certain medications (e.g., Zyprexa) can suppress the symptoms of TD and, therefore, can result in a lowered DISCUS score. This does not equate with the individual no longer having Tardive Dyskinesia. The psychiatrist, physician, or other specialist, such as a neurologist, must evaluate each individual receiving psychotropic medication and apply all relevant clinical information for the determination of accurate diagnostics, intervention, and monitoring of side effects. Tardive Dyskinesia, a movement disorder characterized by frequent, repetitive, involuntary movements of the lip, tongue, jaw, face, trunk, and/or limbs is one of the most notorious side effects of antipsychotic medications. Additionally, medication utilized to target the gastrointestinal system, such as metoclopramide (i.e., Reglan) poses an increased risk for development of movement disorders. There were no individuals receiving Reglan according to the February 2011 itemized medication chart. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements, such that the reduction or absence of the medication that occurred during a taper or discontinuation would result in increased restlessness and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. There may be various symptoms of TD inclusive of, but not limited to, akathisia, choreoathetosis, tics, and blepharospasms. Individuals may experience akathisia whether secondary to a medication increase, due to tardive akathisia, or secondary to an individual refusing and not receiving his or her medication. In some cases, these individuals have been known to exhibit aggressive behavior because they have a subjective sense of psychomotor restlessness and experience abnormal involuntary motor movements that would not be halted with behavioral interventions. The review of a sample of records revealed documentation that the Monitoring of Side	

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		Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) were 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, however, unfortunately revealed a delay in the review of these results by the psychiatric practitioner. For example, the psychiatric practitioner often did not actually review the MOSES or DISCUS until the psychiatric clinic was conducted. The monitoring team expressed concern that if the MOSES or DISCUS revealed side effects associated with the psychotropic medication as outlined in the screen, then the psychiatric practitioner must immediately review and address the clinical findings. Monitoring, detecting, reporting, and responding to side effects of prescribed medication is the generally accepted professional standard of care. In an effort to address the need for review and 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. Individual #197's Quarterly Drug Regimen Review dated 4/6/11 signed by the pharmacist reviewer, home physician, and staff/consulting psychiatrist noted there were "DRRs missing from 7/10 forward." This review also highlighted that there was no DISCUS for 1/11, yet there was a "MOSES-OK." The DRR also questioned whether the individual had EPS, since the individual was prescribed Benztropine. The monitoring team reviewed DISCUS (score=zero) dated 4/12/11 for this individual who had a conclusion "No TD." The monitoring team also reviewed the physician's orders and on 2/8/11 it was noted "Cogentin 1mg BID PO for EPS." It was imperative that this individual received routine DISCUS examinations secondary to receiving a neuroleptic medication, in addition to actually experiencing side effects (i.e., EPS). The list of individuals prescribed anticholinergics, such as Benztropine (two in total), dated 4/4/11, did not include this individual. It is important to pay attention to those individuals who were prescribed anticholinergics, such as Benztropine (i.e., Cogentin) for abnormal motor movements because Tardive Dyskinesia is the late expression of this spectrum of motoric disorders (i.e., EPS).	
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	This provision summarized expectations to be met and delivered by psychiatry in regard to every individual receiving psychotropic medication. The delivery of care was to be outlined as part of the documented services designed for the individual per the personal support plan (PSP): 1. To ensure that the treatment plan for the psychotropic medication identified a clinically justifiable diagnosis or a specific behavioral-pharmacologic hypothesis. • This required validity of the diagnosis supported by psychiatric symptomatology and/or behaviors that resulted in the selected	Noncompliance

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	medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	psychiatric diagnosis. 2. Expected timeline for the therapeutic effects of the medication to occur. • The generally accepted professional standard of care requires the implementation of evidence-based psychiatry that includes (a) the review of research evidence to be applied (b) in concert with the clinical expertise with (c) consideration for the values of the individual for selection of the treatment regimen. 3. Objective psychiatric symptoms or behavioral characteristics monitored to assess the treatment's efficacy, specifically by whom, when, and how this monitoring will occur. • Components of evidence-based psychiatric practice include identification of treatment goals, measures, and methods utilized, including the expected time frame for improvement. 4. Provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly. At the time of the onsite monitoring review, the facility psychiatrists were reportedly participating minimally in PSP activities. There was a recent change in the psychiatry clinic schedule arranged by the lead psychiatrist to allow the psychiatric practitioners to attend the team meetings. The facility psychiatrists were participating in some of the PSP activities. The documentation of the case formulation, diagnostic impression, and psychiatric treatment planning varied across disciplines in records reviewed. The information including, but not limited to, the case formulation and approach to applied treatment were not (perhaps yet?) reflective of evidence-based practice and, thus, insufficient to meet the requirements of this provision item. This monitoring review was additionally complicated by the lack of, and/or minimal, psychiatric documentation in the records. One reason for lack of documentation was the result of a problems encountered with a dictation service as reported by the lead psychiatrist. The psychiatry assistant informed the monitoring team there were only eight individuals whose initial psychiatric evaluation had been completed according to the requirements of Appendix B. Second, one of the psychiatric practitioners resigned since last monitoring visit and there was a new psychiatric staff hired who recently underwent staff training and was just becoming acquainted with the individuals that were assigned. 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. Similarly, the lead psychiatrist also underwent mandatory staff training and was attending to system issues in an effort to	

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		design enhanced psychiatric services at SGSSLC and collaboration with other departments. During the review, it was discussed with members of both the psychiatry and psychology staff that integration of their departments was a basic requirement in order to meet this provision. The lead psychiatrist and director of psychology were receptive and enthusiastic to assist each other. As noted during past monitoring review, the facility had recruited a new director of psychology who was experienced and interested in bringing cohesion to the two historically divergent departments (at SGSSLC). The goal is for all individuals receiving psychotropic medication to have: • 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 for each one of the prescribed medication to determine the efficacy of the medication. Dosage adjustments should be done thoughtfully, one medication at a time, unless otherwise medically indicated (e.g., because of a discovered side effect, adverse drug reaction). Based on the 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. There should be an adequate time period allowed for the medication to reach a steady state, monitor vital signs, weight, medication levels and laboratory data, and to assess whether the individual tolerated the change in medication. This practice pattern was not found at SGSSLC. The monitoring team learned that the plan was to make multiple medication changes concurrently. This made it impossible for the prescribing psychiatric practitioner to determine what medication, if any, had a positive or negative response with respect to the individual's symptoms. As previously summarized in J6, treatment practice pattern per psychiatric practitioners was of concern to the monitoring team due to utilization of long -term benzodiazepine for numerous individuals. In addition, the individual's diagnoses were determined with minimal supporting documentation of a case formulation or justification for a particular diagnosis. In the examples provided during the onsite review, due to the focus of treatment being aggressive behaviors towards self and others, the monitoring team recommended DSM-IV-TR psychiatric disorders be the primary indication for psychotropic medication. Medications for individuals exhibiting acute or chronic aggression are a controversial intervention for individuals with developmental disability. Further, medication efficacy	

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		may be different for those individuals with predatory aggression versus aggressive symptomatology associated with a dysphoric presentation or in combination with disruptive behaviors. The following example was illustrative of the practice at SGSSLC: Individual #247 was an individual receiving a polypharmacy regimen inclusive of a benzodiazepine, Ativan. This individual was recently prescribed Prolixin, in addition to starting Buspar, and continuing Seroquel at a high dose of 800 mg/day. • As noted per the psychiatrist dated 3/09/11, over the past month, the team had been trying to decrease the level of anxiety and panic. "We have had some success with this by adding Prolixin 5 mg b.i.d., starting Buspar and increasing it up to 10 mg t.i.d., adding Ativan 1 mg t.i.d., and have been continuing the Seroquel 800 mg at h.s." • On a positive note, on 3/9/11 the recommendation was for "one change on the Seroquel down to 700 mg and see him back in two weeks for follow-up." Unfortunately, there was no instruction to the team as to why the medication was selected (i.e., Prolixin in addition to Seroquel) and the target symptoms were not summarized for each medication prescribed in order for the team to monitor. This individual had a noted Axis I Diagnoses of Intermittent Explosive Disorder and Panic Disorder Without Agoraphobia. • Eight days later on 3/17/11, an entry in the integrated progress note was made by psychiatry. Another psychotropic medication, Lexapro, was added to Individual #247's regimen "for depression." He had just returned from a home visit and informed staff that "his mother thought he was acting depressed." The follow-up psychiatric documentation per psychiatry on 3/30/11 did not reflect a diagnosis of depression for which the antidepressant was prescribed. The diagnosis remained Impulse Control Disorder and Panic Disorder. Listed under the psychoactive medication section, Prolixin was "for aggressive behavior," however, there was nothing listed justifying the high dosage of Seroquel. Lexapro was "for depression," but without a formal diagnosis, and the Buspar and Ativan were for "anxiety." Treatment plan also noted "continue with the current medication with a decrease in the Seroquel at h.s., and we will follow the patient to see if he is able to maintain stability."	
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	In response to the monitoring team's document request regarding a listing of facility-wide policy and procedures, the facility provided a policy, dated 5/10/02, entitled "Informed Consent: Explanation, Education, and Due Process." Per this document, "basic elements of information necessary to informed consent, and ongoing counseling with the patient regarding his or her care, must be provided by the treating physician or…designee." The policy further stated that the "home psychologist will submit the	Noncompliance

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	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.	consent to the…social worker to obtain guardian approval if there is a guardian." There was also a flow sheet attached, which designated the staff who would be appropriate participants in the explanation and education regarding psychotropic medications. Surprisingly, psychiatry was not indicated as having responsibility or required participation in this process**.** The 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. The lead psychiatrist informed the monitoring team that the consent policy/procedure had not been updated to reflect the change that had occurred at SGSSLC. The psychiatric practitioners were aware of the need for them to actively perform the informed consent discussion with both individuals and their legally authorized representative. The monitoring team reviewed "Consent Explanation and Consent for Use of Psychoactive Medications" for Individual #254, Individual #194, Individual #148, Individual #243, Individual #331, Individual #142, Individual #99, and Individual #159. Of these eight individuals, only one had the signature of a psychiatrist on the consent form (Individual #99). • Individual #99's consent dated 3/28/11 noted Seroquel "has been prescribed for you." The explanation then noted various diagnoses, but did not specify the actual diagnosis of the individual. For example, the consent noted Seroquel was used to treat the symptoms of "psychotic conditions such as schizophrenia and mania associated with bipolar disorder." This type of language did not, however, specifically target the specific diagnosis for the individual. The explanation of the psychoactive medication selected should coincide with listing of relevant psychiatric target symptoms that the individual has displayed that align with the DSM-IV-TR diagnosis. The potential adverse or side effects documented incomplete risks for treatment with this medication. Many pertinent side effects, including, but not limited to, metabolic syndrome, increase in lipids, neuroleptic malignant syndrome, orthostatic hypotension, and tardive dyskinesia were not included. "Inquiries concerning use of proposed psychoactive medication and answer in response" did not have anything listed in that section. 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	

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		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. The monitoring team recognizes 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. Per POI the response for this section was "pending state office policy." The monitoring team reviewed documentation and interviewed the psychiatric staff regarding the consent process implemented at SGSSLC for the use of psychoactive medications.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The medical director informed the monitoring team that individuals requiring neurological consultation were evaluated by neurology in the community setting. The medical director stated that the community neurologist knew many of the individuals because he had provided neurology care for them for many years. The individuals were not under the care of an epileptologist, as the medical director stated the closest expert resided in San Antonio. SGSSLC did not have onsite neurology consultation at the time of this monitoring visit. The psychiatric assistant developed a list of individuals who had a seizure disorder who were also enrolled in psychiatry clinic per monitoring team's request onsite. The list included 74 individuals; therefore, 38% of the individuals enrolled in psychiatric clinic also required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. Individual #359 illustrated good collaborative effort between neurology and psychiatry to determine the diagnostic spectrum and proposed treatment. The community neurologist noted on 8/20/10 that Individual #359 previously received numerous psychotropic medications, inclusive of Lamictal, Inderal, and Abilify, that were successfully tapered to discontinuation. Cymbalta was also prescribed at the time of the neurology consultation. The individual had an abnormal EEG that suggested a "seizure focus in the right frontal-central area," however, did not have any observed seizure activity at SGSSLC. The neurologist clarified that this individual had migraine headaches that sometimes can lead to paroxysmal abnormalities of EEG. There was "no need to	Noncompliance

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		consider seizure medication unless she has an actual verified clinical seizure." Neurology recommended symptomatic treatment for the "occasional migraine headaches." The coordination between neurology, medical, and psychiatry, supported the simplification of agents such as Lamictal, an AED medication, and Inderal (Inderal may have been prescribed to target migraine headaches). The word simplification can capture a reduction of medication and/or actual discontinuation of a medication. The goal is always the least amount of medication to achieve the optimum efficacy. Individual #385 had improved documentation in the psychiatric medication quarterly review. The psychiatrist summarized psychiatric history and diagnoses. The current status of treatment listed that Individual #385 received "400 mg" of Klonopin (apparently a typographical error). The monitoring team recommends the psychiatrist to list all of the current medications together along with dosage. The psychiatrist did not list Vimpat (an AED), with the list of current medications until the next paragraph, therefore, it was difficult to interpret the present regimen. This individual received numerous medications, yet had only an Axis I Diagnosis of PDD, "Criteria Established by History." There was no consideration for other diagnostics, such as an Axis I disorder secondary to a general medical condition for this individual with refractory epilepsy. The psychiatrist's treatment plan did not direct the team regarding monitoring of symptoms to determine medication efficacy. For a neuropsychiatric medical condition, the team must monitor frequency and severity of seizure activity that may result in mental status changes. Additionally, the team must track AED changes and the impact on psychiatric presentation. The neurologist documented on 4/15/11 that "records from the San Angelo School indicate frequent seizures….about two weeks ago his Vimpat was increased….behavior is reported as being fairly good at present." The neurologist recommended an increase of Lamictal if the serum level was low. The psychiatrist must now direct the team about monitoring the individual's medical and mental health status with the change in regimen as recommended per neurology. Also drug-drug interactions need to be addressed for individuals receiving polypharmacy because they are placed at risk for aspiration and respiratory depression superimposed on their compromised medical condition. Drug-drug interactions can occur with agents prescribed by the psychiatrist affecting drug levels of AEDs and antipsychotics can lower the seizure threshold resulting in more seizure activity. In summary, the common comorbidity of physical illness, such as epilepsy in individuals with intellectual disability may increase the risk of the individual experiencing psychiatric symptoms secondary to a general medical condition. Continuity of care between the psychiatrist and neurologist was warranted for the selection of the medication regimen in order to make thoughtful adjustments to the individual's medication regimen, to educate the PST on pertinent target symptoms to track with the	

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		alteration in regimen, to routinely monitor potential side effects, drug-drug interactions, medication levels, laboratory results, vital signs, and other pertinent medical data as clinically indicated. The psychiatry clinic had not established a neuropsychiatric list to identify such individuals requiring these services from a system perspective until requested by the monitoring team. There had been services provided as summarized, but the level of collaboration between neurology and psychiatry for the use of medications, when they were prescribed to treat both seizures and a mental health disorder, did not meet 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 and the recommended follow-up. This would include the number of individuals requiring neurological consultation who were not also prescribed psychotropic medication. The facility must consider options for expanding neurologic consultation availability. This recommendation does not prohibit the present consultation provided by the neurologist who had diligently addressed the individuals' neurological issues (according to the medical director). This could include exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities, and with an epileptologist for case consultation as clinically indicated.	

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. 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.

6. 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.

7. 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 enrolled in psychiatry clinic.

8. 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 start dates of medication, stop dates of medication, medication adjustments, identified antecedents, and specific stressors identified).

9. 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.

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

11. 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.

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

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

14. Ensure that the indications for specific medications correspond to the purported diagnosis, and that appropriate defined behavioral/symptom data points are being monitored.

15. Individualize the process for Informed Consent.

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

17. Improve timeliness of psychiatric documentation.

18. Explore options to increase the availability of neurology consultation and expand services (e.g., consultation with an epileptologist, as clinically indicated).

19. Obtain clinical consultation with a child and adolescent psychiatrist. This could be performed via telemedicine consultation from another DADS facility where a child and adolescent psychiatrist are available.

20. 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.

21. 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.

22. 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.

23. 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:** Documents Reviewed: o Annual Psychological Assessments for: • Individual #279, Individual #3, Individual #41, Individual #75, Individual #116, Individual #148, Individual #119, Individual #80, Individual #295, Individual #135, Individual #277 o Psychological Assessments for: • Individual #147 (3/4/10), Individual #154 (9/11/95) o Functional Assessments for: • Individual #346 (1/14/11), Individual #29 (1/31/11), Individual #279 1/13/11), Individual #3 2/9/11), Individual #184 (1/11), Individual #26 (2/22/11), Individual #383 (2/22/11), Individual #98 2/22/11) , Individual #373 2/11/11), Individual #255 (2/23/11), Individual #34 (12/09/09), Individual #116 (7/27/07), Individual #292 (2/17/09) o Positive Behavior Support Plans (PBSPs) for: • Individual #346 (12/10/10), Individual #29 (2/4/11), Individual #81 (2/18/11), Individual #279 (1/13/11), Individual #3 (2/11/11), Individual #26 (2/25/11), Individual #383 (2/22/11, Individual #98 (2/22/11), Individual #373 (2/11/11), Individual #255 (2/23/11), Individual #116 (4/7/10), Individual #292 (8/9/10), Individual #239 (12/31/10), Individual #34 (1/24/11), o Safety Plans for: • Individual #292, Individual #346, Individual #239, Individual #116 o Six month progress reviews of Positive Behavior Support Plans (PBSPs) for: • Individual #346, Individual #29, Individual #81, Individual #385, Individual #279, Individual #3, Individual #184 o Psychological Services Treatment Plan and Progress Summary for: • Individual #124, Individual #376, Individual #340, Individual #336, Individual #279, Individual #129, Individual #291, Individual #174, o Class/Therapy Syllabi for: • Anger Management, Adolescent Issues, Boundaries, Bulling, Character Education, Choosing Health-Drug Awareness, Communications, Conflict Resolution, Diagnosis and Medication, Emotions, Empathy/Acceptance, Goal Settings, Human Sexuality, Managing Insomnia, Positive Self-talk, Relationship Skills, Relaxation/Stress Reduction, Self-Assessment, Self-Determination/Self-Advocacy, Self-esteem Class, Sex Offender Treatment Program, Thinking Errors, What's in a Group?, Stress Management, Team Work o Sex Offender Treatment plan for: • Individual #169, Individual #398 o Sex Offender Treatment Program Training, 5/17/11, 5/18/11, 5/19/11

	o Sex Offender Treatment Program Training Handouts, undated o Anger Management pre/post test, 2/11 o Self-Esteem pre/post test, 2/11 o Psychological Services Referral Form, 4/12/11 o List of individuals and psychological services offered at SGSSLC, dated 4/14/11 o San Angelo State Supported Living Center Scan Card, May 2011 o A spreadsheet of all individuals for whom a functional assessment was completed in the last 12 months, undated o A list of all psychology department staff and status of enrollment in BCBA coursework, undated o Positive Behavior Support Committee minutes, 10/13/10, 10/20/10, 10/27/10, 11/03/10, 11/16/10, 12/10/10, 12/08/10, 12/15/10, 12/22/10, 12/29/10, 1/5/11, 1/12/11, 1/26/11, 2/2/11, 2/9/11, 2/16/11, 2/23/11, 3/9/11, 3/16/11, 3/30/11, 4/6/11, 4/13/11 o Psychology Internal Peer Review Committee Meeting (PIPRC) Minutes, 2/1/11, 3/10/11, 3/31/11 o Pre-Review Committee (PRC) minutes, 3/25/11 o Policy and Procedure for Psychology Internal Peer Review Committee (PIPRC), 1/5/11 o Policy and Procedure for Positive Behavior Support Committee, 12/6/10 o Graphs Committee meeting minutes, 4/11/11, 4/25/11, 5/9/11 o Treatment Integrity Committee minutes, 5/2/11 o Reliability Probes data sheet, 9/19/08 <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., Director of Psychology o Neal Pearlman, Associate Psychologist o John Church, Associate Psychologist o Cari Stallings, Associate Psychologist o Lynn Zaruba, Associate Psychologist o Jane Bajaj, Associate Psychologist o Pat Moran, Associate Psychologist o Mike Ennis, Associate Psychologist o Robbie Potter, Psychology Assistant <u>Observations Conducted</u>: o Psychiatry Clinic Rounds: • Staff attending: Dr. Mercer, Psychiatrist; Dana Robertson, Associate Psychologist; Mike Fletcher, QMRP; John Church, Associate Psychologist; Roger Abalos, Home Manager; Elizabeth Love, Psychology Assistant • Individuals Presented: Individual #Individual #243, Individual #215, Individual #233 o Psychology Internal Peer Review Committee • Staff attending: Amber McWilliams, QMRP; Sharon Fagan, RN; Spencer Washington, Associate Psychologist; Pat Moran, Psychologist; Cari Stallings, Associate Psychologist; Jesse Santos, DCP; Jeremy Lay, DCP; Magarita Ramirez, DCP; Irma Rangel, Psychology

	Secretary; Robbie Potter, Psychology Assistant; Jane Bajaj, Associate Psychologist; John Church, Associate Psychologist; Lynn Zaruba, Associate Psychologist; Jim Mercer, Psychiatrist; Jennifer Quisenberry, Psychology Assistant; Arin Garivay, DCP; Erick Ybarra, Associate Psychologist; Vicki Hinojos, Unit Director; Neal Perlman, Associate Psychologist; Robb Weiss, Director of Psychology • Individual Presented: Individual #186 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
	Facility Self-Assessment: SGSSLC's Plan of Improvement (POI) indicated substantial compliance for item K2, and noncompliance for the remaining items 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 self-assessment. 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 track and evaluate 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, continued progress in several areas. These include: • At the time of the onsite review all psychologists that write Positive Behavior Support Plans (PBSPs) were enrolled in coursework for board certified behavior analyst (BCBA) certification. One additional psychologist recently became a board certified behavior analysis (K1) • The development of both internal and external peer review (K3) • Continued improvements in the data collection system (K4) • Improvements in the graphing of data (K4) • Plan for the collection of replacement behaviors (K4) • Increase in the variety of therapies offered (K8) • Improvements in ensuring these therapies were goal directed, with measurable goals and progress towards those goals (K8)

	The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that internal peer review occurs at least weekly, and external peer review monthly (K2) • Implement the planned, simplified data system (K4) • Ensure that data are reliably collected by collecting and tracking objective measures of data reliability (K4, K10) • Ensure that psychological assessments contain all the necessary components (K5) • Add indirect and direct data to functional assessments (K5) • Ensure that all functional assessments have a clear summary of the variable or variables hypothesized to affect target behaviors (K5) • Ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions (K9) • Fully implement the psychological group counseling sessions (K8)

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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 reasonable safety, security, and freedom from undue use of restraint.	Despite meaningful improvements in his provision item, it was rated as being in noncompliance because not all psychologists at SGSSLC were certified as applied behavior analysts. At the time of the onsite review, all 12 psychologists that wrote positive behavior support plans (PBSPs) were enrolled in course work toward becoming board certified behavior analysts (BCBA). One psychologist at SGSSLC was recently certified as a behavior analyst, and the director of psychology was seeking eligibility to sit for the BCBA exam based on training and experience. SGSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
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 continued to be in substantial compliance with this item. The director of psychology had a Psy.D., was licensed in several states and in the state of Texas, and had over 15 years of experience working with individuals with intellectual disabilities. Additionally, at the time of the onsite review, Dr. Weiss was seeking eligibility to sit for the BCBA exam based on training and experience. Finally, under Dr. Weiss' leadership, several initiatives had begun toward the attainment of substantial compliance with many of the other items of this provision.	Substantial Compliance

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K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The facility had revised and added several meetings to achieve substantial compliance with this provision item of the Settlement Agreement. Those meetings, however, were recently introduced and, therefore, at the time of the onsite review, were not yet demonstrated to occur at the intervals required for a rating of substantial compliance. Therefore, this item is rated as being in noncompliance. SGSSLC continued to conduct Behavior Support Plan committee (BSPC) meetings weekly. As discussed in the last report, these meetings primarily reviewed cases that required annual approval of PBSPs or safety plans. On 3/20/11, the facility began Psychology Internal Peer Review Committee (PIPRC) meetings to address the opportunity to present cases that were not progressing as expected. The monitoring team observed a PIPRC meeting and was very impressed with the quality of the discussion, and the sharing of strategies and suggestions to improve the understanding and treatment of the target behaviors of the individual presented. At the time of the onsite review, the facility planned to expand peer review by conducting Psychology External Peer Review Committee (PEPRC) meetings. These meetings were designed to consist of peer review meetings that, at minimum, include other Texas DADS, BCBAs, and supervisors (perhaps by teleconference) that were not directly involved in the development of the facilities PBSPs. Operating procedures for the PIPRC were provided to the monitoring team. Documentation that internal peer review occurs at least weekly and that external peer review occurs at least monthly, along with operating procedures for the PEPRC will need to be established prior to achieving substantial compliance with this provision item.	Noncompliance
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	There were several improvements in this provision item since the last onsite review. In order to achieve substantial compliance, however, the facility needs to implement the planned data system, collect and graph replacement behaviors, add data collection reliability and interobserver agreement (IOA), and ensure that data books (or data sheets) are readily available to direct care professionals (DCPs). At the time of the onsite review the facility was using a data system that included the collection of target behaviors on Scan cards (as described in the last report). Additionally, direct care professionals (DCPs) were required to record antecedents, target behaviors, and consequences (ABC recording) for each target behavior. As was discussed in the last report, the ABC system is not well suited for routine frequency recording. The ABC system, on the other hand, is typically used 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	Noncompliance

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	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.	integrity and confusion from DCPs. Since the last report, the facility had designed a simplified data system. The new system planned to continue to use the Scan cards. The new system, however, will include the collection of replacement behaviors, require data collection in 15 minute intervals, and will eliminate the requirement of the recording of antecedents, target behaviors, and consequences. Additionally, the proposed data system will require DCPs to record a zero or their initials in each recording interval if a target or replacement behavior did not occur. This procedure will ensure that the absence of target behaviors in any given interval does not occur because staff forgot to record the data. This requirement also allows the psychologists to review data sheets and determine if DCPs are recording data at the intervals specified (i.e., data collection reliability). It is recommended that this new data system be implemented as soon as possible. As discussed in the last report, the monitoring team found that the data books (that contained data cards) were not readily available to DCPs. Data books were found in locked rooms, away from the area were the individuals were located, in 10 of 11 homes sampled. Therefore, if target or replacement behaviors occurred in these homes, DCPs would need to go to a locked room to record data every 15 minutes (the new data system has 15 minute data recording intervals). This situation would likely result in unreliable data because staff would need to remember data, because they would not be able to leave their direct responsibilities and consistently record data at that frequently. It is recommended that the facility develop a plan to ensure that DCPs do record data as soon as possible after it occurs. The facility had also reported that they had increased the flexibility of their data system by using both frequency and time sampling data. The monitoring team will review those examples during the next onsite review. As recommended in the last review, SGSSLC had improved the graphing of target behaviors by ensuring that data were graphed in increments necessary to make sufficient data-based decisions. For example Individual #215's target behaviors were graphed in weekly intervals. Additionally, Individual #215's graph included phase lines that clearly indicated when medication changes occurred. When these data were presented in psychiatry rounds (observed by the monitoring team), they allowed the treatment team and the psychiatrist to better understand the effects of past medications on Individual #215's undesired behavior, and make future data-based decisions. There was, however, no evidence of the graphing of replacement data. The monitoring team encountered a few graphs (e.g., Individual #186) that included replacement behaviors on the graph, but they were all at zero levels. It is recommended that SGSSLC consistently collect	

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		replacement behaviors and that they include these behaviors in each individual's graph. These improvements to the data system increase confidence in the reliability of the data collected at the facility. As discussed in the last report, however, the addition of data collection reliability described above (which assesses whether data are recorded), along with interobserver agreement data (which assesses if multiple people agree that a target or replacement behavior occurred) represent the most direct methods for assessing and improving the integrity of collected data. It is recommended that the facility begin to track data collection reliability and interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliably collected. Finally, there was some evidence that Positive Behavior Support Plans (PBSPs) were modified based on the absence of progress. For example Individual #346's progress note for February 2011 indicated that his plan had been modified in December of 2010 due to lack of progress and additional information learned from his functional assessment. Additionally, Individual #29's March 2011 progress note indicated that her PBSP was revised February of 2011 due to absence of progress. Nevertheless, progress of the most severe behavior problems (i.e., physical aggression and SIB) over the last six months indicated that one individual (of the seven progress notes reviewed) had an obvious decrease in severe behavior problems. Clearly the lack of treatment progress in all of these individuals was not likely to be solely the result of an ineffective PBSP. The monitoring team, however, will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. The monitoring team was encouraged by these improvements in the data system at SGSSLC, and looks forward to seeing more progress in this provision item in the next review.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical,	This provision item was rated as being in noncompliance due to the lack of comprehensiveness of the majority of the psychological assessments and functional assessments reviewed. Additionally, not all individuals with a PBSP had a functional assessment. <u>Psychological Assessments</u> A spreadsheet including initial psychological assessments completed, and reports from	Noncompliance

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	psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	facility staff, indicated that all individuals at SGSSLC had initial psychological assessments. Twelve annual psychological assessment updates were reviewed by the monitoring team. • One (Individual #75) of 12 psychological assessments reviewed (8%), was considered complete and included a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral and medical status • The remaining 11 psychological assessment updates reviewed were missing one or more of the following; personal history, assessment of intellectual ability, assessment of adaptive ability, and/or assessment of medical status. Similar results were found in reviews of two full psychological assessments. • One (Individual #147) did not have an assessment or review of medical status, and the other (Individual #154) did not have an assessment of intellectual or adaptive ability Each individual's record should contain a psychological assessment 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> As indicated in the last review, reports of psychology staff indicated that not all individuals at SGSSLC with PBSPs had functional assessments (e.g., Individual #239). All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors. A spreadsheet of all functional assessments completed in the last 12 months indicated that 45 functional assessments had been completed since the last review. Ten of those 45 functional assessments (22%) were reviewed to assess compliance with this item of the Settlement Agreement. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. All functional assessments should include direct and indirect assessment procedures. A direct assessment consists of direct observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific	

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		consequences that were observed to follow the target behavior. Indirect assessments help to understand why a target behavior occurred based on results from questionnaires, interviews, or rating scales. All 10 of the functional assessments reviewed indicated that direct and indirect assessments occurred. As discussed in the last report, however, the majority of functional assessments reviewed did not present data from those assessments. Nine of the 10 functional assessments reviewed simply indicated that direct and indirect measures were collected. For example Individual #255's functional assessment stated that "Direct observations of Individual #255 occurred in his home and on the campus in multiple locations and activities from 9/06/05 through the present date with extended direct observations from January 24, 2011 to February 22, 2011." Indirect measures were described as "review of records…" and "informal interviews with direct care staff members who have worked with Individual #255 from 1 month to 3 years." The one functional assessment (i.e., Individual #346) that did identify the measure (i.e., the FAST) and data (i.e., targets were reported to be highest for attention and access to tangible items), did so for only the indirect assessment. All functional assessments should include the measures and results of indirect and direct assessment measures used. As discussed in other reports, one potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data (see K4). In order to be useful, however, ABC data would need to be collected for a duration long enough to observe several examples of the of the target behavior, so that patterns of antecedents and consequences could be identified. As reported in the past two reviews, multiple formats (e.g., Individual #346, Individual #383, and Individual #29's functional assessments were a different format than the other seven functional assessments reviewed) of the functional assessments were found. It is recommended that all functional assessments at the facility use the same format. All of the functional assessments reviewed identified potential antecedents and consequences of undesired behavior. The potential functions (consequences) identified in four of the 10 functional assessments reviewed (40%), however sounded very general and would not likely be useful in developing an effective PBSP. For example: • Individual #3's functional assessment concluded, "Individual #3's challenging behaviors appear to each have multiple functions. It seems as though Individual #3 uses his challenging behavior to meet most of his needs." Clearly some target behaviors may be multiply controlled. To simply conclude, however, that a behavior's function is to meet all of one's needs without further detail (e.g., when working in the workshop physical aggression appears to be a function of escape; physical aggression in a low stimulation environment appears to be to gain staff	

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		attention), does not help to understand the undesired behavior or lead to an individualized treatment plan based on the results of the functional assessment. • Individual #184 functional assessment stated "Individual #184 is likely to be reinforced by the short term effects of his actions. Long term consequences are not likely to have a real impact on his thought process, and often probably don't even enter his mind." On the other hand, in the majority of functional assessments reviewed (nine of 10), the antecedents identified appeared very individualized and would likely be useful for developing effective PBSPs for reducing undesired behaviors. For example: • Individual #383s functional assessment identified the repeated placing of demands, activities that require her to leave her room, unfamiliar staff, and changes in routine, as antecedents to her target behaviors. • Individual #98's functional assessment identified times when her hands were not occupied with an activity, as an antecedent to her self-injurious behavior (SIB). When comprehensive functional assessments are conducted there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Only one (i.e., Individual #346) of the 10 functional assessments reviewed (10%) included a clear summary statement. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors. There was evidence that functional assessments at SGSSLC were reviewed and modified when an individual did not meet treatment expectations. Individual #346's functional assessment was recently modified because his SIB, and the need for personal restraints, was increasing (see K4). Interestingly, the frequency of his dangerous behavior and physical restraints had decreased following these changes. The monitoring team was very encouraged by these activities and behavioral changes, and recommends that when new information is learned concerning the variables affecting any individual's target behaviors at SGSSLC, that it be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually to ensure accuracy. Finally, seven of the functional assessments reviewed attempted to identify motivating operations, but many appeared to incorrectly use the term. For example under the	

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		heading of motivating operations, Individual #373's functional assessment listed events under which target behaviors do not typically occur such as having choices, access to walks, etc. Motivating operations are events that alter (increase or decrease) the reinforcing effectiveness of a stimulus, object, or event. For example, if an individual is thought to engage in disruptive behavior in order to obtain staff attention, the value or effectiveness of attention could be reduced if attention is given frequently in the absence of disruptive behavior. In this way motivating operations could be used to decrease undesired behavior by, in this example, decreasing the value of the reinforcer for the undesired behavior. Motivating operations can, therefore, have important effects on target behaviors. Nevertheless they can be complicated to identify and the term should only be used in those situations where the value of the reinforcer is clearly affected. None of the functional assessments reviewed (0%) were evaluated to be comprehensive and clear. Several functional assessments, however, contained excellent components that could be modeled for future reports. Those include: • Individual #346's indirect assessment. • Good comprehensive summary statement for Individual #346. • Good description of antecedents and consequences relevant to the undesired behavior for Individuals #383, Individual #98, and Individual #26 • Good identification of potential reinforcers for Individual #29, Individual #255, Individual #373	
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 complete (see K5) and, therefore, this provision item was rated as being in noncompliance.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment	Annual psychological assessments were completed for all individuals at SGSSLC. They were not, however, consistently complete (see K5). Additionally, intellectual assessments were more than five years old for eight of the nine psychological assessments reviewed. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years. An annual update should be completed each year. 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 contain the elements identified in K5 and comment on (a) reasons why a full assessment was not needed at this time, (b)	Noncompliance

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	procedures.	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.	
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. This was an area in which the facility had made many improvements since the last onsite review. These improvements included: • a new screening/referral process, • development of a new treatment planning process that included evidence-based curriculum and specific session objectives, and • the development of pre and post tests to objectively assess progress. More work, however, is needed before this provision item can be considered to be in substantial compliance. SGSSLC increased the number and range of classes/therapies offered. At the time of the onsite review, 30 classes and individual therapy were offered, and over 60 individuals were actively receiving therapy. The facility had also worked very hard to ensure that these therapies were goal directed, with measurable objectives, and with specific treatment expectations. Additionally, at the time of the onsite review most of the classes/therapies were derived from evidence-based practices. The need for psychological services should be documented in each individual's psychological assessment, PBSP, or PSP. Although the facility developed a referral form, the need for these services was not found in any of the PBSPs, psychological assessments, or PSPs reviewed. It is recommended that needed services be documented in the psychological assessments, PBSPs, or PSPs. The SGSSLC director of psychology pointed to two areas of psychological services as demonstrating progress towards meeting this provision item: STEPP and DBT. The monitoring team attended a group therapy session for each of these therapies, reviewed documentation about the program, and spoke with the psychologists who were managing, designing, and running these programs. Indeed, the facility was making progress and had devoted a considerable amount of resources to making improvements. For the STEPP program, since the last onsite review, the facility had hired a psychologist with extensive experience in this area. At the time of this review, she was still in the process of developing the curriculum, objectives, and outcomes of the program. Although not yet implemented, the new program appeared to have the potential to be an improvement from what had been observed during the previous onsite reviews. As a result of the program still being in development, the session observed by the monitoring	Noncompliance

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		team did not have clear session objectives and was almost identical to the STEPP session observed during the baseline review. For DBT therapy, since the last onsite review, the facility had sent four psychologists for formal training in DBT, was using the standardized curriculum, and planned to send the psychologists to additional follow-up training. The psychologists conducted several individual and group sessions each week. The monitoring team attended one group session, however, none of the individuals scheduled to participate in the group arrived for therapy. The monitoring team spoke with the psychologists about the challenges they had experienced in getting this program started, as well as some of the successes they've already seen. Thus, the initiation of the STEPP and DBT programming was good to see. Actions were in the very early stages. Based on discussions with the psychology staff, director of psychology, and facility director, there appeared to be a commitment to getting these programs fully implemented by the time of the next onsite review. It is recommended that the facility continue with their efforts to ensure all counseling/ psychotherapy services (including STEPP and DBT) include: • a treatment plan that includes an initial analysis of problem or intervention target • measurable objectives and treatment expectations • evidence-based practices • documentation and review of progress • a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings Finally, the monitoring team suggest that the SGSSLC psychology department collaborate with the Mexia SSSLC psychology department regarding the requirements of this provision item (i.e., the provision of psychological services other than PBSPs) as well as all of the other items of this provision. Working together will allow for consistency, sharing of best practices, and an increase in the SSLC system's likelihood to treat these individuals in an effective manner.	

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K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This item was rated as being in noncompliance because not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. Twelve PBSPs that were written or revised since the last onsite review were reviewed to evaluate compliance with this provision item. All 12 PBSP reviewed had the necessary consent and approvals. All of the necessary components of a PBSP were included in the PBSPs (or in the accompanying functional assessments) reviewed. All PBSPs reviewed included descriptions of target behaviors, however, 11 (92%) of these were not operational. For example: • Individual #279's PBSP defined physical aggression as "Any physical means to injure or attempt to injure another person….." This definition required the reader to infer if Individual #279 did indeed have an intention to injure someone as opposed to hitting them. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior (e.g., hitting or kicking others). • Individual #26's PBSP included a target behavior of verbal aggression that included "Cursing, name-calling, or any verbal form of communication….that is intended to degrade, insult, agitate…another person." • Individual #29's PBSP aggressive behavior was defined as "Any attempt to inflict harm on another individual…" On the other hand, Individual #239's PBSP contained operational definitions that were operational, clear, and complete. For example • Individual #239's physical aggression was defined as "Biting, hair pulling, hitting, kicking, punching, pushing, scratching, slapping, spitting, throwing objects…directed towards another person…." All PBSPs should include operational definitions of target behaviors. All 12 PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but only four of the consequences (33%) identified were clearly based on the results of the functional assessment. Interventions that appeared to be inconsistent with the functional assessment results were: • Individual #3's PBSP described his physical aggression to have multiple functions, including negative reinforcement (i.e., a way to escape unpleasant activities). His intervention, however, following target behaviors included "Attempt to direct him to a quieter place so he can calm down." If his aggression	Noncompliance

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		was maintained by negative reinforcement, then this intervention would likely encourage, rather than discourage, his physical aggression because it allowed him to escape unpleasant activities by engaging in the target behavior (see K5 for a discussion of the challenges of designing effective interventions when the functional assessment simply concludes that the undesired behavior serves multiple functions for an individual). • Individual #29's PBSP appeared very general and was not based on the hypothesized function of her target behaviors. The intervention for physical aggression, SIB, and unauthorized departure consisted of counseling, redirection, and relocation. On the other hand all 12 of the PBSPs reviewed included the use of antecedent interventions that appeared to be based on the results of the functional assessment. For example: • Individual #346' PBSP hypothesized that attention was the primary function of his SIB. His antecedent intervention focused on the provision of staff attention for appropriate attention seeking behaviors, such as asking for assistance. • Individual #239's PBSP concluded that the primary function of her physical aggression appeared to be escaping undesired situations. Her antecedent intervention included the explicit reinforcement of engaging in undesired activities, such as classes or low preference activities. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #81's PBSP hypothesized that her verbal aggression functioned to gain attention. Antecedent interventions included attending to her when she initiated appropriate social interactions. Additionally, her intervention following verbal aggression included telling her that you cannot talk to her until she can talk to you in an appropriate manner. Both the antecedent and consequent interventions were clearly based on the hypothesized function of the behavior (i.e., staff attention), and were designed to ensure that Individual #81 would receive more attention following desired behavior (appropriate staff initiation) then following the occurrence of undesired behavior (i.e., verbal aggression). All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior.	

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		A clear strength of all of the PBSPs at SGSSLC was the contingent use of reinforcement. The following examples were typical: • Staff attention was identified as a high preference for Individual #26. Her PBSP specified several desired behaviors and instructed DCPs to follow the occurrence of those behaviors with social interaction. • Individual #373's PBSP specified the contingent provision of positive attention and tokens (which could be exchanged for a variety of tangible reinforcers) contingent on attending programming, eating meals, or engaging in conversations with others. Replacement behaviors were included in all 12 PBSPs reviewed. Replacement behaviors should be functional (i.e. should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified, and providing that reinforcer for alternative behavior is practical. The monitoring team found that all the replacement behaviors that practically could be functional, were functional. As reported in the last review, none of the 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 included into the current methodology, data system (when appropriate), and schedule of implementation for other skill acquisition plans at SGSSLC. 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). Overall, one (Individual #98) of the 12 PBSPs reviewed (8%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. Several other PBSPS, however, contained components of a good plan that should be modeled in future plans. These include: • Antecedents that were based on functional assessment results (Individual #81, Individual #26, Individual #346, Individual #34) • Good use of consequences that were based on the hypothesized function of the target behavior (Individual #81, Individual #34) Additionally, the monitoring team was encouraged by other general improvements in PBSPS at SGSSLC. These included: • Improvements in the use of functionally equivalent replacement behaviors • Improved use of reinforcement	

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		• Establishment of the Psychology Pre-Review Committee (PRC), designed to provide clinical review of functional assessments and PBSPs It is recommended that the facility, for the next review, focus on increasing the percentage of PBSPs that are representative of clear, concise plans based on the results of a functional assessment.	
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 requirement of this provision item. Target behavior data were consistently graphed monthly at SGSSLC. At the time of the onsite review, replacement behaviors were not consistently collected, therefore the graphs of replacement behaviors were all zeros. Nevertheless, when replacement behavior is collected, replacement behavior data should also be graphed. As discussed in K4, the facility had substantially improved the quality and usefulness of the graphs of target behavior by adding a more sensitive graphing increment and/or a cleaner, more readable graph. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path.	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 demonstrate that PBSPs were reliably implemented by DCPs. As discussed in K9, many of the PBSPs reviewed did not specify clear and concise interventions following the occurrence of undesired behaviors, thereby decreasing the likelihood that DCPs would implement the PBSP with integrity. The most direct way, however, to ensure that PBSPs are implemented as written is to establish a system to systematically monitor treatment integrity. SGSSLC had used a treatment integrity tool in the past, and had recently begun to review the tool and begin the systematic collection of treatment integrity. There were no integrity data available for review during the onsite review. The monitoring team looks forward to reviewing integrity data during the next onsite review. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established.	Noncompliance

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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 last 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 assistant for every two such professionals.	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 245 individuals and employed 12 psychologists responsible for writing PBSPs. Additionally, the facility employed seven psychology assistants. None of the psychologists, however, had obtained BCBA certification (see K1). In order to achieve substantial compliance with this provision item, the facility must have at least nine psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that internal peer review meetings occur at least weekly, and external peer review occur at least monthly.
2. Implement the simplified data collection system.
3. Develop a plan to ensure that DCPs do record data as soon as possible after it occurs.
4. Replacement behaviors should be consistently collected and graphed.
5. It is recommended that the facility begin to track data collection reliability and interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site.
6. Each individual's record should contain a psychological assessment 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.

7. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors.

8. Functional assessments should include the measures and results of indirect and direct assessments used.

9. All functional assessments should use the same format.

10. Functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors.

11. Functional assessments should be revised when new information is learned concerning the variables affecting any individual's target behaviors.

12. Functional assessments should be reviewed at least annually to ensure accuracy.

13. The term motivating operations should only be used in those situations where the value of the reinforcer is clearly affected.

14. Needed psychological services should be documented in the psychological assessments, PBSPs, or PSPs.

15. It is recommended that the facility ensure that all counseling/ psychotherapy services (including STEPP and DBT) include:
    - a treatment plan that includes an initial analysis of problem or intervention target
    - measurable objectives and treatment expectations
    - evidence-based practices
    - documentation and review of progress
    - a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

16. All PBSPs should include operational definitions of target behaviors.

17. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior.

18. All replacement behaviors should include specific skill acquisition plans for training.

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

20. Staff training of PBSPs should include a competency-based component. Additionally, a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP should be developed.

The following are offered as additional suggestions to the facility:

21. 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.

22. It is suggested that ABC data collection be used to collect direct functional assessment data.

23. The monitoring team suggests that the SGSSLC psychology department collaborate with the Mexia SSLC psychology department regarding the requirements of provision item K8 (i.e., the provision of psychological services other than PBSPs).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 o DADS Policy#006.2: At Risk Individuals, 12/29/10 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/Procedure Medical Consultation, 4/8/11 o SGSSLC Routine Laboratory and Tests Screenings, 11/18/10 o Mortality Reviews for individuals who died between November 2010 and April 2011 o Listing, Individuals with seizure disorder, status epilepticus o Listing, Individuals diagnosed with pneumonia o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Individuals diagnosed with osteoporosis or osteopenia and treatment regimen o Listing, Individuals with diabetes mellitus o Listing, Individuals with hypertension o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o DEXA reports for individuals with osteoporosis and osteopenia o Report of external medical review conducted in March 2011 o Reports of internal medical reviews o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, quarterly medical summaries, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records, MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #40, Individual #161, Individual #243, Individual #331, Individual #18, Individual #386, Individual #60, Individual #278, Individual #15, Individual #164, Individual #109 o Medical caseload data o Tracking log for histories and physicals o Collaborative Practice Agreements for Advanced Practice Registered Nurses Interviews and Meetings Held: o Rebecca McKown, MD, Medical Director

	o John Burnside, MD, Primary Care Physician o Scott Lindsay, APRN, FNP o Jimmy Mercer, MD, Lead Psychiatrist o William Bazzell, MD, Psychiatrist o Angela Garner, RN, Chief Nurse Executive <u>Observations Conducted</u>: o Multidisciplinary POI meeting o Risk Management meetings with two PSTs o Observations occurred in various day programs and residences at SGSSLC
	Facility Self-Assessment: The facility rated itself noncompliant for provision items L1, L3, and L4 and compliant with provision L2. Issues related to provision of key preventive services, such as colonoscopies and mammograms, lack of medical staff documentation related to hospital transfers and follow-up, significant delays in receipt of consults, and review by the medical staff resulted in the monitoring team's findings being congruent with that of the facility's self-assessment for L1. The monitoring team agrees with noncompliance for provision L3 due to a lack of a medical quality program that assesses process and outcome indicators, collects adequate data, and uses those data to identify problems, and to develop and implement corrective action plans. The lack of development and implementation of clinical guidelines resulted in the monitoring team's concurrence with a noncompliant rating for L4. With regards to Provision L2, the monitoring team recognizes that the external review had just completed the first round of auditing. At the time of the onsite review, information, from the March 2011 review had not been shared with the medical staff and, therefore, no movement had occurred with regards to corrective action plans. The monitoring team also believes that a robust medical quality review must have an appropriate mix of process and outcome indicators.
	Summary of Monitor's Assessment: Although the monitoring team found noncompliance in all areas, continued progress from the November 2010 review was noted in some areas while other areas demonstrated no appreciable progress. The facility completed its first external medical review in March 2011 and the review generated some excellent feedback for the medical staff. That information had not been disseminated to the medical staff at the time of the onsite review so corrective action plans had not yet been implemented. The medical department implemented new policies related to medical consultations and tracking of consultations and labs. When fully implemented, this process change should improve the delays that were occurring related to review of documents by the medical staff. The facility's lab matrix had been expanded and this was good

	to see. The lab matrix provided guidance related to drug use monitoring parameters and preventive care services, such as cancer screenings and immunizations Annual medical assessments continued to be problematic with a significant number of assessments noted to be delinquent. Overall, however, there was some improvement. A facility wide compliance rate was not available at the last visit. Active problem lists presented another concern because none of the problem lists contained within the records reviewed were updated in the manner required by the Health Care Guidelines. Documentation was lacking on hospital transfers and returns, follow-up of acute medical problems, and responses to the various types of consults. Physician orders for routine matters were too frequently given verbally and orders and were not always timely. Additionally, quarterly medical summaries were not found consistently in the records. Compliance ratings for some key preventive services, such as cancer screenings were unfortunately low. Compliance with core immunizations was very good. Screening for osteoporosis appeared to be low based on risk factor assessments. The expanded lab matrix, if followed, should prove beneficial in increasing compliance rates with some key preventive services. Do not resuscitate orders were in place for 13 individuals and many of these had been in place for several years. One individual's DNR order was implemented in 2003 and did not appear to be questioned by the PST. Finally, the provision of neurologic services appeared to be good, but was not without some concern. Primary providers and psychiatrists missed the recommendations from the neurologist on several occasions. Equally or even more important, the integration of neurology and psychiatry was far from optimal and it was clear that the facility had no immediate plans to correct this problem. The facility also cited a lack of any individuals with refractory seizure disorder. One such case, however, was found in the records reviewed and the neurologist gave the diagnosis. This called into question the accuracy of the data submitted for the refractory seizure disorder list.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the	**Overview** The medical staff included a full time medical director, one full time primary care physician, and one full-time family practice advanced practice registered nurse (APRN). In addition to this, there was one locum tenens physician who provided full time services on a biweekly basis. Two full time physicians and one APRN provided psychiatric services. Since the November 2010 onsite review, the medical director was relieved of a full time caseload. Documents provided to the monitoring team reported the caseload for the primary care physician was 137 while the family nurse practitioner maintained a	Noncompliance

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	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.	caseload of 107. Caseloads of more than 100 are not acceptable because they do not allow for adequate patient care and participation in an integrated team process. The collaborative practice agreement for the family nurse practitioner was signed on 9/28/10. A similar agreement for the psychiatry APRN was signed, but not dated by either physician. The psychiatry APRN's signature was dated 5/17/11, however, there was no date by the supervising MD's signature, and there should be. The facility conducted onsite ophthalmology, podiatry, and shoe clinics. Gynecology clinic was conducted by the medical director for the completion of routine exams and pap smears. The medical director reported this service had been interrupted due to the lack of a consistent clinic nurse since August 2010. It was reported that a clinic nurse was to be assigned at the end of May 2011. Individuals who needed acute care and/or admission were almost always admitted to the local Shannon Medical Center. Labs were drawn at the facility and sent to Shannon Medical Center. Results for routine labs were returned within one to two days while the results for stat labs were available in about two hours. A mobile x-ray company completed roentgenograms and a disc was provided for viewing immediately following completion. The images were capable of being viewed online provided adequate band length was available. After hours, roentgenograms were completed through emergency department assessment at the local hospital. This was a reasonable arrangement. The medical director indicated that a stamp had been developed to assist in routing of lab results and consults that retuned to the facility. The stamp required approval by the appropriate committee prior to implementation. Quarterly reviews continued to be conducted by a board certified clinical pathologist. The format for those reviews had recently been revised. See comments in L3 below. Individuals who required neurology services were seen off campus. There was currently no process to have a joint neurology–psychiatry clinic. During a meeting with the monitoring team, the medical director indicated that the facility appreciated the recommendation to have a joint clinic, but had elected not to pursue the addition of a joint neurology-psychiatry clinic. The monitoring team suggests that, at a minimum, the feasibility of options, such as telemedicine or phone conferences, be explored as other SSLC facilities had determined phone conferences to be of some value. SGSSLC did not routinely utilize the services of an epileptologist. Also see section J15 of this report.	

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		General Medical Care and Documentation The individuals received a variety of medical services. They were provided with preventive services. Specialty care and acute care were available. The medical director performed pelvic exams and completed pap smears. As previously discussed, there had been some lapse in this service. Several of the requirements of the Health Care Guidelines are discussed below. It should be noted that the previous staffing required multiple physicians to routinely provide care to one individual and this resulted in interruptions in continuity of care within the facility. Many of the observations cited below varied throughout the record. Additional discussion is found in Section L2. Examples of deficiencies are found in this section under case reviews. <u>Annual Medical Assessments</u> Annual medical assessments were contained within the integrated record, but most were not current. Nine of 11 (80%) records contained AMAs that were not current. • A tracking log was provided that contained the facility's census. Based on the data reviewed, at the time of the onsite review, 40% of the annual medical assessments (facility wide) were not current. Annual medical summaries were completed in varying formats. Some utilized charts for physical findings while others did not. The plans of care were often presented as the health management plans. At times, the name of the plan was listed and the actual plan not detailed. <u>Active Problem List</u> Most of the records contained an active problem list. None of the records reviewed contained appropriately updated active problem lists. <u>Integrated Progress Notes</u> Medical providers documented in the integrated progress notes. There were several issues related to documentation. Documentation was frequently lacking prior to hospital transfer, for follow-up of acute medical problems, in response to quarterly drug regimen reviews, in response to the recommendations of consultants, and in response to abnormal lab results. Documentation in SOAP format was also not consistent. <u>Quarterly Summaries</u> A quarterly summary document was found in many records, but this was not noted in every quarter in every record as required by the Health Care Guidelines.	

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		Physician Orders Physician orders were very often verbally provided. It was not unusual to find a physician order page that contained two or three stamps with physician signatures indicating that verbal orders were carried out. This pattern was seen for 75% of the primary medical providers. **Routine and Preventive Care** Individuals received routine and preventive care. Some areas achieved high rates of compliance, such as vision and hearing screenings. Yearly influenza, pneumococcal, and Hepatitis B vaccinations were provided with high rates of compliance, too. Compliance with varicella, Zoster, and Hepatitis A vaccinations seemed more problematic. There were significant problems observed in the areas of colorectal cancer screening, cervical cancer screening, and even bone mineral density screening. Observations below are based on review of 11 comprehensive records, compliance and tracking lists submitted by the facility, and the various other documents listed in the documents reviewed section above. Screenings • 11 of 11 records contained documentation of appropriate vision and hearing screenings Prostate Cancer Screening • 3 of 5 males met criteria for PSA testing o 3 of 3 males had appropriate PSA testing o 1 of 3 males had a PSA that needed additional follow-up testing Breast Cancer Screening • 3 of 11 (27%) individuals females met criteria for breast cancer screening o 0 of 3 (0%) females had current breast cancer screenings o 2 of 3 (66%) females completed appropriate screening in 2009 o 1 of 3 (33%) females had all screenings, including mammography cancelled due to age and health status A list of all females over the age of 40, date of last mammogram, and reason for noncompliance was provided. The list contained 48 individuals: • 21 of 48 (44%) females had current breast cancer screenings • 9 of 48 (19%) females had completed screenings within the past two years	

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		• 12 of 48 (25%) females had completed screenings more than two years ago • 4 of 48 (8%) females had refused screenings • 2 of 48 (4%) of 48 females had screenings discontinued <u>Colorectal Cancer Screening</u> • 6 of 11 individuals met criteria for colorectal cancer screening o 3 of 6 individuals had undergone colonoscopy for colorectal cancer screening A list of all individuals over the age of 50 was provided. The list contained 95 individuals: • 31 of 95 (33%) individuals had undergone colonoscopy within the last 10 years • 55 of 95 (58%) individuals had no record of colonoscopy • 3 of 95 (3%)individuals had no colonoscopy due to age and health reasons • 3 of 95 (3%) individuals had orders to discontinue colonoscopy • 2 of 95 (2%) individuals had colonoscopy cancelled by the local provider <u>Immunizations</u> • 11 of 11 individuals received pneumococcal, hepatitis, and yearly influenza vaccinations. • 5 of 11 individuals qualified for the Zoster vaccination o 2 of 5 individuals received the Zoster vaccination The facility's preventive care flow sheet stated one Zoster vaccination was due beginning at age 60. <u>Additional Discussion</u> Overall, significant deficiencies were found in areas, such as colorectal and breast cancer screenings. The medical director should review these data to determine the reasons for the low compliance rates. When the decision is made to cancel screenings, a careful risk/benefit analysis must be completed and clearly documented. Cancellation for age and health reasons should be viewed carefully in those cases where an individual has lived with this designation for many years.	

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		Medical Management <u>GERD</u> • 6 of 6 individuals were diagnosed with GERD o 6 of 6 individuals with GERD received appropriate medical therapy <u>Osteoporosis</u> • 5 of 11 individuals were identified as having osteoporosis or osteopenia o 5 of 5 individuals received Vitamin D supplementation A list of all individuals with osteoporosis and osteopenia was provided. The list contained 28 individuals, but it did not differentiate the diagnosis of osteoporosis and osteopenia. The complete medication profiles were provided, but the medication indications were not included. The facility should review the census to determine who is at risk for osteoporosis and ensure that testing as indicated is completed and that individuals receive adequate therapy. A comprehensive clinical pathway would be helpful in achieving this goal. <u>Hypertension</u> • 2 of 11 individuals were clearly identified as having hypertension. o 1 of 2 individuals received appropriate treatment o 1 of 2 individuals had documented "over treatment" of HTN by nephrology <u>Bowel Management</u> • 8 of 11 individuals were identified as having constipation o 2 of 11 individuals received medication for constipation, but did not have a diagnosis of constipation o 2 of 11 individuals were hospitalized for bowel obstructions and ultimately had the diagnosis of ileus o 1 of 2 individuals had a colectomy for Ogilvie's Syndrome, but continued to have atony of the small bowel.	

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		Case Reviews Individual #386 Individual #386 had a history of seizure disorder, constipation, hyperlipidemia, and psychiatric issues. The last annual medical assessment was completed in March 2009. • On 4/17/11 at 10:45 pm, nursing documented that this individual had experienced two episodes of emesis and was sitting on the commode a long time passing gas with an abdomen that was "8 months pregnant." No bowel sounds were heard and the individual had obvious discomfort. The individual was given milk of magnesia in prune juice, but experienced projectile vomiting. The on-call primary provider was notified and the individual was transferred to the local emergency department. There was no medical documentation prior to transfer. The last medical documentation was dated 3/14/11 and was a response to community consults. The individual was admitted to the intensive care unit with a possible small bowel obstruction and provided conservative treatment. The discharge diagnosis was ileus. Upon return to the facility on 4/22/11, there was a note written by the primary provider. The note was not written in SOAP format. There was no change in the bowel management plan or regimen for this individual. • The individual had no bowel movement for three days and was seen by the primary provider on 4/25/11 at which time fiber wafers were added to the bowel regimen. The individual had a good immediate response to this change, but on 5/2/11 at 9:30 am, nursing notes indicated that the individual had no bowel movement for three days. At 11:00 am the nursing entry noted rounds were completed with the physician and an order was given for Dulcolax suppositories. There was no progress note written by the physician. On 5/6/11, nursing noted a good response to suppositories. • On 5/23/11 at 11:30 am, nursing noted rounds with physician. A new diagnosis of conjunctivitis was made and treatment provided. There was no physician documentation of the assessment and plan. At 1:00 pm, the nursing entry noted rounds with physician and stated that a Dulcolax suppository was given due to the fact that the individual had one formed bowel movement over the past week. There was no documentation from the physician related to the assessment, bowel management, or what would be done to prevent further constipation and use of acute interventions, such as suppositories. • The final primary provider note was 5/26/11 which indicated the individual had no contraindications to the intended dental procedure. The physician note did not state what procedure was planned. Additional Discussion This case highlighted several issues including:	

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		• A lack of documentation by the primary providers, including documentation related to hospital transfers and management of acute problems. There were several instances in which the physician made rounds, but provided no documentation of the individual's assessment or plan. This occurred even when a new problem, such as conjunctivitis, was identified. • There appeared to be a lack of adequate response to the problem of obstipation. The individual returned to the facility and continued the exact same bowel management plan that was ineffective prior to hospital transfer. • Individuals were not followed until problems improved or resolved. There was no specific local policy related to this. • There was a delay in responding to recommendations made by consultants. The neurology note dated 3/4/11 made specific recommendations related to adjustments needed for AEDs. Seizure control was noted to be very good. The same neurology consult discussed adverse behaviors, and drug adjustments were recommended relative to that assessment. These recommendations were implemented on 3/14/11 when orders were written. There was no evidence that the psychiatrist noted this and the psychiatry quarterly review dated 3/30/11 did not reflect the recommendations made or medication changes implemented with the physician orders. Integration of medical and psychiatry was clearly absent in this decision. • The QDRR completed on 4/8/11 was received on 5/19/11. This represented a six-week delay between generation of the recommendation and physician review. Clearly, there could have been a change in circumstances or health status. • The preventive care flow sheet was not updated and cited Vitamin D and DEXA testing as NA although the individual was on long term AED therapy and received Vitamin D supplementation. <u>Individual #109</u> Individual #109 had problems including seizure disorder, dementia, bowel management issues, HTN, GERD, blindness due to glaucoma, and osteopenia. The individual had a DNR implemented in 2003. This order was renewed annually. The most recent annual assessment cited dementia, hemiplegia from CVA, multiple medical problems, and gradually declining health as the reasons for focusing on palliative care and limiting intrusive investigations. The initial reason for the 2003 DNR was not clear. • The individual received recommended immunizations with the exception of the Zoster vaccination. Vision and hearing screenings also occurred but much of the other recommended preventive services had been discontinued or were considered not applicable (NA). Colorectal cancer screening was considered NA, as were cervical cancer screening and mammography.	

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		• The individual was transferred to the emergency department on 10/17/10 and was admitted with a diagnosis of UTI and pyelonephritis. There was no physician assessment of documentation prior to transfer. Upon return to the facility on 10/21/11, a note was written, but there was no further medical documentation until 12/17/10 when the individual had respiratory problems. The next medical note was dated 1/7/11 and addressed a toenail issue. • The individual was seen by the neurologist on 3/5/10. The recommendation was to simplify the medication regimen and discontinue baclofen since it appeared not to be beneficial. Although this consult was documented in the most recent annual assessment, it did not mention the recommendation to discontinue baclofen. • The physician orders were largely verbal orders. There were multiple stamps prompting the physician to sign verbal orders. Additional Discussion There were several concerns related to this case: • The DNR status should be reviewed to determine if it meets state issued guidelines since it was in place for many years. • It was not clear why so many routine physician orders that occurred during normal business hours were verbal orders. These would normally occur as part of physician rounds. • There was a lack of medical documentation including documentation related to hospital transfers and follow-up of acute and chronic medical problems. • The neurology consult dated 3/5/10 was reviewed on 5/5/10. There was no acknowledgement of the Baclofen recommendation in the annual medical assessment. • The problem list was not updated. <u>Individual #243</u> Individual #243 had multiple problems including bipolar disorder, hyperlipidemia, and hyperprolactinemia. The individual received appropriate preventive services including hearing and vision screenings, and immunizations. • On 4/7/11 the individual received Thorazine 200 mg IM at 9:30 am and at 4:35 pm. Thorazine 200 mg was given on 4/9/11 at 9:50 am. At 3:00 pm, the individual experienced tachycardia and was transferred to the local emergency department. The individual was admitted with a diagnosis of supraventricular tachycardia. The individual had received other psychotropics including IM Zyprexa on 4/6/11. It was believed that the drugs might have induced the arrhythmia. The facility completed an ADR report and found that this was a probable ADR.	

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		• The primary care provider was notified of the tachycardia at 3:35 pm on 4/9/11. There was no physician assessment documented in the progress notes. There was a brief re-admit summary documented on 4/13/11. • The individual was sent out again on 4/14/11 due to tachycardia. There was no medical documentation prior to transfer, but a readmit note was documented upon return. The next medical note was dated 4/17/11. • Physician orders were not always timed and dated (4/13/11). • Very few physician orders were actually written by the physician. Most pages contained multiple verbal orders, including routine orders. • The QDRR represented one concern surfaced by primary providers. In the QDRR, dated 4/21/11 and received 5/19/11, the clinical pharmacist documented "the medical staff agreed to add C-Q-10 to persons receiving statins to prevent depletion." The provider responded, "still awaiting evidence based research." Another QDRR was dated 2/25/11, but was not received until 3/10/11. Primary providers were concerned about a lack of evidence relative to pharmacy QDRR recommendations. • A quarterly medical summary was completed on 4/12/11. It did not comment on the lack of medical transfer note, the overuse of verbal orders, or the lapse in time between completion of the QDRR and provider review. • This individual experienced a 25 pound weight gain from 1/10 to 4/11. The health management plan of the annual medical assessment dated 2/11/11 noted, "we need to pay attention to the significant weight gain." It did not provide any plan for how this would be accomplished or managed. The PSP addendum, 4/11/11 noted that the weight gain was likely due to meds, and that the team was to await recommendations from psychiatry. <u>Individual #331</u> Individual #331 had multiple problems including obesity, hyperlipidemia, fatty liver, new holosystolic murmur, and diabetes mellitus. The last annual assessment was dated 12/03/09. Preventive care including vision/hearing screenings and cervical cancer screening was provided. The new holosystolic murmur was evaluated by echocardiography. • The individual had continued to gain weight and was given a new diagnosis of diabetes mellitus in February 2011. The medical provider documented and increased in free insulin and HbA1c and started the individual on metformin. A dietary consult was also requested. The note, which was not written in SOAP format, did not discuss any relationship between this new diagnosis and the use of the new generation antipsychotic medication being prescribed. • Neurology consult dated 3/4/11 made the recommendation to double the dose of Keppra to 1000 mg BID. The consult was stamped received 5/20/11 and the	

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		verbal order to increase Keppra was given on 5/19/11. • The QDRR completed on 4/8/11 did not note the diagnosis of diabetes mellitus or provide any laboratory monitoring related to diabetes. • Notes were not consistently in SOAP format (12/11/10 and 2/24/11). There was no quarterly medical summary included in IPNs. Additional Discussion Several concerns were noted with management of this individual: • Physician documentation failed to provide a review of risk assessment related to the onset on diabetes. The individual's risk factors, or how those risk factors could be mitigated, were not mentioned. There was no documented consideration of how the NGA impacted the onset of the disease. • The QDRR did not provide any information on the monitoring for the use of metformin. • In the absence of a current AMA, the PSP utilized dated information that had the potential to negatively impact the planning process. **Do Not Resuscitate** A list of individuals with the Category III Resuscitation Status (DNR) was provided. The list contained 16 individuals, 9 of which had the DNR status implemented in 2009 or earlier. One individual maintained DNR status since 2003. Several had a qualifying diagnosis of adult failure to thrive. When DNR status was implemented, many preventive care requirements, such as colorectal cancer screening, breast cancer screening, cervical cancer screening, and bone mineral density screening were discontinued. DNR status should be considered for those individuals with a terminal illness whose expected lifespan is not measured by years. The facility should review the list of individuals who currently have a DNR order in place and rescind those that do not meet criteria of state issued policy. **Seizure Management** A listing of all persons with seizure disorder was provided to the monitoring team. The list included 75 individuals with seizure disorder and some without seizure disorder who received AEDs for a psychiatric diagnosis. A list of individuals with refractory seizure disorder was requested. It was reported that no individuals had refractory seizure disorder. During an interview with the medical director, the monitoring team was asked to define the term refractory seizure disorder due to the "vagueness" of the	

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		term. While the monitoring team appreciates that the term may vary, a suitable definition could be considered, such as an individual with 10 or more seizures over a 12-month period. Reviews of neurology notes provided by the facility indicated that the neurologist had categorized Individual #164 as having "refractory seizure disorder." In order to better serve the individual, it would be helpful for the medical staff to discuss with the neurologist the reasons or definition used in providing the diagnosis of refractory seizure disorder. With regards to the neurology services provided, there appeared to be no substantial issues on the part of the neurologist. The clinic notes provided good documentation of historical events, reviews of data submitted including labs, and drug levels. There was usually some discussion of the individual's functional status. The neurologist commented on information provided by the persons attending the clinic with the individuals. Detailed directions were provided for drug changes and titrations. Clinic notes also discussed simplification of mediation regimens and a preference for monotherapy when possible. Overall, this appeared to be a valuable service for the individuals and the facility. There were, however, some concerns related to these services. When issues related to behavior arose, the neurologist clearly commented on potential drug changes. Yet it appeared that the facility primary provider and/or psychiatrist sometimes missed these recommendations. There were several clinic consultation referral forms that cited, "we missed your previous recommendations" and requested further guidance. This guidance was often sought <u>many months</u> after the recommendation had been made. Individual #109, Individual #386, Individual #385, Individual #164, and Individual #294 all had documentation of neurology recommendations that were missed by the primary provider. There were also several consults that mentioned that hospital information and other neurology information had not been received by the medical staff. Among the various documents reviewed, there were statements regarding frequent seizures. The facility should develop a database for storing information and use this data to determine if other individuals not included in this review had refractory seizure disorder. Individuals who meet the criteria for refractory seizure disorder should be referred to a qualified epileptologist. This information should also be used to determine accurate AED polypharmacy rates.	

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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.	Medical Reviews Two physicians from two other SSLCs completed external medical reviews in March 2011. According to the medical director, the results had just been received at the time of the onsite review and data had not been discussed with or disseminated to the medical staff. A five percent sample of records was examined for compliance with 32 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were seven essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required in addition to receiving a score of 80% on nonessential items. Provider compliance with essential elements ranged from 57% to 79%. Nonessential compliance ranged from 57% to 79%. The medical director reported that the state medical services coordinator would develop corrective action plans. Data received after the onsite visit included a corrective action plan dated 5/20/11 that was developed by the QA Department for each primary provider. The review, however, was focused entirely on processes. There were no outcome indicators among the 32 items. Because outcomes of individuals are the primary focus, a quality review must include these. The addition of outcome indicators is critical in determining the quality of medical care provided. In order to standardize this review across the state, consideration should be given to utilizing the same outcome indicator(s) with each review statewide. Selecting clinical outcome indicators based on the state issued clinical guidelines would be an appropriate starting point since these are the high priority issues targeted by the state. Mortality Reviews Mortality reviews were completed by the facility per state policy. There were eight deaths in 2010 and three deaths in 2011 at the time of the onsite review. A fourth death occurred during the week of the review. The mortality documents for the three deaths listed in the documents section above were reviewed. Adult failure to thrive was cited as the cause of death for two individuals. The third individual's autopsy listed aortic stenosis as the cause of death. The average age of death for the three individuals reviewed was 85 years. The Clinical Death Review Committee and Administrative Death Review Committee meetings were completed within the appropriate timeframes. The participants were not listed on the actual committee reports and not all attendance sheets were provided. One lacked a date and the name of the individual under review. There did not appear to be an external physician participating in all reviews. It was noted that the locum tenens physician who works regularly at the facility as a primary care physician was	Noncompliance

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		documented as an outside MD. The locum arrangement must preclude that physician from serving as the external participant. In all three clinical reviews, there were no concerns cited related to the medical care provided. There were several recommendations made related to medication management, pain management, and other nursing issues. One death was attributed to aortic stenosis, which was diagnosed approximately one month prior to death. The individual was given DNR status due to advancing dementia. Annual medical assessments and other medical evaluations did not mention any cardiac issues or abnormalities other than a heart murmur. This murmur was noted in the 2009 AMA. There did not appear to be any further investigation of the etiology of this murmur. The individual's congestive heart failure and cardiac arrhythmia are sequelae that are known to be associated with aortic stenosis. While this individual may not have been a candidate for surgical correction during the months immediately prior to death, the murmur was noted as an active problem at least two years prior to death. Survival is linked to surgical correction prior to the onset of symptoms. Even with correction of the problem, the co-morbidities associated with dementia and the other medical problems would likely have resulted in the same outcome. The risk/benefit discussion should have occurred with the PST and clearly documented. Another concern noted was the use of the term adult failure to thrive. This diagnosis was used as a qualifying diagnosis for hospice care. This is a vague diagnosis, that when used, should be supported by appropriate criteria and the criteria should be well documented. Six of the last 11 deaths were attributed to adult failure to thrive. The current mortality review system did not require a physician to complete a thorough review of all records, inclusive of the integrated record, to determine if there was compliance with the standards of care of medical practice. This review should result in a written report that reviews all aspects of medical care and highlights the positive aspect of care in addition to those areas where there is opportunity for improvement. An external physician should preferably complete this task.	
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;	The facility had not implemented a formal medical quality program at the time of the onsite visit. The medical director reported that a board certified clinical pathologist completed quarterly reviews and these reviews were being used to determine quality. These reviews, however, focused on process indicators and did not assess clinical outcomes. The medical director believed that these quarterly medical summaries satisfied the requirements for completion of quarterly summaries in addition to serving as the audit tool for the internal audits. In its current format, it satisfied neither	Noncompliance

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	assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	requirement. As a quality tool, there was no formal procedure in place to guide this process, or explain sample size, frequency of the audits, or indicator selection. There was no documentation of how the data were used, including corrective action plans and follow-up after implementation of corrective action plans. The process should be formalized. In order to achieve credibility related to outcome indicators, the appropriate clinician should be utilized to determine adequacy of medical care. Until an effective medical quality program is developed, the medical director should initiate quality improvement projects based on data that are already available. Data were provided to the monitoring team on colonoscopies, mammograms, and osteoporosis. Collecting these data may have impact on the provision of care as several individuals appeared to have been identified as needing colonoscopy. It did not appear that the data were, however, being utilized for any other purpose. Data related to hospital transfers, admissions, bowel obstructions, and seizures can be used to assess the quality of care. • The medical director should review the hospital data at least monthly and look for patterns and trends. For example, individuals who were hospitalized twice in 30 days should have an intense review, preferably a multidisciplinary clinical review, to ensure adequate supports were provided. The result of such a review would be identification of good care, problems with care and a plan individualized to support the individual. When an individual returned to the hospital shortly after discharge, there should be a review to ensure that there were no gaps in care or perhaps if the discharge occurred prematurely. The current internal and external reviews emphasized processes resulting in a lack of information related to outcomes. While clinical guidelines are needed to establish expectations for clinicians, adequacy of care can be established for certain diseases processes using well-known and established guidelines. • The simplest example would be monitoring the care provided to and clinical outcomes for diabetic individuals. The process and outcome indicators issued by the American Diabetes Association Standards of Care in Diabetes 2011 are generally accepted standards from a leading organization. The facility must determine if it provided adequate services to diabetic individuals and monitored these individuals appropriately. In addition to this, the facility must have data that speaks to the actual clinical outcomes experienced by the individuals. This is only understood through the use of a robust mix of process and outcome indicators. Several sister SSLCs have utilized this information to	

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		make improvements in the quality of care provided to diabetic individuals.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The medical department had implemented several new or revised policies related to medical consultation and routine test screenings. A particular need to track consultations and labs was noted and the policies addressed these issues. In actuality, this was a mini-performance improvement project based on data that showed a problem with this process. The monitoring team suggests that the medical director adopt a performance improvement approach when framing such problems and develop solutions with the input of the QA department for documentation of true performance improvement initiatives. No clinical guidelines had been developed since that last visit. • The medical director reported that state approved guidelines had not been issued at the time of the onsite review. • The facility had not developed any clinical guideline or policies independently. • The facility's lab matrix was provided to fulfill the request for submission of clinical guidelines. While the lab matrix provided guidance on preventive care services, it was not considered a clinical pathway or guideline.	Noncompliance

Recommendations:

1. The facility should re-evaluate the current medical staffing. The part-time nature of the current structure has resulted in caseloads that remain too high. Three full-time physicians would provide an acceptable caseload of 80. Caseloads of more than 100 are not acceptable because they do not allow for adequate patient care and participation in an integrated team process.

2. The medical department needs to develop local medical policy consistent with state policy. This policy should outline requirements for the medical staff in terms of completion of
    a. annual medical assessments,
    b. active problem lists, and
    c. specific requirements for follow-up of individuals after hospital discharge.

    When expectations are clearly outlined, the medical staff should be held accountable for these requirements.

3. Address the practice of verbal orders.

4. Ensure all preventive screenings are provided.

5. Reduce the length of time in provider response to QDRRs.

6. The DNR status should be reviewed to determine if it meets state issued guidelines since it was in place for many years.

7. Clinical guidelines are needed for bowel management and osteoporosis. Recurrent episodes of ileus and obstipation may receive better management with clearly defined evidence based protocols. Likewise, a comprehensive osteoporosis protocol is needed. The number of individuals being screened for osteoporosis appeared low based on the number of individuals receiving AEDs alone.

8. The facility's internal medical reviews should be separated from the current quarterly medical summary. In fact, the internal review should actually assess the quality of documents, such as the quarterly medical summary and annual medical summary.

9. The external medical reviews should be revised to include process and outcome indicators. If not already done, physicians should receive immediate feedback on relevant issues at the time the review is completed. This is necessary to avoid a two-month or greater delay in implementation of corrective actions.

10. Mortality reviews should include a physician review that is comprehensive. A written report should be produced that includes pertinent findings, including what the facility did well and what areas exist as opportunities for improvement. An external physician would preferably complete this review. Information from the medical and nursing reviews would be used to generate a comprehensive corrective action plan that provides action steps, responsible persons, and timelines for completion. The facility administrator should adopt a hands-on approach and meet with the medical director and chief nurse executive on a regular basis to obtain status updates. The ultimate goal of the process is to improve outcomes for those who continue to be supported by the facility.

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:** <u>Documents Reviewed</u>: 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 (6) 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 11/1/10, individuals who have been seen in the ER, including date seen and reason for visit o Since 11/1/10, individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o Since 11/1/10, 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 11/1/10, individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial, etc.); 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 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 11/1/10, list of individual who died at SGSSLC or after being transferred to a hospital or other care setting o SGSSLC Self-Assessment: POI April 2011 o SGSSLC Meeting Schedule updated 5/13/11, updated o Copy of Medication Over/Short form o Draft policy of Assessment after Allegation of Sexual Incident o Inter-rater reliability scores for 12 nursing monitoring tools by section by tool o Minutes from all Pain PIT meetings o Corrective Action Plans developed in response to recommendations from QA death reviews o Job descriptions for Infection Control Nurse, Clinic Nurse, Nurse Educator, and Hospital Liaison o Table of Contents of Nursing Education Handbook o List of nurses absent from structured training and education sessions with verification of informal training for the last six months o Nurses assigned "NCC" and average length of time "NCC" for the last three months o Daily Nursing Staff Matrix for 5/1-5/26/11 o Records and MARs of: • Individual #232, Individual #251, Individual #384, Individual #222, Individual #202, Individual #129, Individual #382, Individual #168, Individual #290, Individual #283, Individual #386, Individual #218, Individual #194, Individual #179, Individual #377, Individual #10, Individual #76, Individual #352, Individual #7, Individual #345, Individual #278, Individual #109, Individual #122, Individual #159, and Individual #117 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Angela Garner o Nursing Operations Officer, Lisa Busby o Quality Enhancement Nurse, Lisa Owens o Nurse Hospital Liaison, Chey McCray o Infection Control Nurse, David Ann McKnight o Nurse Educator, Maria DeLuna o Medication Performance Improvement Team Meeting o Informal interviews with nine nurses (included RN case managers, RNs, and LVNs)

	o Meeting with Pharmacist, Medical Director, Chief Nurse Executive, and consulting Pharm.D. <u>Observations Conducted</u>: o Visited individuals residing in buildings 501, 502, 504, 508, 509, 510, 512, and 516 o Medication administration (508A, 508B, 509A, 509B, 510A, 510B, 516E, and 516W) o Enteral nutrition (516W)
	Facility Self-Assessment: The facility's self-assessment for section M indicated that since the prior monitoring review, the facility received new guidelines from state office regarding nursing management of individuals with acute illness and injury, nursing assessment and documentation, risk assessment, and medication administration. In addition, several important training sessions were held for all members of the nursing department, and self-monitoring reviews were in the initial stages of implementation. Thus, the facility rated noncompliance for all items. The monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: During the conduct of this onsite monitoring review, eight homes were visited, 15 nurses were interviewed, and 25 individuals' records were reviewed. Since the prior review, SGSSLC took swift action to address the nursing shortage. Specifically, the facility administrators lifted their ban on the use of contract/agency nurses and carefully selected, oriented, and trained contract nurses to fill the gap created by the nursing shortage. Although there continued to be vacancies, utilization of overtime, and almost daily use of nurses to "cover" homes, during the conduct of the review, nurses expressed nothing but appreciation and positive regard for the administrators' efforts and support to promote the their ability to carry out their duties. Although the facility should be commended for the organization of individuals' records organized, during the monitoring team's visits to the individuals' homes, it continued to be commonplace for the individuals' records to be "off the home" and not available or accessible to the physicians and/or 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. In addition, many nurses' notes continued to be inconsistently documented in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format. Also, as noted in the prior review, the content as well as signature/credentials appearing in some nurses' notes were not legible. A review of the sample individuals' records revealed that 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.

	The majority of the individuals' HMPs and ACPs continued to need improvement, especially with respect to the development of acute care plans in response to acute illness and injury and the review/revision of health management plans in response to changes in clinical indicators. At SGSSLC, there was evidence of some nursing assessment and reporting protocols, however, as noted in the prior review, the presence of these protocols was not sufficient to ensure that the health needs and risks of the individuals at SGSSLC was consistently identified and addressed. As noted above, there were numerous problems, described in sections M1, M2, and M3, in the implementation of nursing assessment and reporting protocols. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not yet evident in the 25 records reviewed. SGSSLC had implemented the state approved health risk assessment rating policy and procedures and rating tool and held regular assessments of risk as part of the PST process. According to the facility's POI, Ms. Valerie Kipfer from the state office visited the facility on two occasions, participated in two PST meetings, and provided additional information and observations to the teams to improve their knowledge and ability to implement the new process. Several PST Health Risk Assessment reviews that were completed more recently were more comprehensive and ensured more realistic ratings of risk, however, a number of individuals had yet to receive risk assessment reviews and ratings, in accordance with the newly implemented policy and procedures. Also, as noted in the prior review, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. The administration of medication and the management of the medication administration system at SGSSLC had not substantively improved since the prior monitoring review. According to the Pharmacy Director, on a monthly basis, hundreds, if not thousands, of medications continue to be unaccounted for and returned to the pharmacy. 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	Since the prior review, SGSSLC took swift action to address the nursing shortage. Specifically, the facility administrators lifted their ban on the use of contract/agency nurses and carefully selected, oriented, and trained contract nurses to fill the gap created by the nursing shortage. Although there continued to be vacancies, utilization of overtime, and almost daily use of nurses to "cover" homes, during the conduct of the review, nurses expressed nothing but appreciation and positive regard for the administrators' efforts and support to promote the their ability to carry out their duties. During the conduct of the monitoring review, eight of the nine homes were visited, 15	Noncompliance

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	individuals' health care status sufficient to readily identify changes in status.	nurses were interviewed, and 25 individuals' records were reviewed. As noted in the prior review, the records were very well organized and maintained since the prior review. However, during the monitoring team's visits to the individuals' homes, it continued to be commonplace for the individuals' records to be "off the home" and not available or accessible to the physicians and/or 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. Also, of note, the Integrated Progress Notes (IPNs) of a significant number of the records provided to the monitoring team were underlined and marked with check-marks, plus-signs, parentheses, etc., which appeared to have been made and inserted into the medical record at some time after the progress notes were originally documented by their author. Although it was not clear whether or not this apparent alteration of these medical/legal documents was done on a copy of the record, which was copied yet again and provided to the monitoring team. However, if that was not the case, this improper conduct should be immediately investigated and addressed by the facility's medical records department. Many nurses' notes continued to be inconsistently documented in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format. Also, as noted in the prior review, the content as well as signature/credentials appearing in some nurses' notes were not legible. Many nurses' notes continued to include uninformative, cryptic phrases that provided little, if any, specific, objective and/or subjective information to guide and direct planned interventions and/or caregivers' activities (e.g., "Face redder than usual," "Did not appear to be in pain," "No N/V, drinking Coke," "Going to the bathroom several times," "Did fall and hurt her teeth," "Less anxiety and related SIB and yelling," "Neuros are good"). A rating of noncompliance was made for this provision 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 23 of 25 of the sample individuals reviewed. The one exception to this	

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		pattern was that a review of Individual #210's record revealed that his RN case manager effectively ensured that his nurses had consistently addressed any and all changes in his health status and needs. 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. • Individual #382 was a challenging 42-year-old woman, who had many and frequent complaints regarding her health. In response to Individual #382's frequent complaints, her record notes revealed that her nurses often treated her as though she were feigning illness and/or injury. Thus, there were many occasions when her nurses failed to conduct adequate and appropriate assessments of her reports of changes in her health. For example, during the 14-week period of 1/23 – 5/9/11, on four separate occasions, Individual #382 reported to her nurses that she had "thrush." On 1/23/11, Individual #382's nurse noted that he/she observed plaque on Individual #382's tongue and throat that was "not very white," and concluded that Individual #382 had "potential infection" and placed her name on the board for Doctor's Rounds. Notwithstanding Individual #382's nurse's findings, she was not afforded a complete assessment of her mouth. In addition, on not one of the other three occasions when Individual #382 complained of "thrush," did her nurses assess her. Rather, on the basis of Individual #382's self-reported "thrush," her nurses notified her physician who, on 1/27/11, 3/18/11, 4/19/11, and 5/9/11, ordered treatments of Nystatin (an anti-fungal to treat infections of the mouth) three times a day for two weeks at a time. At no point during these 14 weeks was there documentation of an examination and complete assessment of Individual #382's mouth, periodic evaluation of her response to treatment, and evidence of communication with her physician regarding the recurrence of her infection and its apparent lack of response to treatment. • During the period of 1/11 – 5/11, Individual #382 also frequently complained of a "rash" to her inner thighs, peri-area, and lower abdominal folds. On some of these occasions, in response to her complaints, her nurses locally applied either aloe vesta ointment or a barrier cream. Throughout this period, there was no evidence that Individual #382's nurses performed a complete assessment of her rash or considered that the yeast that caused her thrush may have spread outside of her mouth. • On 4/11/11, Individual #382 complained of a runny nose, congestion, sneezing, and sinus pressure. Her nurses obtained two sets of vital signs and administered one dose of Benadryl 25 mg. On 4/12/11, Individual #382's nurse again noted that she complained of a runny nose and congestion. Another set of vital signs	

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		was obtained, and Benadryl 25 mg was administered. Although Individual #382's nurses noted that they would continue to monitor these changes in Individual #382's health status and provide medication as needed, there was no evidence of follow-up by her nurses. • On 2/16/11, Individual #7's physician noted that this 68-year-old woman was "frail" and "very unstable." Over the next several months, Individual #7 suffered 14 falls. Despite Individual #7's high risk of fall-related injuries, her nurses frequently failed to document the results of complete post-fall assessments. Rather, Individual #7's nurses usually noted, "she fell" or was "found on the floor (or ground)," indicated that their assessments revealed "no injury," and put forward no plans other than "to monitor" her for any problems. Notwithstanding Individual #7's nurses' plans to monitor her post-fall, there was no evidence of consistent monitoring to ensure that Individual #7 was not in pain, had not developed late bruising, and/or suffered more serious injury than what was initially noted. • There were also several occasions when Individual #7's nurses identified that she had not moved her bowels for three or more days. On these occasions, Individual #7's nurses noted that they administered Dulcolax suppositories, but failed to consistently follow-up on these significant changes in Individual #7's health status to ensure that she moved her bowels and obtained relief from the suppositories. Of note, on one of these occasions, <u>two days</u> after Individual #7's nurse had administered the Dulcolax suppository, it was noted that Individual #7 had moved her bowels as a result of the suppository given two days ago. First, waiting for two days for results from a suppository without proceeding with other interventions was not consistent with Individual #7's bowel management plan. Second, it was clear from the nurse's note that he/she failed to understand the intended use and effects of stimulant laxatives, such as Dulcolax, which provide fast relief and results within 15 to 60 minutes. • There were also at least two other occasions when significant changes in Individual #7's health status were not adequately assessed and appropriate follow-up to resolution by her nurses was not ensured. On 1/28/11, Individual #7's nurse noted that she had a possible urinary tract infection. Although a urine sample was obtained and sent for testing, there was no evidence of follow-up by Individual #7's nurses to this potential change in her health status. On 4/6/11, Individual #7's direct care staff member reported to her nurse that she had vomited brown liquid with chunks of undigested food. At this time, Individual #7 would not permit her nurse to obtain her vital signs, save for her temperature. There was no evidence of any other attempts by Individual #7's nurses to conduct a complete assessment and no evidence of follow-up to this change in her health status to ensure that she had not suffered aspiration during	

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		this untoward event. • On 1/14/11, Individual #168 underwent a dilation and curettage (D&C) with hysteroscopy and fibroid removal/biopsy. Individual #168 returned to the facility "dripping watery blood" from the pressure dressing on her lower abdomen. She was sent back to the hospital's emergency room forthwith and returned to the facility several hours later with a dressing that was saturated with bloody drainage. Individual #168's physician was called and he/she indicated that Individual #168 was to spend the night in the facility's infirmary, presumably under the close supervision of the infirmary nurses. Notwithstanding Individual #168's change in health status and risk of post-surgical complications, there was no evidence that during the first 24 hours of her re-admission to the facility that her nurses closely monitored her status. For example, from 9:25 pm (on 1/14/11) to 10:00am (on 1/15/11), there was no evidence that her vital signs were obtained, her surgical wounds were checked, and other indicators of her health status were monitored more than once. In addition, there was no evidence that Individual #168's nurses identified, assessed, or reported significant changes in her heart rate (i.e., on 1/15/11 at 10:00am, Individual #168's pulse was 69 beats per minute, at 3:30 pm, it was 115 beats per minute, and on 1/16/11 at 9:15 am, it was still elevated at 112 beats per minute). This was significant because a rapid heart rate could have been indicative of a number of significant health changes, including, but not limited to inadequate pain management and infection. • On 2/14/11, Individual #168's direct care staff member reported to her nurse that she "fell backward at the workshop." Individual #168's nurse noted, "…O: Back clear. No injury noted. Knees ROM good. No injury noted. 101/67 – 96.4 – 120 – 20, 97%. A: Altered comfort r/t fall. P: Staff to monitor. Report any c/o pain or distress noted to nurse." Despite the potential risk of serious injury from a backward fall, there was no evidence that Individual #168 received a complete assessment, which would have included ruling out a posterior head injury and gathering data to rule out a health/medical cause of Individual #168's fall. There was also no evidence that her nurse provided any first aid treatment. • On 2/20/11, Individual #168's direct care staff member reported to her nurse that she was "unresponsive behind the cantina." According to Individual #168's nurse's report, upon his/her arrival, Individual #168 was in a cart, very diaphoretic, drooling, responded only with nods, appeared very weak, and had been incontinent of urine. Individual #168's nurse obtained a set of vital signs and gave her four ounces of Sprite. According to Individual #168's nurse, Individual #168 became more responsive and reported seeing stars and feeling very weak. Notwithstanding these serious findings, Individual #168's nurse precipitously concluded Individual #168's "symptoms resolved" and sent her	

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		with staff for a snack. According to Individual's #168's nurse's note, she obtained Individual #168's blood sugar, notified the RN on duty, and indicated that he/she would "continue to monitor." There was no evidence that the RN on duty conducted an assessment and no evidence of any follow-up monitoring to ensure Individual #168's health and safety. • On 5/3/11, at 6:00 pm. Individual #251's direct care staff member reported to his nurse that he "went limp," but he did not lose consciousness. According to Individual #251's nurse, at the time of this report, Individual #251 was not at the facility. Rather, he was downtown on an outing. Although Individual #251's direct care staff member reported a possible medical emergency, Individual #251's nurse told the staff member to bring Individual #251 back to the facility. Forty minutes later, Individual #251's direct care staff member called his nurse again. This time they reported that Individual #251, who was still downtown, was "getting worse" and that he was not able to move his right side at all. At this time, Individual #251's nurse told his staff member that an ambulance needed to be called. However, Individual #251's direct care staff member told his nurse that they were "close to the hospital," and he/she told the staff member to "go ahead and take him to [the hospital]." Although, clearly, Individual #251 suffered a significant change in his health status, tantamount to medical emergency, his nurse failed to obtain complete information and failed to appropriately instruct his staff members to call "911" to transport him to the nearest medical facility. • Individual #251 was hospitalized from 1/30 – 2/1/11 for treatment of hematuria, neurogenic bladder, and urethral stricture. On 2/3/11, Individual #251 was brought to the medication room by his direct care staff member who had observed blood in Individual #251's catheter bag. The nurse on duty observed that Individual #251's urine was amber in color and small blood clots were present. According to Individual #251's nurse's note, Individual #251 denied pain and his abdomen was not distended. On the basis of this incomplete assessment of change in Individual #251's health status, his nurse indicated that he/she would "continue to monitor for fever and medication reaction." Despite Individual #251's recent discharge from the hospital for treatment of complications related to his genitourinary system and high risk of urinary tract infections, there was no evidence that the nurse conducted any further assessment or monitoring of Individual #251's health status. • On 2/16/11, Individual #251's RN noted that he/she checked Individual #251's foley catheter, and it appeared to have been pulled out approximately two to three inches. According to Individual #251's nurse's note, he/she proceeded to "push back" the two to three inches of catheter tubing into Individual #251's urethra. There was no evidence that the RN, at least, disinfected/cleansed the	

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		catheter tubing with soap and water and cleansed Individual #251's meatus before pushing the tubing back into his urethra and introducing bacteria into his urinary tract and increasing his risk of urinary tract infection. In addition, Individual #251's RN failed to document whether or not he/she noted a return of urine prior to adding nine cubic centimeters of normal saline to the catheter's balloon and failed to monitor Individual #251's urine output to ensure that the catheter was patent. • Individual #384 was an elderly 81-year-old man with multiple health needs and risks. On 3/24/11, at 6:15 pm, the operator, who reported that Individual #384 had fallen and was badly hurt, paged Individual #384's RN. The RN responded to the call and noted that Individual #384 had several abrasions on both of his knees and right wrist and abrasions and slight bump on his middle upper forehead. According to the nurse's note, Individual #384 was agitated, but allowed the nurse to clean his wounds and obtain a set of vital signs. On the basis of an incomplete assessment, the nurse concluded that Individual #384 had his "usual ROM," "no obvious neuro deficits noted," and "not necessary to continue (sic)." Approximately one hour later, another nurse administered Individual #384's bedtime medications, and applied triple antibiotic ointment to his wounds. Notwithstanding the seriousness of Individual #384's fall and his risk of injury, there were no other assessments of Individual #384 until the next day at 10:40 am when he was found "unarousable (sic)" and emergently transferred to the hospital. • On 3/6/11, Individual #202's nurse noted that she "Doesn't sleep well at night and is up frequently roaming the hall." There was no evidence of follow-up to this important health issue until over two months later, on 5/24/11, when her psychiatrist noted, "Reviewed records. Pt not sleeping. Will add Benadryl 50 mg q hs and D/C Buspar, as it is not effective…" • On 3/9/11, at 5:45 am, Individual #202 fell out of bed and suffered a serious injury to the area above her left eye. According to Individual #202's nurse, she obtained a set of vital signs, initiated 72-hour neurological checks, and offered Individual #202 an ice bag, which she promptly threw away. There was no evidence that after Individual #202's initial refusal of first aid that any attempts were made to encourage her to apply ice to the "large goose egg" above her left eye, no evidence of a pain assessment, and no evidence of communication or collaboration with Individual #202's physician regarding Individual #202's head injury save for the brief reference, "Refer to Dr. on rounds." • On 4/22/11 at 4:30 pm, Individual #202's direct care staff member reported that Individual #202 fell off the parked cart. Individual #202's nurse obtained a set of vital signs and noted, "no bruising on her bottom [and] no scratches seen." In addition, Individual #202's nurse reported that Individual #202 said "No" when	

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		she was asked if she hurt anywhere. There was no evidence that Individual #202's nurse conducted a complete assessment, which would have minimally included an evaluation of Individual #202's range of motion and assessment beyond her "bottom," and no evidence of additional follow-up by her nurses. • Individual #352's direct care staff member stated to Individual #352's nurse that Individual #352 was not feeling well. According to his nurse's note, he/she obtained a set of vital signs and noted that Individual #352 complained of nausea, dizziness, and difficulty breathing. Individual #352's nurse also measured his blood-glucose level and administered three units of insulin and a breathing treatment. Although Individual #352's nurse failed to gather all relevant data pertinent to a complete nursing assessment, he/she concluded that Individual #352 had no distress, and the RN was notified. There were no other nursing assessments or evidence of monitoring of Individual #352's health status until almost 24 hours later when he was evaluated by the RN, who noted that he required treatment for shortness of breath and low blood-oxygen saturation. • On 5/6/11, at 11:50 am, Individual #76's direct care staff member reported to his nurse that Individual #76 fell to his knees choking on food. According to Individual #76's nurse's notes, he/she called for medical and the RN. During Individual #76's nurse's response to the medical emergency, he/she noted that Individual #76 was positioned on his left side, and he expelled a large amount of food. Individual #76's physician was contacted, and he ordered a change of Individual #76's diet and evaluation by OT/PT. In addition, Individual #76's physician ordered, "Vital signs every 15 minutes for one hour and watch him on the home (emphasis added)." Individual #76's RN noted that his lung fields were clear and his respirations were unlabored and even. Notwithstanding this significant untoward event and heightened risk of aspiration and pneumonia, there were no other nursing assessments or follow-up notes indicative of Individual #76's nurses' close monitoring of his health status, as ordered by his physician. • From 1/1-5/26/11, on two occasions Individual #194 fell, on 10 occasions she complained of nausea/vomiting/diarrhea or other gastrointestinal problem, and on over 20 occasions she complained of other physical ailments such as earache, arm pain, shoulder pain, calf pain, burning on urination, headache, sore throat, neck ache, and eye redness/pain/burning. On not one of these occasions was there evidence of a complete nursing assessment and/or follow-up to resolution.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18	According to the facility's POI and the 5/23/11 presentation by Ms. Angela Garner, CNE, to the monitoring team, "The nurses are utilizing the state's approved Comprehensive Nursing Assessment form after receiving training." In addition, it was reported that the	Noncompliance

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	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.	monitoring of the completeness, accuracy, and quality of the assessments was underway; the results of the monitoring were entered into a database for tracking and trending; and that corrective actions were taken as needed. Of note, during the interview with Ms. Maria DeLuna, Nurse Educator, she informed the monitoring team that, on 5/25/11, she satisfactorily completed the state-approved physical assessment education and training program, which was held at Denton SSLC and attended by all of the state school nurse educators. The SGSSLC's nurses recent re-training regarding the nursing process had a specific focus on nursing assessment and documentation. Generally accepted professional standards of care indicate that 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. Accordingly, 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. Quarterly nursing assessments were present in 24 of the 25 of the sample individuals' records reviewed. Three of these 25 sample individuals had nursing assessments that were complete, accurate, and informative (Individual #386, Individual #210, and Individual #283). The individuals' nurses ensured that all of the individuals' health needs and risks were identified; responses to all medications and treatments were thoughtfully evaluated and described; the findings and recommendations of external providers, labs, and diagnostic test results were completely listed and reviewed; history and physical assessment data were collected and accurately documented; and all of the complex data and information obtained was synthesized relevant to the individuals and their situations to identify nursing diagnoses and develop expected outcomes. Notwithstanding these positive findings, a rating of noncompliance was made for this provision item because in 22 of the 25 records reviewed (88%), nursing assessments were either absent or failed to provide a complete, accurate, and 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, which 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	

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		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 for at least two reasons. One reason was 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 other reason was because the individuals' QMRPs and other personal support team members relied upon these assessments to inform their decisions, plans, strategies, and interventions to help the individuals achieve their highest practicable level of health and functioning. The most commonly occurring problems in the nursing assessments were: (1) incomplete lists of consultations and associated recommendations, (2) no evaluations of the individuals' response to and effectiveness of their medications and treatments, (3) brief and uninformative notes of the results of the nurses' quarterly meal monitoring (e.g., "Eats > 50%," "No problems during meal," etc.), (4) inaccurate history, function, psychosocial, and physical assessments with little to no explanation of negative findings, (5) underscored Braden Scales, and (6) wholly deficient identification of nursing problems and diagnoses. Examples of these findings are presented below. • Individual #377 was a 26-year-old man diagnosed with GERD, hyperlipidemia, acne, and allergic rhinitis. One of this individual's most salient physical characteristics that increased his risk of health problems was, what his ENT physician called, "a very deviated and obstructed nasal septum with very engorged inferior turbinates." According to Individual #377's ENT, Individual #377 was prone to sinus infection, difficulty breathing, and airway obstruction. Notwithstanding the significance of these health issues on Individual #377's daily living and quality of life, the "respiratory" section of his nursing assessment failed to reference his almost constant congestion and difficulty breathing; the "nose" section of his nursing assessment inaccurately indicated that he had "no abnormal findings" and failed to reference his very deviated septum; and the "sleep" section of his nursing assessment inaccurately indicated that he had "no problems" with sleep and failed to indicate his risk of sleep apnea. Thus, it was not surprising that the nursing diagnoses derived from this incomplete assessment failed to include any of these health issues. • Individual #109 was a 74-year-old woman diagnosed with many chronic health needs and risks that included dementia, CVA with right hemiplegia, marked spasticity and contractures of limbs with chronic pain, seizure disorder, hypertension, GERD, glaucoma, blindness, osteopenia, urinary retention, and	

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		bowel management issues. Individual #109's 3/11 nursing assessment failed to list her medications and treatments and evaluate her response to and the effectiveness of her treatments. Her nursing assessment also failed to reference her GERD, osteopenia, use and risks of indwelling foley catheter, and bowel management issues. In addition, there was no summary of Individual #109's health status during the quarterly period reviewed by her nurse. • Individual #382 was a 42-year-old woman diagnosed with bipolar disorder, triple X syndrome, asthma, insomnia, hypothyroidism, GERD, constipation, glaucoma, allergic rhinitis, obesity, and varicose veins. She had many health and behavior needs, challenges, and risks that required regular monitoring by her nurses. Part of that monitoring included the completion of regularly scheduled, quarterly nursing assessments. According to Individual #382's record, her most recent Comprehensive Nursing Assessment was completed on 11/18/10. According to Individual #382' nurse's notes, on 5/10/11, Individual #382 requested an assessment by her nurse and stated, "I guess you need to do my quarterly assessment." At this time, Individual #382's nurse noted that the individual denied any complaints, her lung sounds were clear in all areas, no distress was noted, she talked without difficulty, she had some thrush in her mouth, her bowel sounds were present, her skin was warm, dry, and pink, no cyanosis was noted, her pedal pulses were palpable, her O2 saturation was 95% on room air, and no edema was noted. Individual #382's nurse concluded his/her note with the phrase, "This is my quarterly assessment of Individual #232." Of note, the nursing assessment was tardy, incomplete, and not performed in accordance with the facility's policy and procedure. • Individual #232 was a 21-year-old woman who was morbidly obese, diabetic, arthritic, and diagnosed with a sexually transmitted disease (STD). Her nursing assessments failed to reference an evaluation of her response to and effectiveness of her multitude of medications and treatments, failed to provide information obtained as a result of the nurse's monitoring of mealtime, save for the two-word phrase – "No problems," and inaccurately portrayed her oral hygiene as "good." According to Individual #232's dentist, her oral hygiene was poor, but she "seemed interested in oral hygiene improvement." Since that dental report, Individual #232 required the restoration of multiple decayed teeth and has of late refused to accept dental prophylaxis and attend scheduled appointments. None of these issues were identified vis a vis Individual #232's nursing assessments, and none were addressed. • Individual #129 was a 23-year-old woman who was diagnosed with bipolar disorder, hypothyroidism, hyperlipidemia, enuresis, nicotine addiction, and insomnia. The sections for "Current Active Medical Diagnosis" nursing assessments for Individual #129 were incomplete and listed only two diagnoses	

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		– hypothyroidism and hyperlipidemia. In addition, Individual #129's nursing assessments failed to reference her insomnia, enuresis, and significant history, as well as frequent, ongoing complaints, of pain in her shoulder, head, and right lower quadrant of her abdomen. • Individual #7's 2/16/11 Annual Physical Examination report indicated that she was "frail" and "very unstable." Indeed, Individual #7 fell at least 10 times in the three months preceding her most current quarterly nursing assessment (4/18/11). In addition, to Individual #7's falls, during the quarterly period, she suffered problems with imbalanced nutrition, weight loss, constipation, cerumen impaction, h. pylori infection, skin breakdown, and a sprained ankle. Notwithstanding the aforementioned problems, needs, and risks, Individual #7's nursing assessment failed to reference her GERD, constipation, and use of the emergency room. In addition, although Individual #7's record was replete with reports, summaries, and notes that referenced her risks related to weight loss and imbalanced nutrition, the results of Individual #7's nurse's meal monitoring only noted, "Eats > 50% of meal monitored (sic)." • Individual #384 was an 81-year-old man diagnosed with multiple health needs and risks and determined by his PST to be at high risk of weight loss and osteoporosis. Individual #384's nursing assessments failed to reference a complete review of the abnormal results of his blood tests and his response to and effectiveness of his medications and treatment. In addition, despite his high risk of weight loss and direct care staff members' reports of increased coughing during meals there was no date of mealtime monitoring by his nurse. Rather, the same phrase, which was repeated from one quarterly nursing assessment to the next was carried forward – "Individual #384 tends to eat fast. Staff is instructed to prompt and encourage him to slow down and to take smaller bites." This statement failed to provide and specific findings and/or evidence that Individual #384's nurse had actually conducted a face-to-face monitoring of his meal. Of note, Individual #384's nurse referenced in his nursing assessments that Individual #384 "smokes heavily," but failed to put forward any information that would have helped clarify and/or explain the nature and impact of Individual #384's nicotine addiction on his current health status and quality of life. • Individual #10 was a 45-year-old man diagnosed with schizoaffective disorder, hypertension, benign prostatic hypertrophy, insomnia, onychomycosis, and hyperammonemia. One of his most salient physical characteristics that increased his risk of health problems was his cervical dystonia, a condition that caused a painful twisting and turning of his head and neck. According to Individual #10's PST, "the only risk that could be a problem is caused from his dystonia of the neck." Notwithstanding the significance of this health issue on Individual #10's daily living and quality of life, the "neck" section of his nursing	

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		assessment was blank, and the "spine" section inaccurately indicated that he had "no abnormal findings." In addition, Individual #10's nursing assessments failed to reference a complete review of his lab tests, especially those with significant abnormal findings. Also, although Individual #10 was a notorious "picky eater" who had recently lost over six pounds during the most recent quarterly review period, his nurse's assessment and report of his/her monitoring of Individual #10's meal was uninformative and limited to two words – "No complications." • Individual #179 was a 78-year-old man diagnosed with diabetes, chronic renal insufficiency, chronic anemia, hyperlipidemia, hypothyroidism, osteoporosis, GERD, degenerative joint disease, sarcoidosis, and history of multiple episodes of pneumonia. Notwithstanding Individual #179's significant health needs and risks, his nursing assessments failed to reference his chronic renal disease, chronic lung disease, and history of multiple pneumonias. Thus, there were no nursing diagnoses put forward to facilitate the determination of the expected outcomes and plans to address any of these chronic health needs and risks. • Individual #202 was a 61-year-old woman diagnosed with pervasive developmental disability, autism, hyperlipidemia, hypertension, hypothyroidism, osteoarthritis, cerebral vascular disease, multi-infarct dementia, cholelithiasis, constipation, diverticulosis, onychomycosis, insomnia, and pica. Individual #202's nursing assessments failed to reference her occasional diarrhea, insomnia, and many missing teeth. Individual #202's nursing assessments also failed to include an adequate evaluation of her response to and the effectiveness of her medications and treatments. In addition, the nursing summary section of Individual #202's 3/11 nursing assessment only referenced that there were changes in her psychotropic medication regimen and that she "eats well" and uses a gait belt when up with her walker. Although Individual #202's 3/11 nursing assessments noted that she had a "couple of hard falls this quarter" and "this month, she fell out of bed," it failed to accurately portray the nature and severity of the falls, injuries, and risks\ of harm associated with the three falls and serious head and facial injuries suffered by Individual #202 during the five-month period of 11/21/10 – 4/22/11. As a result of the inadequate assessment of these risk issues, there were no nursing diagnoses generated, and no plans to address Individual #202's risks of falls and injuries. • Individual #222 was a 79-year-old man who was diagnosed with dementia, chronic obstructive pulmonary disease (COPD), mild peripheral vascular disease (PVD), osteoporosis, onychomycosis, periodontal disease, benign prostatic hypertrophy, and prostatic nodule, probably cancerous. Neither his prostate problem nor his likelihood of prostate cancer was referenced in his nursing assessments. In addition, although Individual #222 had many chronic health needs and risks, there were only two (2) nursing diagnoses referenced in his	

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		nursing assessments – risk for impaired skin integrity and decreased cardiac output with excess fluid volume/water retention. <u>Pain Assessment Monitoring</u> Of the 25 sample individuals reviewed, several individuals required pain assessment and monitoring as a result of acute changes in their health that occurred proximate with acute illness, injury, and/or surgery. However, three of the 25 sample individuals' nurses' monitored their pain regularly, at least weekly, using the Pain Assessment Monitoring forms. • Individual #7 was an ambulatory 68-year-old woman who was diagnosed with many chronic health conditions and considered by her physician and PST to be "frail" and "very unstable." In addition, from 1/11 – 5/11, she suffered 14 falls accompanied by both serious and non-serious injuries. Individual #7's physician prescribed daily doses of the non-steroidal anti-inflammatory drug, Mobic 7.5 mg, to treat the pain and inflammation associated with Individual #7's arthritis. • Individual #109 was a non-ambulatory 74-year-old woman who was also diagnosed with many chronic health needs and risks that included marked spastic, rigid, contracted limbs associated with chronic pain. Individual #109's physician prescribed a potent synthetic narcotic analgesic that was 100 times more potent than morphine, Fentanyl 7.5 mcg every 72 hours to treat Individual #109's chronic pain. • Individual #122 was a non-ambulatory 92-year-old woman who was diagnosed with Parkinsonism with dementia, osteoporosis with kyphosis, osteoarthritis, hypercholesterolemia, chronic obstructive pulmonary disease with chronic intermittent bronchospasm, mild glaucoma with cataract, incontinence, seasonal allergies, and dermatitis. Individual #122's physician prescribed Celebrex 100 mg every day and also prescribed Fentanyl 12 mcg every 72 hours to treat Individual #122's chronic pain. A review of all three individuals' Pain Assessment Monitoring Forms for the period of 3/1-5/26/11 revealed that throughout the three-month period, all individuals scored "0," indicative of "No hurt," on all of their pain assessments. A closer review of these data revealed that Individual #109's and Individual #122's pain was assessed once a week between the hours of midnight and 5:00 am, presumably during the time they were in bed asleep. Individual #7's pain was assessed once a week between the hours of 8:00 am and 1:00 pm, presumably during the hours immediately after her 8:00 am dose of Mobic. Although reducing, controlling, and possibly eliminating chronic pain was the desired outcome that these data seemed to indicate, repeatedly conducting assessments of pain during only one narrow window of time and under the same, predictable set of	

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		circumstances may have resulted in measures of pain control/management that were not indicative of actual pain control/management over the natural course of the individuals' day, which would usually include their participation in ADLs, repositioning, treatments, leisure activities, etc.	
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. Since the prior monitoring review, the nursing staff members at SGSSLC received additional training regarding the development and implementation of health management plans, as well as training in the new planning processes that were underway at the facility. According to the results of the SGSSLC QA nurse's and members of the nursing leadership team's monitoring of the HMPs and ACPs, they continued to need improvement, especially with respect to the development of acute care plans in response to acute illness and injury and the review/revision of health management plans in response to changes in 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 being in noncompliance. At SGSSLC, health management plans and acute care plans were designed to promote health and/or prevent, reduce, or resolve the problems and risks that were identified via the nurses' assessment and nursing and medical diagnoses. In total, the nursing care plans were expected to 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. It was anticipated that the nursing interventions put forward in these plans would 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. As such, the individuals' status and the effectiveness of the plans to achieve their goals required continuous evaluation and modification as needed. To ensure that the monitoring team received complete, accurate, and up-to-date records of individuals' health management plans, the home secretaries submitted all of the current health management plans in the individuals' active records. All 25 individuals reviewed had some of their health needs and risks referenced in health management plans (HMP). Only three of the 25 sample individuals reviewed had complete health management and acute care plans developed by their RN case manager in a timely manner, in accordance with their health needs and risks, and in a form/format that clearly showed that they were developed from a complete database of information and in collaboration with the individuals and their team members.	Noncompliance

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		For example, for Individual #386, all of the significant changes in his health, which included the emergence of acute health issues, were promptly identified and addressed. These health issues ranged from relatively low risk matters such as impacted earwax to relatively high risk matters such as abdominal distention and small bowel obstruction. Nonetheless, his RN case manager ensured follow-up to all of his health needs and documented comprehensive nursing assessments that adequately informed his caregivers and interdisciplinary team members and provided a solid foundation for the development of complete and individualized health management and acute care plans. The other 21 individuals' health management plans were in different forms/ formats and varying states of completion. Almost none were reviewed at least quarterly, appropriately individualized, revised when the individuals' status and needs significantly changed, signed by the appropriate staff members (nurse and ATP), and properly dated with dates of implementation, review, and, when applicable, revision and/or resolution. Although 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), there were many more problems existed that were not explained by these deficiencies. Some general comments are presented below. • In 21 of the 25 individuals reviewed, 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. ▪ All of the 25 individuals reviewed had one or more stock care plans, which when assembled together were considered to be the individuals' HMPs. However, almost none of the stock care plans had been adequately customized and/or personalized to address individuals' specific health problems and risks. And, not one related to the other. Rather, these stand alone plans referenced generic interventions mostly related to "monitoring" and "reporting" activities and usually instructed the reader to follow other plans and/or do "as ordered." ▪ Most of the 25 individuals reviewed failed to have one of more of their chronic health needs, such as hypothyroidism, hyperlipidemia, seizure disorder, osteoporosis, constipation, peripheral vascular disease, incontinence/enuresis, asthma, insomnia, and hearing/vision impairments addressed with a health management plan(s). ▪ Most of the sample individuals who were usually prescribed at least two psychotropic medications failed to have HMPs that referenced nursing and direct care staff members' interventions to monitor side effects. The only	

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		exception to this pattern was when the individual(s) suffered an adverse drug reaction that was of a relatively high level of seriousness and severity, such as Stevens-Johnson syndrome. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs were not revised, and they did not reflect the most current conditions and intervention strategies. • For the majority of the individuals, there was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' current HMPs and 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 Nursing Assessment portion of the individuals' PSPs continued to be uninformative and did not provide even a brief recapitulation of the individuals' health status over the past year. As noted during the prior review, 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. Although the quarterly Comprehensive Nursing Assessments were reportedly provided to the individuals' QMRPs and other relevant PST members on a quarterly basis, it was unclear whether or not the assessments were provided to the QMRP and PST members in a timely manner and/or whether or not the assessments were read and incorporated into the PSP and PSPA processes. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #352 was a 56-year-old man who was diagnosed with diabetes, chronic obstruction pulmonary disease, history of multiple pneumonia complicated by reactive airway disease, hypertension with left ventricular hypertrophy, hypothyroidism, benign prostatic hypertrophy, blindness, probably diabetic neuropathy, genital warts, and nicotine addiction. At the time of the review, Individual #352 had only two HMPs filed in his record – one was related to his chronic obstructive pulmonary disease (COPD), and the other was related to continuous positive airway pressure breathing (CPAP). There were no other health plans developed to address any of his other chronic health problems and needs. In addition, Individual #352's plan to address his COPD referenced "criteria for consulting with a nurse," which required that Individual #352's direct care staff members' monitor his heart and respiratory rates. Of note, both of Individual #352's HMPs were missing the signature of his ATPs. • Individual #117 was a 22-year-old woman who was diagnosed with bipolar disorder, personality disorder, HIV, asthma, migraine headaches, GERD,	

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		constipation, hearing loss, insomnia, and nicotine addiction. Her health management plans failed to reference interventions to address her frequent complaints of pain, falls, insomnia, hearing loss, and nicotine addiction. In addition, although Individual #117 had HMPs to address her HIV, asthma, constipation, and GERD, all of these plans were inadequate to address the complexity of her health needs and risks in these areas. Several of Individual #117's HMPs did not put forward specific interventions for her direct care staff members to carry out and/or the criteria for what they should promptly or immediately report to the nurse. This was especially significant since Individual #117's direct care staff members were often assigned the responsibility to monitor and report significant changes in Individual #117's health status to her nurses. • Individual #202 had many chronic health problems not addressed by health management plans. For example, there were no plans to address her hypothyroidism, hyperlipidemia, constipation, osteoarthritis, onychomycosis, and insomnia. In addition, despite Individual #202's three serious falls with head injuries, which occurred on 11/21/10, 3/9/11, and 4/22/11, no acute care plans were developed to address her injuries and reduce her risk of falls. • Individual #232 was a 21-year-old morbidly obese, HPV+, woman who was diagnosed with diabetes, hypertension, arthritis, and anemia. As of the review, Individual #232 had only one HMP filed in her record. Individual #232's single HMP was developed to address her obesity. Despite Individual #232's dire need for health education, counseling, support, planning, and close monitoring, there was no evidence that her nurses had made any substantive attempts to develop health plans with her cooperation and collaboration to address her serious health problems, all of which posed actual and potential risks to diminishing the quality and longevity of her life. In addition, Individual #232's PST members were clearly misinformed about the nature and consequences of Individual #232's health problems and risks when they concluded during the annual meeting that "Individual #232 has some medical issues…but nothing really major…with taking baby aspirin to help her heart and Lisinopril to protect her kidneys…she is not at high or medium risk at this time (3/1/11)." Clearly, Individual #232's PST was in dire need of complete and accurate information regarding Individual #232's health needs and risks. • Individual #194 was a 31-year-old woman diagnosed with disruptive behavior disorder, hypothyroidism, severe speech disorder, GERD, obesity, chronic cystitis with microhematuria, myopia, and tinea pedis. At the time of the review, despite the presence of several chronic health problems, needs, and risks, Individual #194 had only two health management plans – one related to her obesity and the other related to GERD. As noted in the prior review, according to	

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		Individual #194's nursing assessment, her constipation, hypothyroidism, and other 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 #179 was a 78-year-old man who was diagnosed with several chronic health problems that included diabetes, hypothyroidism, GERD, degenerative joint disease, osteoporosis, sarcoidosis, chronic kidney disease stage III, and chronic anemia. Despite the complexity of managing, monitoring, and caring for Individual #179's chronic conditions and health needs, Individual #179 had only six, one-page HMPs, which were related to aspiration, hyperglycemia, hyperlipidemia, constipation, impaired skin integrity, and impaired mobility/falls, filed in his record. These one-page "plans," failed to provide adequate interventions, directions, and guidance for his nurses and direct care staff members to follow to ensure that Individual #179's health needs would be met and his health risks reduced. For example, Individual #179's aspiration plan provided only two directions for his direct care staff to follow - use his mother-care spoon and use verbal prompts to encourage safe bite sizes and slow down his rate of eating – to ensure his safety before, during, and after mealtime and reduce his risk of aspiration. • Individual #222 was a 79-year-old man who was diagnosed with dementia, chronic obstructive pulmonary disease, hypothyroidism, osteoporosis, osteoarthritis, mild peripheral vascular disease, benign prostatic hypertrophy, prostate nodule - probably cancerous, mild cataracts, onychomycosis, and periodontal disease. In addition, Individual #222 was reportedly a "heavy smoker." Although Individual #222 was in the latter years of his life, he, with the support of his PST, planned that his latter years be free, independent, and retired. Effective management of Individual #222's multiple chronic health conditions was an important part of his plan. However, only two of Individual #222's health needs and risks – impaired skin integrity and decreased cardiac output - were addressed with health management plans. None of his other actual and potential problems and risks were minimized through consistent implementation of planned strategies and therapeutic interventions. • Individual #384 was an 81-year-old man who was diagnosed with dementia, GERD, osteoporosis, hypertension, mitral valve disease, history of seizure disorder, history of duodenal ulcers, status post urinary tract infection, bilateral cerumen impactions, and weight loss. Notwithstanding his many chronic health needs and risks, at the time of the review, Individual #384 had health	

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		management plans to address only two of his needs – weight loss and risk of aspiration. There were no plans in place to address his other, equally salient chronic health needs and risks. In addition, there was no evidence that an acute care plan was developed after Individual #384 suffered a serious fall and was "hurt badly (sic)" to address his post-fall injuries and health risks. Thus, there was no evidence of monitoring Individual #384's acute health needs and risks post-fall and no evidence of interventions prior to the next day when he was discovered "unarousable (sic)" and emergently transferred to the hospital. • Individual #382 was a 42-year-old woman with multiple challenging health and behavior needs and risks. She was diagnosed with borderline personality disorder, triple X syndrome, asthma, insomnia, hypothyroidism, GERD, allergic rhinitis, acute pancreatitis, constipation, glaucoma, club feet, varicose veins of legs, and overweight. Although Individual #382 has many health needs, at the time of the review, the only health problem addressed vis a vis health management plan was her obesity. During the year preceding the review, she gained 31 pounds, but her health management plan was not reviewed and/or revised. Over the past six months, on four separate occasions, Individual #382 reported that she had "thrush." There was no evidence that an acute care plan was developed to address her oral infections. In addition, on several occasions, Individual #382 reported to her nurses that the skin of her groin, upper thighs, and lower abdomen was irritated and raw. Although Individual #382's nurses applied ointment or barrier cream to her skin when she complained, they did not develop an acute care or health management plan(s) to address her skin breakdown and reduce the likelihood of recurrence and/or infection.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	At SGSSLC, there was evidence of some nursing assessment and reporting protocols, however, as noted in the prior review, the presence of these protocols was not sufficient to ensure that the health needs and risks of the individuals at SGSSLC was consistently identified and addressed. As noted above, there were numerous problems, described in sections M1, M2, and M3, in the implementation of nursing assessment and reporting protocols. 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	Noncompliance

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		nursing management team reviewed the role and responsibilities of nurses across various processes and protocols, discussed newly revised policies and procedures, and made recommendations to improve the delivery of nursing supports and services across the facility. Notwithstanding the regular meetings of nursing management to present information and respond to questions and concerns from the facility's nurses, there were problems within the Department of Nursing. During the monitoring team's informal interviews with several Nurse Managers, RNs, and LPNs, they complained of their dissatisfaction with the conduct and effectiveness of the facility's nursing leadership to promote positive change and progress toward achievement of compliance with the provisions of Section M of the Settlement Agreement. The nurses who were interviewed also reported that during the Summer of 2010, a formal grievance was filed with the State Office regarding the ineffective management of SGSSLC's Department of Nursing. A "management specialist" was assigned to address and resolve the grievance, but, apart from recommending that several members of the nursing leadership attend a management-training seminar, the management specialist has not conducted any additional follow-up. The monitoring team recommends that the facility's senior administration look at the nursing department management and provide follow-up and support. During one of many informal interviews with the CNE and NOO, they clearly spoke of their commitment to do whatever was needed to deliver the best care possible to individuals. Notwithstanding the CNE's and NOO's commitment to their colleagues and the individuals they served, it was imperative that they address the work force issues, which presented serious and persistent barriers to much needed improvements in nursing care. Unless these issues are addressed, the effectiveness of interventions to address problems and the consistent implementation of action steps to achieve compliance with the Settlement Agreement will be diminished. As of the review, the Infection Control Nurse had been in her position for six months. During the six months preceding the review, the Infection Control Nurse received some training and mentoring from another state school's Infection Control Nurse. However, as of the review, she was still "trying to figure out how to gather data to see what the [facility's infection control] problems really were." During the review, it was apparent that the Infection Control Nurse was not being adequately supported from both within and outside the Department of Nursing.	

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		Although the Infection Control Nurse has delved into her new position and duties and was in the process of developing an infrastructure and plan to implement an infection control program at the facility, she was provided with little to none of the tools she needed to do her job. Thus, the appropriate assessment and reporting processes, which were contemplated and planned six months ago, were derailed. In addition to the apparent lack of structure of an infection control program at the facility, there were insufficient processes in place to identify and address actual and potential infections and reduce the likelihood of contagion and outbreaks of infection(s). For example, according to the Infection Control Nurse, there were no training curricula developed for specific high risk infections, which were associated with residential facilities like SGSSLC, because "[SGSSLC] hadn't had the diseases." In addition, the facility's database of immunizations was "no where to be found," reportedly as a result of the former Infection Control Nurse's failure to provide these data to the facility prior to her departure. Thus, more than half of the database of individuals' immunization records was not up-to-date. Also, although the Infection Control Nurse developed a form for conducting oversight of the implementation of infection control processes and procedures at the facility, as of the review, none had been done. Of note, the Infection Control Nurse planned to conduct two such reviews the week after the monitoring review. A review of the Infection Control Meeting Minutes revealed that although there were a number of serious problems identified – episodes of serious infections, some of which were highly contagious, increased frequency of urinary tract infections, occurrences of aspiration pneumonia, etc. – adequate assessment and reporting processes failed to occur. For example, specimens to assess presence of bacteria and sensitivity to treatment interventions were not appropriate obtained and contaminated, infections were not reported in a timely manner, and the only recommendations put forward to address these serious problems were limited to "Continue Monitoring," save for one recommendation to "Re-train RN and LVNs" to properly obtain specimens. At the time of the review, the Nurse Educator had satisfactorily completed the Mosby physical assessment training program. According to the Nurse Educator, over the next several months, this training program will be provided for all RNs at the facility. However, as of this review, the dates of these training sessions were not scheduled, and it was unclear whether or not the specialty RNs, including the QA Nurse, PNMT Nurse, and Clinic Nurse, would be included in the training program. Also, the Nurse Educator reported that a standardized nursing education handbook was being finalized and would be available for the conduct of new employee training and the annual nursing competency training within the next month or so.	

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		During the monitoring team's interview with the Nurse Educator, she reported that while there had been some improvement in the facility's training and education protocols, there continued to be areas where nurses continued to struggle. For example, she reported that several buildings continued to be understaffed, records continued to be unavailable to the clinical professionals when needed, and corrective action plans to address the findings of the monitoring review tools, otherwise known as "chart audits" were not developed and implemented in a timely manner. For example, the Nurse Educator reported that, on one occasion when the results of her monitoring reviews revealed problems with nursing care, she immediately reported her findings to the CNE and recommended that when problems with nursing care and treatment were discovered during the monitoring reviews, that real time interventions and corrections something must be done in a real time way. The Nurse Educator conveyed her deep concern over the findings of the monitoring reviews, but remained optimistic that in the coming months, with the implementation of the new assessment and reporting protocols, nursing care would improve. It was not uncommon for the Nurse Educator to be called upon to provide re-education and training to nurses, and direct care staff members, in areas where performance improvement was needed. A review of the Nurse Educator's presentation books revealed that, since the prior monitoring review, she conducted formal training for the nurses in SOAP documentation, seizure management, reporting infections, transcriptions of orders/MARs, medication administration, administration of enteral feedings, injections, use and maintenance of Fentanyl/Duragesic patches, at-risk individuals, weight measurement and monitoring, pretreatment and post-sedation monitoring, suction toothbrushing, and adverse drug reactions. On each of these topics, the Nurse Educator held multiple sessions of training and education. However, a review of lists of nurses who missed one or more of the Nurse Educator's training/education sessions, revealed that many nurses missed the structured training/education sessions, and, as a results, were required to submit only written verification that they participated in "informal training." For example, 14 nurses missed the structured training/education session related to SOAP documentation; 32 nurses missed the structured training/education session related to seizure management and administration of medications and enteral feedings; 18 nurses missed the structured training/education session related to adverse drug reactions; 24 nurses missed the structured training/education session related to reporting and follow-up for individuals with infections, etc. Although the Nurse Educator received some type of "verification" that the nurses obtained "informal training," the nature of their informal training was usually limited to reading and signing training materials without the benefit of	

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		instruction, discussion, interactions with colleagues, etc. As noted in the prior review, the Hospital Liaison continued to conduct daily visits to individuals who were in the hospital. A review of the Hospital Liaison's integrated progress notes revealed that during her visits she made observations, reviewed records, and received reports from the clinical professionals 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. In addition, she facilitated consultations between the clinical professionals at the tertiary care facilities with the clinical professionals at SGSSLC. She also verified that accuracy and completeness of transfer information upon individuals' admission to and discharge from tertiary care providers. According to informal interviews with the facility nurses, the Hospital Liaison was very knowledgeable and experienced, always ready to lend a hand, always available to help solve problems, and willing to take leadership roles in various performance improvement activities. For example, at the time of the review, the Hospital Liaison was leading at least two performance improvement activities. She led and organized the facility's efforts to bring individuals' annual physical examinations up-to-date and thoughtfully designed and led the facility's performance improvement activities to improve the pain assessment and reporting protocols, which had been identified during the monitoring reviews as an area that was in dire need of improvement. Over the past six months, as part of the Hospital Liaison's role and responsibility to ensure smooth and safe transitions and improve communication with tertiary care facilities, the Hospital Liaison has expanded her role to more fully advocate on behalf of the individuals' needs for safety and proactive treatment to protect them from harm. For example, the Hospital Liaison met with the tertiary care facilities speech and language pathologists to help them identify and address individuals' risks of aspiration and reduce the likelihood that they will suffer aspiration-related complications. During an interview with the Quality Assurance (QA) Nurse, she reported that, since the prior monitoring review, the facility has used 12 monitoring tools to conduct monthly reviews of nursing care. In addition, she reported that the measurement of inter-rater reliability was underway. A review of the results of the 12 monitoring reviews revealed that there were widely varying and significantly low scores for both item-specific and overall compliance with indicators of compliance with standards of care across all 12 monitoring reviews. A review of the results of the ongoing measurement of the inter-rater reliability revealed	

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		that the inter-rater scores related to the monitoring of acute illness/injury, documentation, and infection control were 94-95% consistent across reviewers. However, a review of the results of the ongoing measurements of the inter-rater reliability related to the other nine monitoring tools were only 15-79% consistent across reviewers. Despite the monitoring reviews results that were indicative of patterns of scores of noncompliance with many expectations and standards of care and widely varying measures of reliability across reviewers that were indicative of inconsistent applications of measurement criteria, there was no evidence of plans to address these significant findings. According to the QA Nurse, the Department of Nursing, with the help of the facility's Quality Improvement Council, was getting ready to prepare corrective action plans to address areas of performance with less than 80% compliance with standards of care. Despite the Department of Nursing's lack of corrective action plans, during the interview with the QA Nurse, it was noted that she had continued to provide on-the-spot technical assistance and training to all nurses, RNs and LVNs, regarding the purpose of quality assurance and how it can improve care of individuals. During the interview with the QA Nurse, she also reported on the various performance improvement team activities, which were underway at the facility. The "PITs," which stood for Performance Improvement Teams, were the facility's designated oversight and monitoring teams developed in response to problems and performance issues identified vis a vis the monitoring reviews and other reports (also see section E above). For example, during the prior monitoring review, 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. The Med PIT, which was still underway, had achieved only very few of its goals (see Section M6). As of the review, another PIT called the Pain PIT was developed to address the problems and performance issues that were revealed during the conduct of the QA Nurse's reviews of individuals' deaths and the Pain Management monitoring reviews. Although the Pain PIT was in its early stages of development and partial implementation, a review of the Pain PIT meeting minutes revealed that several steps had already been taken to improve the assessment and reporting of individuals' pain, including, but not limited to, "helping [individuals'] direct care staff members know when someone is hurting." As reported in the prior monitoring review, the QA Nurse continued to play a vital role in	

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		the facility's efforts to meet the provisions of the Settlement Agreement. Since the prior review, the facility administrators lifted their ban on the use of contract/agency nurses and carefully selected, oriented, and trained contract nurses to fill the gap created by the nursing shortage. Although there continued to be vacancies, utilization of overtime, and almost daily use of nurses to "cover" homes, during the conduct of the review, nurses expressed nothing but appreciation and positive regard for the administrators' efforts and support to promote the their ability to carry out their duties. At the time of the review, the Nurse Recruiter position was filled. However, the nurse hired for this position worked during the night shift and was unable to transition to the Nurse Recruiter position until her night shift position was filled. At the time of the review, the Nursing Department continued to have six vacant positions. This was a significant improvement from the prior monitoring review finding of 19 vacant positions. Notwithstanding this positive finding, it was reported that the facility had reduced its vacancies by hiring five graduate nurses. Although hiring new graduates had the advantage of bringing nurses on board who were "starting fresh," it also carried with it some disadvantages, such as nurses who lacked experience and who may or may not meet their licensure requirements. So, as noted in the prior review, it remained critically important for the facility administrators and the Department of Nursing to work together to develop a strategic plan to build a stable, competent nursing workforce.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	SGSSLC had implemented the state approved health risk assessment rating policy and procedures and rating tool and held regular assessments of risk as part of the PST process. According to the facility's POI, Ms. Valerie Kipfer from the state office visited the facility on two occasions, participated in two PST meetings, and provided additional information and observations to the teams to improve their knowledge and ability to implement the new process. During the PST meetings, the Health Risk Assessment Rating Tool was used 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. Since 1/1/11, Eighteen of the 25 individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across	Noncompliance

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		the above-referenced health and behavior indicators. All 25 individuals reviewed had multiple risks related to their health and/or behavior, and seven of the 25 individuals reviewed were assigned one or more "high" health risk ratings at the time of their reviews. Several PST Health Risk Assessment reviews that were completed more recently were more comprehensive and ensured more realistic ratings of risk. However, a number of individuals have yet to receive risk assessment reviews and ratings, in accordance with the newly implemented policy and procedures. Also, as noted in the prior 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 being in noncompliance. Examples included the following: • Individual #117 was a 22-year-old woman at increased risk of infection due to her immuno-compromised health status, potential for weight loss and impaired nutrition, and risk of health complications due to non-adherence to prescribed treatments. As of the review, there was no evidence that Individual #117's health risks were assessed and interventions to reduce her health risks were identified, planned, and implemented. • According to Individual #283's 9/1/10 Personal Support Plan, all of his risk were low, including his risk of self-injurious behavior. A little over one month after Individual #238's PSP date, he ingested a foreign object, suffered upper gastro-intestinal bleeding, and required surgery to remove the object. Neither his 2009 annual physical examination nor his 9/2/10 PSP listed pica as a current diagnosis. Despite the serious nature of this incident, there was no evidence that his health risks were assessed post-incident, and his risk level remained low. • Individual #7 was a 68-year-old woman diagnosed with osteoporosis and considered by her physician to be "frail" and "very unstable." Since 1/1/11, Individual #7 suffered 14 falls, some with injury and some without. Despite Individual #7's PNMT recommendation to increase her level of risk of injury from low to high based upon the results of a gait assessment, there was no evidence that Individual #7's PST convened in a timely manner to reduce Individual #7's risk of multiple falls and no evidence of follow-up to Individual #7's PST's recommendation. • Individual #179 was a 78-year-old man who was diagnosed with sarcoidosis and suffered multiple episodes of pneumonia. Recently, from 4/17-4/21/11, Individual #179 was hospitalized with fever and hypoxia and diagnosed with pneumonia, which, as of 5/10/11, was not completely resolved. Nonetheless, Individual #179's respiratory risk remained low.	

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		• Individual #218 was a 64-year-old woman who was diagnosed with hypertension, which according to her neurologist "should be more closely monitored (11/19/10)." In addition, on 2/16/11, Individual #218 experienced palpitations and was provided with a Holter monitor, which identified multiple episodes of bradycardia. However, as of the review, Individual #218's cardiac risk remained low. • One individual was diagnosed with a highly contagious sexually transmitted disease. In addition, his physician noted on 3/8/11, that he had varicose veins that "bear watching." Nonetheless, as of his 2/11/11 PSPA, his PST considered him to be at "low risk for health."	
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 substantively improved since the prior 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 508A, 508B, 509A, 509B, 510A, 510B, 516E, and 516W. Observation of medication passes continued to reveal 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. • During six of the eight medication passes observed, nurses had set up medications to be administered one to several hours later and failed to re-check the individuals' Medication Administration Records prior to administering the medications to the individuals. Thus, it was clear, that if/when a nurse was distracted during his/her "set up" of medications, failed to pre-assemble the right medications at the right time, at the right dose, at the right route, for the right individual, etc., and failed to check the MAR prior to the administration of the medications, the likelihood that an actual/potential medication error would be detected prior to the individual's receipt of his/her medications was miniscule. • During two of the eight medication passes observed, nurses documented the individuals' receipt of medications on the Medication Administration Records (MARs) prior to administration. • During one of the eight medication passes, liquid- and pill-form medications were pre-poured into unlabeled medication cups and administered by a nurse	Noncompliance

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		who may/may not have been 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. 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. There were two exceptions to this pattern – during the medication administrations on 511 and 509, the nurses' encouraged individuals to participate in this aspect of their health care in a manner that was consistent with the individuals' interest and abilities. As of this review, monitoring of medication administration by the CNE and QA nurse occurred monthly. According to a review of these reports, the monitoring reviews revealed continued problems with ensuring compliance with standards of practice, the provisions of the Settlement Agreement, and the Health Care Guidelines. The review of the 25 sample individuals' May2011 MARs revealed the following problems: • Individual #384's 5/12/11 12 pm Calcarb and Prostat 1 tablespoon, and 5/20/11 5 pm suction toothbrushing with toothettes were not signed as given. • Individual #222's 5/12/11 12 pm Calcarb, dipyridamole 50 mg, Isopto tears and 5/3/11 and 5/20/11 12 pm Isopto tears were not signed as given. • Individual #202's 5/18/11 and 5/19/11 12 pm Buspar 7.5 mg and 5/25/11 bedtime Benadryl 50 mg were not signed as given. In addition, although her MAR revealed that she "refused" all of her weekly blood pressure checks, there were no explanations provided for the reason for the refusal(s) and/or the plan to address her refusal(s). • Individual #382's 5/23/11 12 pm Isopto tears was not signed as given. In addition, although her MAR revealed multiple medication refusals, there were no explanations provided for the reason for refusal(s) and/or the plan to address her refusal(s). • Individual #159's 5/15/11 12 pm KCl 10 meq was not signed as given. • Individual #168's 5/3/11 and 5/15/11 12pm Haldol 20 mg were not signed as given. • Individual #218's 5/23-5/25/11 8 am Geodon 80 mg, 5/25/11 8 am clonazepam, 5/19/11 daily blood pressure check, 5/13/11 and 5/24/11	

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		bedtime prune juice, 5/3-5/6/11, 5/12-5/13/11, 5/18-5/19/11, 5/22/11, and 5/24/11 apical pulse, and 5/19/11, 5/24-5/25/11 cranberry juice were not signed as given. • Individual #194's 5/20/11 8 pm Lactulose 15 ml and 5/4-5/5/11, 5/25/11 8 am pantoprazole sodium were not signed as given. • Individual #377's 5/18/11 8 am Zetia and Protonix, 5/13/11 8 am benzoyl peroxide facial cleanser, and 5/13/11, 5/24/11 8 am and 5/5/11, 5/20/11 Flonase were not signed as given. • Individual #10's 5/23/11 8 am Seroquel 200 mg was not signed as given. • Individual #76's 5/21/11 12 pm Lithobid 600 mg was not signed as given. • Individual #352's 5/16/11 and 5/21/11 2 pm Xopenex 1.25 via nebulizer were not signed as given. • Individual #7's 5/14/11 12 pm Tricor 48 mg and 5/22/11 8 pm nitrofurantoin were not signed as given. • Individual #232's 5/6/11 8 pm metformin hcl 500mg was not signed as given. In addition, although Individual #232 frequently complained of knee pain, she was not administered local application of Capsaicin cream. • Individual #278's 5/23/11 ear drops, 5/23/11 8am acidophilus/bulgar chew, 5/23/11 8 pm alphagan ophthalmic drops, 5/23/11 4 pm and 8 pm pilocarpine eye drops, 5/23/11 8 pm Cosopto eye drops, and 5/2/11/, 5/13/11, and 5/23/11 suction tooth-brushing were not signed as given. In addition, there were multiple crossed-out and circled entries for Baclofen 5 mg tid that were not explained. • Individual #109's 5/22/11 8 pm Levabuterol inhaler, weekly weights, and daily suction toothbrushing were not signed as given. During the monitoring team's review of two individual May 2011 MARs, it was noted that neither individual received their enteral feedings, water, and other fluids, in accordance with their physician's orders. Specifically, there was no evidence that Individual #109 received her enteral nutrition in accordance with her physician's orders on 20 of 23 days and no evidence that she received her normal saline in accordance with her physician's orders on 16 of 23 days. Similarly, there was no evidence that Individual #278 received his enteral nutrition in accordance with his physician's orders on eight of 23 days and no evidence that he received his Pedialyte, Gatorade, and water in accordance with his physician's orders on 11 of 23 days. These variations in the delivery of food and fluids were not minor discrepancies in the individuals' daily requirements for food/fluids, rather, on a number of days, Individual #109 and Individual #278 failed to receive one-quarter to one-half of their prescribed food and fluids. These findings were reported to the CNE and NOO during the onsite review.	

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		Since the prior monitoring review, the facility acquired the services of a consulting pharmacist to conduct quarterly drug regimen reviews and to assist the Pharmacy Department with compliance-related activities, such as reviewing medication policies, practices, and procedures. To that end, in January 2011, the pharmacist conducted an inspection of nine medication rooms and evaluated the appearance, security, controlled substances, and storage of medications. The results of his review revealed serious problems in the areas of cleanliness, infection control, and safety, and showed only 58% overall compliance with expectations for clean and safe medication rooms and practices. Despite the alarming nature of these findings, as of the review, the CNE reported during a meeting with the monitoring team that she had not been made aware of either the inspection or its results. Since the prior review, the Nurse Educator has continued to maintain 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 data, in December 2010, there were six reported medication errors, in January 2010, there were eight reported medication errors, in February 2011, there were nine reported medication errors, and in March 2011, there were 16 reported medication errors. Almost all of the reported errors were due to "omission," or failure of the individual(s) to receive their prescribed medication(s). The number of reported medication errors, however, was far less than the number of medications unaccounted for by the pharmacy, nursing, and medical departments. During the monitoring team's interview with the Medical Director, Pharmacy Director, Chief Nursing Executive, QA nurse, and consulting pharmacist, it was revealed that since the prior review, the Pharmacy Department created a database for reconciling the occurrences of medication "shortages" and "overages." As of the review, the Pharmacy Department reportedly entered over 500 occurrences of these problems in their database. Strikingly, the overwhelming majority of these occurrences have no explanation for why the medication supply was short/over the expected number of medication. It was also learned that there are many more over/short forms "piled up" in the pharmacy that have not been examined or analyzed for patterns/trends. According to the Pharmacy Director, on a monthly basis, hundreds, if not thousands, of medications continued to be 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, "Nothing." Moreover, the SGSSLC system was fraught with accountability issues that included that the medications returned were not even labeled with the name of the recipient.	

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		As noted in Section M4, the Medication PIT, which was developed during the Summer of 2010 to identify and address problems related to medication administration and accountability, continued to regularly meet. As a result of the combined efforts of the Medication PIT, the Medication Error Committee, the Pharmacy and Therapeutics Committee, and the monthly medication monitoring reviews, several steps toward compliance were taken: • The over/short forms were developed and implemented, • Data entry of the unexplained overages/shortages was initiated, • Some individuals' physician's orders for time(s) of medication administration were adjusted to improve accuracy and accountability of administration, • New photographs of individuals were taken and made available on the homes for help with identifying individuals, • Nurse education and training in the state's approved Medication Administration Guidelines was provided, and • A medication counting procedure was implemented on 508, where problems were identified. Notwithstanding these positive findings, as reported in the prior review, the Pharmacy Director reiterated that none of the pharmacy staff members had received training in the pharmacy software program – WorX, and he was not aware of how the system could be modified to reduce medication errors. Also, there continued to be no assurance that when the pharmacy technicians delivered medications to the homes that the nurses on duty verified that the correct amount of medication(s) delivered were actually present and accounted for. Absent that assurance, it remained difficult, if not impossible, to identify the areas where system improvements were most needed in order to significantly improve the accountability of medication administration, substantially reduce errors, reduce individuals' risk of consequences of missed medications, and minimize the waste of thousands of medications a year.	

Recommendations:

1. The facility should, with the assistance of the Nurse Recruiter, develop a strategic plan to develop a stable competent nursing workforce, reduce unscheduled absence, and develop and implement recruitment and retention strategies that provide long-term solutions to the nursing shortage.

2. Problems pertaining to morale and dissatisfaction with leadership and management of the Department of Nursing must be addressed and resolved in order to promote positive change and progress toward achievement of compliance with the provisions of Section M of the Settlement Agreement.

3. Records must be available and/or accessible to the physicians and/or nurses, who need 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.

4. The Nursing Department should address the practice deficiencies that have persisted. The "short-cuts," "timesavers," and other peculiar habits, which were noted during the review are dangerous practices, and they should stop.

5. Documentation expectations, particularly the SOAP charting as specified in the Health Care Guidelines, needs to be reinforced and monitored until nurses are implementing the process more systematically.

6. The facility should take steps to ensure consistent development of adequate, appropriate, individualized care plans that address all of the individual's health problems, needs, and risks.

7. The facility's Nurse Educator should take steps to ensure that the majority of the facility's nurses attend her structure/formal education and training sessions and not so heavily rely upon their individual attempts to complete "informal training," which may continue to contribute to misunderstanding expectations and noncompliance with standards of care.

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

9. 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.

10. Continue to take strong and swift actions to significantly improve the accountability of medication administration, substantially reduce errors, reduce individuals' risk of consequences of missed medications, and minimize the waste of thousands of medications a year.

11. 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.

12. Provide the Infection Control Nurse with adequate support and the tools necessary to do her job, including, but not limited to, access to training and education programs that are designed to help professionals design and implement successful infection control programs, ongoing mentorship by an experienced Infection Control Nurse, and limited use of her time on other, non-infection control-related projects, at least until the infection control program at SGSSLC is developed and underway.

13. The Department of Nursing leadership should consider taking steps toward (a) being visible on the homes every day with a purpose or goal to achieve, (b) being vigilant with all monitoring activities and going well beyond collecting and recording data on monitoring tools, and (c) being vocal by articulating the standards and expectations for nursing care, advocating on behalf of individuals during Risk Assessment meetings, PSPs, Doctor's Rounds, clinic appointments, etc., and speaking out for nurses who need the support and leadership.

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 DADS Policy #009.1: Medical Care, 2/16/11 o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised 4/10 Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o SGSSLC Policy/Procedure Pharmacy and Therapeutics Committee, 3/10/06 o SGSSLC Policy/Procedure Medication Review Process, 4/7/11 o SGSSLC Policy/Procedure Adverse Drug Reaction, 1/27/11 o SGSSLC Policy/Procedure Drug Utilization Committee, 4/28/11 o SGSSLC Policy/Procedure Medical Consultation, 4/8/11 o SGSSLC Policy/Procedure Lab Matrix, 11/18/10 o SGSSLC Policy/Procedure DISCUS – Monitoring of Medication Side Effects and Tardive Dyskinesia, 4/26/11 o SGSSLC Policy/Procedure MOSES – Monitoring of Side Effects, 6/3/2008 o Restraints Monitor Notification and Responsibilities, 3/31/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 3/30/11 o Medical/Psychiatry/Pharmacy Meeting Notes, 11/4/10,12/9/10,1/27/11,2/24/11, o Medication Review Meeting Notes, 3/3/11,3/17/113/24/11,4/14/11,4/28/11 o Medication Error Committee Meeting Minutes, 10/26/10, 11/12/10, 12/9/10 o Medication Variance Data Analysis from April 2011 to April 2011 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #40, Individual #7, Individual #127, Individual #328, Individual #2, Individual #127, Individual #188, Individual #321, Individual #368, Individual #116, Individual #218, Individual #198, Individual #177, Individual #330, Individual #45, Individual #313, Individual #316, Individual #254, Individual #126, Individual #40 o MOSES and DISCUS forms for the following individuals: • Individual #318, Individual #128, Individual #64, Individual #189, Individual #150, Individual #196, Individual #175 Individual #351, Individual #331, Individual #292, Individual #99, Individual #81, Individual #239, Individual #215, Individual #233, Individual #385, Individual #230, Individual #198, Individual #194, Individual #197, Individual #119, Individual #1, Individual #143, Individual #375, Individual #193, Individual #382, Individual #210, Individual #388, Individual #249 o Single Patient Interventions and Notes Extracts for 14 individuals: • Notes extracts for Individual #290, Individual #105, Individual #194 • Single Patient Intervention notes did not have names of individuals o Drug Utilization Evaluation Summaries:

	• Depakote • Olanzapine • Medication room audits <u>Interviews and Meetings Held</u>: o Don Conoly, RPh, Pharmacy Director o Bob Bishop, RPh, Clinical Pharmacist o Rebecca McKown, MD, Medical Director o John Burnside, MD, Primary Care Physician o Scott Lindsey, APRN, FNP o Jimmy Mercer, MD, Lead Psychiatrist o William Bazzell, MD, Psychiatrist o Donna Yates, APRN, Psychiatry o Angela Gardner, RN, Chief Nurse Executive o David Anne Knight, MSN, RN, Infections Control Nurse o Lisa Owens, RN, Quality Enhancement Nurse o Maria DeLuna, RN, Nurse Educator o Meeting with Pharmacy Director, Medical Director, Clinical Pharmacist, and Chief Nurse Executive <u>Observations Conducted</u>: o Pharmacy Department o Medication Variance Performance Improvement Team o Multidisciplinary POI Meeting
	Facility Self-Assessment: In the facility's POI, SGSSLC rated itself noncompliant on all eight provision items. After many interviews, observations and multiple document reviews, the monitoring team agrees with the facility's self-assessment. While some progress was noted, none of the provision items fully met the requirements of the Settlement Agreement.
	Summary of Monitor's Assessment: The Pharmacy Department was staffed with a full time pharmacy director, one pharmacist, and three pharmacy technicians. A clinical pharmacist began providing services Wednesday through Friday starting in late November 2010. This monitoring review was impeded by document production. Several document requests required a specific number of documents be provided for review. In one instance, the actual sample provided turned out to be half of what was requested because the documents were submitted in duplicate. The ADR reports were unsigned and lacked documentation of the required P&T Committee review and recommendations.

	Minutes and meeting agendas for the same date and time were listed for different meetings, such as Medical/Psychiatry/Pharmacy Meeting (12/9/10) and Medication Error Committee Agenda (12/9/10). Small incremental gains were noted in some areas while other areas failed to achieve any measure of progress. Outdated policies and procedures were reflective of the lack of forward movement. Most had not been revised and many had not been reviewed in more than five years. The ADR policy, however, had been updated and a new DUE Committee policy was implemented. All other policies still referred to the facility as a state school. The clinical pharmacist, who appeared eager to effect departmental change, reported that he and the pharmacy director worked independently. This disconnect may have contributed to the limited progress demonstrated. The pharmacy director reported that the facility had not received any training on the use of the WORx system since the last onsite review. The SPI and notes extracts were reported to be used to document interactions between the pharmacist and the clinicians. The documents provided did not contain adequate evidence to support compliance with this requirement. Improvement was noted in the requirements for completion of QDRRs. This area will require additional work. The reports were handwritten and many were difficult to read due to side notes, comments, and strikethroughs. The reports also lacked the detail required to substantiate compliance with appropriate laboratory monitoring of drug use. The MOSES and DISCUS assessment tools were completed, but provider response and use remained problematic. DUEs were completed and provided useful information. Corrective action plans commensurate with the deficiencies documented, however, were not evident. The facility implemented a new ADR policy and ADRs were reported. Some were formally reported using the ADR report forms while others appeared in the P&T minutes. Notwithstanding the implementation of a new monitoring and reporting process, the facility's response to significant adverse events appeared inappropriate. Finally, medication variances were examined by several committees, yet no progress was made in determining the reason that hundreds of medications were returned to the pharmacy each month. The findings in each of these provision items resulted in determining an overall rating of noncompliance in pharmacy and safe medication practices.

#	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	The pharmacy director indicated that the WORx software continued to be utilized to complete prospective reviews for all new orders. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. Interactions between the pharmacists and medical providers were captured in the WORx under the intervention mode and documentation could be provided with the Single Patient Intervention (SPI) Forms and notes extracts. This process was	Noncompliance

#	Provision	Assessment of Status	Compliance
	medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	implemented in March 2011. Since the last onsite review, there had been no training on use of the WORx program. During a meeting with the pharmacy director, the monitoring team inquired about the process for reporting drug interactions. The pharmacy director responded that the pharmacist called the medical provider and the response was noted on the physician order and captured in WORx. There was no formal policy that determined the actions of the pharmacist based on the severity level of the drug interaction. The pharmacy director stated that if the identified reaction was a potentially dangerous one, the medication would not be released until the matter was resolved. The medial director was notified if the pharmacist was not satisfied with the response of the clinician. A document entitled "Interventions 2/18/11 – 4/18/11" was provided for review. The four-page document contained 11 items labeled "Patient Interventions" on the first two pages. The date of the intervention and medical provider was listed. No information about the intervention, however, was provided. Nine of the 11 entries were dated 3/23/11, one 3/25/11, and one 4/1/11. The last two pages, the notes extracts, contained five entries. Two entries were dated 4/1/11 and three were dated 4/7/11. There was no correlation between the notes extracts and the reported 11 patient interventions. The following notes extracts and classification of interventions were provided: • <u>Allergy/Disease State Contraindication</u> o Individual #290: 4/7/11 10:23 am - On 12/13/10 MD ordered silvadene for individual. The individual had allergy, so MD was notified by pharmacy and the med was dc'd before the med was to be dispensed. • <u>Order Clarification/Confirmation</u> o Individual #105: 4/7/11 10:17 am - On 1/14/11 MD ordered clindamycin 200 mg BID for seven days. MD was called and was told Clindamycin came in 150 mg or 300 mg capsules. Order changed to 150 mg x 7 days. o Individual #194: 4/7/11 10:21 am - On 1/13/11 MD ordered clindamycin 250 mg BID x 10 days. MD notified by pharmacy that clindamycin came in 150 mg and 300 mg capsules. Order changed to 300 mg BID x 10 days. • <u>Patient Care</u> o Individual #(No name provided): 4/1/11 11:04 Patient on KCl liquid 20 meq (15ml) and practitioner wrote to continued for 180 days, but wrote 15 meq instead of 15 ml and therefore caused a reduction in amount of potassium. RPh called practitioners and the order was corrected to 20 meq.	

#	Provision	Assessment of Status	Compliance
		• Unclassified o Individual #(No name provided): 4/1/11 11:05 am - Patient Intervention The facility's POI stated that a policy for the pharmacist's review of new medication orders was implemented along with a form designed to report prospective verifications. Furthermore, the POI stated that a method was developed to ensure that follow-up related to the prospective verification was done and results forwarded to the P&T Committee for review and feedback. The pharmacy director reported that the SPI form was used to document the interventions. He was not familiar with any new polices other than the ADR and DUE policies. The monitoring team was not given any new polices related to the required prospective reviews. A review of P&T Committee meeting minutes contained no references to this provision item or new policies related to it. The minimal number of SPIs and notes extracts very likely represented underreporting. All drug interactions should be communicated to the medical providers. The most severe drug interactions should prohibit dispensing of the medication until the issue is addressed formally by the provider. Less severe drug interactions would not necessarily prohibit use of the medication, but reporting would provide the medical provider the opportunity to make changes. Given the complexity of the medication regimens reviewed in the various samples, and the small number of interventions documented, it appeared that underreporting or failure to document occurred. This provision item required the need for review of laboratory testing associated with the use of medications prior to dispensing the medications. In order to achieve compliance with this provision item, the pharmacy will need to have access to laboratory data that is monitored during use of the medications and there will need to be a consensus on the requirements prior to dispensing medications. Review of the facility's lab matrix would be helpful in making this determination.	
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.	In order to assess compliance with this provision item, a request was made to provide 40 QDRRs. Thirty-eight DRRs were provided, however, 18 of the documents provided were duplicates. Further, the sample provided did not appear to be the most recent QDRRs completed and the methodology for selection was not clear. A total of 20 of the 38 QDRRs were for timelines, pharmacy assessment, and physician response. The table below captures the key dates, drugs with monitoring parameters, pharmacy comments/recommendations, and physician responses. Listing of monitoring parameters in parentheses indicates those that should have been monitored or listed but were not. The "discussion" represents comments from the monitoring team.	Noncompliance

#	Provision	Assessment of Status				Compliance
		Individual #	Review Dates Pharmacy Primary Provider Psychiatry Provider	Medication (monitoring per lab matrix)	Pharmacy Comments/Recommendations Primary Provider Response Psychiatry Response Monitor Discussion:	
		Individual #40	12/22/10 No date No date	Atorvastatin (lipids, liver enzymes) Zonisamide Olanzapine (lipids, glucose)	Pharmacy Comments: • Consumer on clonazepam; chart indicates allergy. • Consider increase in folic acid. • Consider getting B12 and folate levels. • Consider changing lactulose to prn and increasing water. Lab: check mark Primary Provider Response: • Allergy issue referred to psychiatry. See dictation dated 1/12/11. • Disagree with changing lactulose to prn. Psychiatry Response: No psych med changes Discussion: Lipids, glucose, and liver enzymes needed for monitoring. Most recent drug level should be documented.	
		Individual #7	3/16/11 3/21/11 No date	Levothyroxine Ibandronate Dilantin Olanzapine (lipids, glucose) Fenofibrate (lipids, liver enzymes) Fluvastatin (lipids, liver enzymes)	Pharmacy Comments: • Please increase Vitamin D to 6000u QOD. • Patient on nitrofurantoin long term; is it ok to D/C? • Order CPK to monitor statin and fenofibrate. Labs: 1/11 – phenytoin - WNL; TSH – WNL; 12/10 – MOSES/DISCUS - OK Primary Provider Response: • Will recheck Vitamin D • No history of interstitial cystitis (indication documented); on suppression therapy. Psychiatry Response: No psych med changes Discussion: Exact values should be documented for phenytoin level and TSH. Lipids and liver enzymes needed. Additional monitoring could have included BMD results. The indication for long-term antibiotic therapy should be corrected.	

#	Provision	Assessment of Status				Compliance
		Individual #127	3/16/11 No date No date	Quetiapine (lipids, glucose) Clonidine (BP, pulse)	Pharmacy Comments: • Last QTR DRR not signed by psychiatrist • Labs show increased calcium, please D/C • Staff tells me that instaport never used; can we remove it? Labs: 2/11 - WNL; 12/10 - MOSES/DISCUS – masked or marked TD Primary Provider Response: • Consider decreasing calcium after checking labs. See note dated 3/21/11. • Needs IV access. Psychiatry Response: No psych medication changes Discussion: Specific lab values should be documented.	
		Individual #328	3/18/11 No date No date	Atorvastatin (lipids, liver enzymes) Alendronate Fenofibrate Olanzapine (lipids, glucose) Clonazepam	Pharmacy Comments: • Please consider D/C calcium – leads to kidney stones • Please change lansoprazole to q HS. • Please add Co-Q-10 as agreed. Labs: 3/11 - OK; B12 and folate WNL; CPK – OK; 12/10 - MOSES/DISCUS OK Primary Provider Response: Referred to PST for risk/benefit discussion. See note dated 3/21/11. Psychiatry Response: No psych med changes. Discussion: In addition to documenting specific lab values, BMD studies could be recorded.	
		Individual #2	3/17/11 No date No date	Atenolol (BP, pulse) Lisinopril Digoxin Glipizide (Hba1c, CMP, UA, microalbumin) Dilantin Ferrous sulfate	Pharmacy Comments: • D/C Geri tonic • 74 yo on ranitidine and digoxin will continue to be dig toxic; d/c dig and diltiazem and start warfarin Labs: 3/11 – all OK; digoxin ^; HbA1c – OK Primary Provider Response: Not a candidate for warfarin; see note. Psychiatry Response: No psych med changes Discussion: The lab matrix provided a panel of monitoring parameters for individuals with diabetes mellitus. The HbA1c value should be documented, as the degree of control required may be specific to comorbid conditions.	

#	Provision	Assessment of Status				Compliance
					Response to iron therapy, such as hemoglobin and hematocrit should be monitored. Electrolytes for use of Lisinopril could also be documented.	
		Individual #127	12/22/10 No date No date	Clonidine (BP, pulse) Quetiapine (lipids, glucose) Lansoprazole	Pharmacy Comments: • Can we move lansoprazole to HS? • Can we add benztropine for TD x 30 days? • Can sennosides and docusate be prn? • Reason for hep lock and lactated ringers? Labs – check mark Primary Provider Response: See dictated progress note 1/12/11 Psychiatry Response: TD does not seem to bother him. Discussion: There was no documentation of any monitoring parameters.	
		Individual #188	3/31/11 No date No date	Fenofibrate Lovastatin (lipids, liver enzymes) Clonazepam Fazaclo (Clozaril panel)	Pharmacy Comments: • Lipids WNL, can we now d/c lovastatin and fenofibrate and use Omega 3 and diet for control? • Increase Vitamin D to 10,000 • Start fiber and water Labs: 3/11 - WNL; TSH - OK Primary Provider Response: • Recently started atropine for psychiatry; may cause constipation so no change at this time. • Consider mono statin attempt first. Psychiatry Response: Atropine dose is very low so hopefully will not affect constipation. Discussion: Lipids, liver enzymes, and Clozaril requirements should be documented.	
		Individual #218	3/31/11 No date No date	Levothyroxine (TSH) Atorvastatin (lipids, liver enzymes) Lamotrigine Lisinopril Aripiprazole (lipids, glucose) Ziprasidone (EKG, lipids, glucose) Clonazepam Lansoprazole	Pharmacy Comments: • Increase Vitamin D • H pylori (-); D/C Prevacid • Long term mometasone is inappropriate • Renal disease continues to progress, clonazepam will continue to accumulate. • DRRs missing Labs: 3/11 - H. pylori (-); 2/11 - MOSES/DISCUS – OK Primary Provider Response: • Increase Vitamin D level after	

#	Provision	Assessment of Status				Compliance
					checking if necessary • Plan to decrease clonazepam if aggression can be controlled. Psychiatry Response: Agree Discussion: Labs as indicated needed for monitoring.	
		Individual #198	3/31/11 No date No date	Levetiracetam Diazepam Clonazepam	Pharmacy Comments: • K+ nl; can we d/c both supplements? • No evidence for B6, can we d/c? • QDRRs missing from 7/10 forward Labs: 2/11 - Keppra level - OK Primary Provider Response: No changes until research. Psychiatry Response: No psych med changes Discussion: Keppra level should be documented.	
		Individual #177	3/31/11 No date No date	Simvastatin (lipids, liver enzymes) Levothyroxine (TSH)	Pharmacy Comments: • Suggest d/c tums – leads to kidney stones • Ammonium lactate appears ineffective; suggest D/C • Add Co-Q-10 as agreed Labs 3/11 – WNL Primary Provider Response: 1,2. Research before changing Psychiatry Response: No psych med changes Discussion: Specific lab values should be documented.	
		Individual #321	3/31/11 No date No date	Levothyroxine	Pharmacy Comments: • Consider d/c chewable antacids • Long term Rhinacort use not appropriate • Could not find evidence to need of HRT; D/C • Defer HRT issue to GYN provider. • QDRRs missing from 7/10 forward Labs: 10/10 - TSH – OK; all others - WNL; 2/11 - MOSES/DISCUS - OK Primary Provider Response: Psychiatry Response: No psych med changes Discussion: TSH and other relevant lab values should be documented.	
		Individual #368	3/31/11 No date No date	Atorvastatin (lipids, liver enzymes) Lisinopril Gabapentin	Pharmacy Comments: • Change frequency of pantoprazole to HS for efficacy • K- WNL, D/C	

#	Provision	Assessment of Status				Compliance
				Lantus Humalog Furosemide	• All lipids OK, can we control with Omega 3 • QDRRs missing from 7/10 forward Labs: 1/11 - K+ - WNL Primary Provider Response: • Disagree with potassium recommendation due to use of Lasix. • Disagree with stopping statin due to diagnosis of diabetes mellitus. Psychiatry Response: Discussion: Discontinuing the Atorvastatin in this individual contradicted the standards published by the American Diabetes Association. Maintaining the individual on potassium supplementation is a reasonable response given continued use of furosemide.	
		Individual #116	3/31/11 No date No date	Lisinopril Atorvastatin (lipids, liver enzymes) Levothyroxine (TSH) Clonazepam Metformin (diabetes panel) Invega Oxcarbamazepine	Pharmacy Comments: Increase Vitamin D Labs: None documented Primary Provider Response: Vitamin D level? No change until chart review. Psychiatry Response: No psych med changes Discussion: There was no lab documentation for this individual with diabetes, hyperlipidemia, hypothyroidism, and psychiatric illness.	
		Individual #330	3/31/11 No date No date	Metformin (diabetes panel) Propranolol (BP, pulse) Aripiprazole (lipids, glucose) Lorazepam Lamotrigine	Pharmacy Comments: • Notes reveal eye problem resolved; can we d/c sulfacetamide? • Propranolol - suggest SR form due to better efficacy. • Consider D/C tums - leads to kidney stones • QDRRS missing from 7/10 forward Labs: 1/11 - TSH -OK; Lamotrigine - OK; MOSES/DISCUS - OK Primary Provider Response: Review chart on rounds. Psychiatry Response: No psych med changes Discussion: Labs needed as indicated. Documentation of pulse should be provided particularly since requesting medication change.	

#	Provision	Assessment of Status				Compliance
		Individual #45	3/31/11 No date No date	Quetiapine (lipids, glucose) Clonazepam	Pharmacy Comments: • Labs reveal folate elevated; is it time to d/c folic acid • Consider D/C tums • Change dosing of lansoprazole • QDRRS missing from 7/10 forward Labs: 3/11 – folate ^; MCV^; 1/11- MOSES/DISCUCS- OK Primary Provider Response: Consider after research. Psychiatry Response: No psych med changes. Discussion: Lipids and glucose needed for monitoring.	
		Individual #313	3/31/11 No date No date	Levothyroxine (TSH) Clonazepam Lithium (lithium panel)	Pharmacy Comments: • QDRRs missing from 7/10 forward • No evidence found for Vit C deficiency; can we now D/C ascorbic acid? • Please change pantoprazole to HS • Notes reveal no bowel problems; can we now DC docusate and Miralax Labs: 3/11 - WBC ^; lithium – OK; MOSES/DISCUS - OK Primary Provider Response: Agree to trial of decreasing meds with monitoring. See note Psychiatry Response: No psych med changes Discussion: The narrow therapeutic index of lithium should result in documentation of monitoring with every drug review.	
		Individual #316	3/31/11 No date No date	Levothyroxine Quetiapine (lipids, glucose)	Pharmacy Comments: Start Vitamin D Labs: 2/11 – Lipids - OK; TSH - OK Primary Provider Response: No known deficiency. Will start Vitamin D for immune support and check level. Psychiatry Response: No med changes. Discussion: Glucose needed as indicated.	
		Individual #254	3/31/11 No date No date	Levothyroxine	Pharmacy Comments: 1. QDRRs missing from 7/10 forward 2. Please change fiber wafer to am with water Labs: 11/10 - TSH - OK; all WNL; 2/11 - MOSES/DISCUS - OK Primary Provider Response: Agree Psychiatry Response: No psych med	

#	Provision	Assessment of Status				Compliance
					changes Discussion: Relevant lab values should be documented.	
		Individual #126	3/16/11 No date No date	Levothyroxine Atorvastatin (lipids, liver enzymes) Risperidone (lipids, glucose)	Pharmacy Comments: Can we add Co-Q-10? Labs: 2/11 - TSH - WNL; GFR>60; CPK - WNL; 1/11 - MOSES/DISCUS– noticeable TD Primary Provider Response: Agree - ordered Psychiatry Response: No psych med changes Discussion: TSH value should be documented in addition to lipids, liver enzymes, and glucose.	
		Individual #40	3/16/11 No date No date	Atorvastatin (lipids, liver enzymes) Zonisamide Olanzapine (lipids, glucose) Clonazepam	Pharmacy Comments: • Pt is on a benzo and may be allergic • Calcium WNL; labs show stone formation; can we stop calcium • B12 and folate WNL; please D/C folic acid. • Previous DRR not signed by psychiatrist. • Notes reveal constipated; suggest stop docusate and lactulose and start fiber wafers tid and water. Labs: 1/11 - PSA^; 12/10 - DISCUS/MOSES OK - marked TD Primary Provider Response: • Disagree with bowel recommendations; history of significant constipation. • Will reduce calcium dose and recheck. Psychiatry Response: See note above. Discussion: The exact PSA level should be provided. Documentation of the results of the record review relative to this abnormal value would have been helpful. Lab values as indicated should be documented.	

#	Provision	Assessment of Status	Compliance
		Improvement was noted relative to the content, timelines for completion, and medical provider response. Every QDRR in the sample submitted contained evidence of review and response by the providers. When the provider disagreed with the recommendation, the reason was documented on the report and, in many instances, a reference was made to IPN documentation. It was quite evident that the primary provider (in the case of this sample) reviewed and gave consideration to the recommendations. Dictated IPN notes were found related to several of the recommendations. This was a skewed sample, however, because the medical provider for 18 of 20 samples was the same. The following observations were noted by the monitoring team with regards to the QDRRs. Observations are divided into matter of content, timelines, and format: <u>Content</u> • The QDRRs addressed issues related to polypharmacy and recommendations to minimize polypharmacy were frequently noted. • Drug delivery, dose, frequency, and routes of administration, as well as drug interactions, were also addressed. • The anticholinergic burden, use of stat and prn meds, and seizure control were not addressed in the reviews. • The pharmacy director reported that the lab matrix was used as the guidelines for monitoring when completing the QDRRs, but there was no specific policy to guide this process. The request for a copy of the DRR policy was returned with the response of "no evidence." Another single page document was provided to the monitoring team. This documented listed 14 items stating, "Under the new DRRs the lab requirements are as follows:" There were some differences in lab requirements in comparison to the lab matrix. • Laboratory monitoring was not consistent with the facility's lab matrix. The majority of the reports reviewed did not document adequately the review of lab data. Additionally, when labs were cited, the exact value was not provided. Labs were noted to be OK, WNL, or increased. The minority of reports offered no commentary on required lab monitoring. <u>Timelines</u> • It was difficult to determine if the QDRRs were reviewed in a timely manner because neither the primary care provider nor psychiatry provider dated their signatures. • The clinical pharmacist documented that DRRs were missing in a significant percentage of the sample reviewed. In the multidisciplinary POI meeting attended by the monitoring team on 5/26/11, the clinical pharmacist commented that many DRRs were nowhere to be found.	

#	Provision	Assessment of Status	Compliance
		Format • The QDRRs were handwritten and several contained strikethroughs. Comments from providers were squeezed between recommendations and in the margins of the documents contributing to difficulty in reading the documents. • Item number five was blocked out in the pharmacy assessment. This item referred to the guidelines related to the use of pharmacotherapy. • The records were stamped "DRR completed per DOJ Requirements." Additional Discussion The Medication Review Committee meeting minutes dated 3/17/11 documented that the clinical pharmacist was not getting completed DRRs from the previous quarter. "Some DRRs that are in the chart have neither signatures nor dispositions, i.e., either agree or disagree with my recommendations and if not, why, others that are missing have no way of being implemented on a timely basis." This was not consistent with the findings of the monitoring team's review of the QDRR sample provided. These findings were noted in the QDRRs that were reviewed as part of the record sample for Provision L. The medical director should review the lab matrix and other documents to ensure that the requirements are the same. Facility staff should be made aware that completion of QDRRs is a fundamental CMS ICFMR requirement. A policy related to the QDRR is needed. The policy should outline the procedure including: • Content of the review and requirements for lab and other relevant monitoring • Timelines for completion of review • Routing of the report • Provider responsibilities for review and timelines for return • Tracking procedure by medical director The content of the review should be documented on the QDRR Worksheet and should include information pertinent to: • Responses from providers from previous quarter • Lab monitoring orders and vital signs • Use of high risk medications, such as benzodiazepines and anticholinergics Additional information might include: • Seizure data (number of seizures, neurology consults, therapeutic levels if indicated, laboratory monitoring parameters) • Psychotropic data, such as target symptoms and lab monitoring	

#	Provision	Assessment of Status	Compliance
		• Use of stat medications for chemical restraints • Orders for pretreatment sedation medications • Comments on provider IPN notes.	
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 Polypharmacy Committee met weekly to discuss justification of the use of polypharmacy. The anticholinergic burden was not represented in the QDRRs. Issues related to polypharmacy were addressed in several the QDRRs reviewed. While attention may have been given to issues related to monitoring of the metabolic side effects, there appeared to be several missed opportunities to address the issue. • The QDRRs did not provide adequate detail to assess the issue. Lab values pertinent to metabolic syndrome and other parameters, such as weight and abdominal girth were not cited consistently or adequately. • The MOSES tool recorded weight, but few weight issues were identified. • Quarterly medical reviews also did not address the issues adequately. • The QDRR did not address the issue of stat med use.	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 recommendation is not followed.	Twenty QDRRs were reviewed. Of the 20 reviewed: • 20 of 20 documents included signatures of the primary care provider indicating that review occurred. • 20 of 20 documents had notations from the primary provider explaining agreement, disagreement, or the need to obtain additional information. There were several instances in which agreement/disagreement was not explicitly stated, but all documents contained comments from the primary provider. The psychiatric provider was also required to review the QDRRs. There were significant deficiencies related to the monitoring based on the facility adopted lab matrix. This resulted in relatively few recommendations related to the use of psychotropics. • 20 of 20 documents included a signature from the psychiatric provider • 5 of 20 documents contained comments pertinent to psychiatry o 5 of 5 documents contained a noted from the psychiatric provided related to agreement or disagreement with recommendations.	Noncompliance

#	Provision	Assessment of Status	Compliance
		None of the providers dated their signatures resulting in the inability to determine if the reviews were timely. More recent QDRRs in the sample selection included in Provision L were noted to be stamped with time and date. This was not present in the sample of documents reviewed for this section. The medical director should ensure that all providers' signatures are dated.	
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.	Forty examples of MOSES and DISCUS tools were provided. Several were eliminated due to a lack identifying data or second page. Twenty-nine MOSES tools were reviewed. The findings of the documents were: • 10 of 29 (35%) lacked prescriber review (no conclusion, comments, or signature) • 13 of 29 (45%) documented no action necessary by the prescriber • 1 of 39 (3%) documented no conclusion by the prescriber • 1 of 29 (3%) lacked reviewer documentation, but provider indicated no action necessary • 3 of 29 (10%) provided specific medication changes • 1 of 29 (3%) lacked assessment due to refusal by the individual • 2 of 29 (7%) had >7 days between evaluation and prescriber review Twenty-eight DISCUS tools were reviewed and showed that: • 11 of 28 (39%) lacked prescriber evaluation (no conclusion, comments, or signature) • 14 of 28 (50%) indicated TD was absent • 1 of 28 (4%) lacked a prescriber conclusion • 1 of 28 (4%) indicated possible minimal TD • 1 of 28 (4%) lacked assessment due to refusal by the individual • 2 of 28 (7%) had >7 days between evaluation and prescriber review • 1 of 28 (4%) had 30 days between evaluation and prescriber review According to facility policy, the RN Case Manger was to provide the DISCUS assessment to the provider for review and signature during the home psychiatric rounds. If an issue of concern was noted, the nurse would contact the provider immediately. The policy further stated the provider was responsible for completion of the entire Evaluation section and its accuracy. The purpose of completing the assessment was to actively look for the onset of TD symptoms so that the provider could intervene early enough to prevent a debilitating condition. The MOSES assessment was also to be provided to the primary care provider for prescriber review and completion. The assessment was to be completed for any individual receiving AEDs or psychotropic medications.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Based on the sample submitted, the MOSES and DISCUS tools were being completed in a timely manner. In each sample, however, a significant percentage of forms contained a blank prescriber review/evaluation section and were, therefore, not completed. The P&T Minutes dated 3/30/11 documented that the clinical pharmacist questioned if the tools were being completed in a timely manner and if the psychiatrists were signing them (DISCUS), though there appeared to be greater compliance with review in the most recent documents. There continued to be little evidence that the primary care providers utilize this information. The information did not appear to be provided to the neurology consultant and it should be.</td><td></td></tr>
<tr><td>N6</td><td>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.</td><td>According to the pharmacy director, the facility began reporting adverse drug reactions in April 2011. P&T minutes documented that training on ADRs was completed on 3/18/11. The nursing staff and home mangers were trained on the new policy. The home mangers were responsible for training the direct care professionals.

Three adverse drug reactions reports were submitted. The information from the three reports is summarized in the table below:

<table>
<tr><td></td><td>Prolixin
Individual #149</td><td>Prolixin
Individual #149</td><td>Thorazine
Individual #243</td></tr>
<tr><td>Date of ADR:</td><td>3/20/11</td><td>3/20/11</td><td>4/9/11</td></tr>
<tr><td>Symptoms suggesting adverse drug reaction:</td><td>Due to akathesia – sweating, excess movement of tongue, gait slow</td><td>Drooling, excess perspiration, drawn up hand baby steps, unsteady, lips down tense</td><td>Tachycardia (157) and complaints of dyspnea. Had been receiving Thorazine 200mg IM for emergency medication (3 doses) without any adverse reactions, AEB completion of VS on the restraint form.</td></tr>
<tr><td>Suspected Medication:</td><td>Prolixin 15 mg po HS started 3/11/11</td><td>Prolixin 10 mg po BID started 3/11/11</td><td>Thorazine 200 mg po TID started 4/8/11</td></tr>
<tr><td>Probability Score:</td><td>1-4 possible</td><td>5 Probable</td><td>6 Probable</td></tr>
<tr><td>Classification:</td><td>--</td><td>Moderate</td><td>Moderate</td></tr>
<tr><td>Outcome:</td><td>Hold prolixin 15 mg po at hs, Give Cogentin 2 mg po now,</td><td>Needed Cogentin BID started with stat dose; also prolixin was held for tonight</td><td>Will stop thorazine on a regular basis</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

	Cogentin 2mg bid x 90 days Psych consult		
P&T Review and Recommendations:	--	--	Meeting 3/30/11

Two ADR reports were submitted for the same ADR. In addition to these formally reported ADRs, the P&T Committee meeting minutes dated 3/30/11 documented the following:

> "We had one documented ADR, to septra couldn't get the last dose due to rash. Individual #290 had an ADR and got Stevens-Johnsons Syndrome. Individual #218 had a new antipsychotic medication and then got hypothermia and pneumonia. Another with Loxapene. There was no further discussion of ADRs within the minutes and no reports were submitted for these three events. Further discussion of these ADRs was warranted."

Stevens-Johnson Syndrome is a potentially lethal disease that is usually a result of a hypersensitivity drug reaction. It is associated with the use of several drugs, including sulfa antibiotics. In spite of the serious nature of this reaction, the P&T minutes provided no information aside from the statement above. One goal of ADR reporting and monitoring is to prevent future ADRs. The minutes did not clarify if this individual's allergy to sulfa was documented prior to administration of the drug septra. The notes extract associated with the SPI discussed in section N1, mentioned that this individual had a known sulfa allergy requiring a physician order for silvadene cream to be discontinued. The exact chronology of these events could not be determined. A more in depth investigation of this event was warranted to determine if this was a preventable event and, if so, what steps should have been taken to prevent future similar events from occurring.

The thorazine ADR report also appeared to lack critical information. It documented that thorazine 200 mg po TID was started on 4/8/11. The report failed to document that the individual received Thorazine 200 mg on 4/7/11 at 9:30 am, 4:35 pm, and 4/9/11 at 9:50 am. Although the severity was determined to be moderate, the actual reason for that was not documented. Based on agency policy, an ADR was considered moderate for any one of the following: (1) suspected drug was held or discontinued, (2) antidote or other treatment was required, or (3) hospitalization was required. This individual required hospitalization for treatment of a cardiac arrhythmia. Any ADR that results in hospitalization should prompt further intense investigation of the circumstances surrounding the use of the drug and the clinical outcome. There was no documentation by the primary care physician related to this event in the integrated progress notes reviewed.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>All of the reports submitted lacked the signature of the P&T Committee Chair and none included the outcome and recommendations from the P&T Committee. In spite of two significant events, there was no documentation of the analysis and what, if any, measures were taken to prevent future occurrences.

The facility should revise the ADR policy to include a threshold for intense case analysis and ensure that this action is taken when warranted.</td><td></td></tr>
<tr><td>N7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td><td>A new DUE Committee was created to oversee the DUE process and provide reports and recommendations to the Pharmacy and Therapeutics Committee. The facility completed three DUEs since the last onsite review and a DUE calendar had been set to complete one DUE in each quarter of 2011. During a meeting with the pharmacy director, clinical pharmacist, and medical director, the results of three DUEs were reported by the clinical pharmacist: depakote, olanzapine and medication room audits. The depakote DUE and medication room audit findings were presented to the P&T Committee and documented in the minutes. The olanzapine DUE had not been presented to the P&T Committee at the time of the onsite review. The findings and summaries of the evaluations are below.

<u>DUE #1 Depakote – 1/21/11</u>
Objective: Evaluate if 80% thresholds being met
Type of data collection: retrospective
Planned study size: 16
Source of data elements: Patient charts, laboratory ledgers, and MOSES/DISCUS
<table>
<tr><th>Criteria and Indicators</th><th>Compliance (%)</th></tr>
<tr><td>Justification for Drug Being Prescribed</td><td></td></tr>
<tr><td>Seizure</td><td>47</td></tr>
<tr><td>Mania (aggression)</td><td>35</td></tr>
<tr><td>None</td><td>17</td></tr>
<tr><td>Process Indicators</td><td></td></tr>
<tr><td>Liver function</td><td>100</td></tr>
<tr><td>Depakote level</td><td>81</td></tr>
<tr><td>Ammonia level</td><td>12.5</td></tr>
<tr><td>CPK level</td><td>6</td></tr>
<tr><td>Outcome Indicators</td><td></td></tr>
<tr><td>MOSES/DISCUS</td><td>87.5</td></tr>
<tr><td>Decreased seizures</td><td>75</td></tr>
<tr><td>Decreased aggression</td><td>25</td></tr>
<tr><td>Dose, frequency, time all appropriate</td><td>75</td></tr>
<tr><td>Other Indicators or Criteria</td><td></td></tr>
<tr><td>Neurology consults done</td><td>--</td></tr>
<tr><td>Seizures confirmed with EEG</td><td>31.5</td></tr>
<tr><td>CBC, plts, CMP</td><td>100</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Results of data analysis: • Only three of 15 criteria met the 80% threshold. • All patients taking <max dose of 60 mg/kg Conclusion: • Indication/justifications for the use of depakote far too often are missing or not confirmed in chart. • Use of depakote to reduce frequency of aggression is lacking efficacy. Recommendations: • 100 % of patients have ammonia blood levels taken at initiation and q6 months • 100% of patients have CPK level taken at initiation and q6 months • If total daily dose > 250 mg, dose frequency divided • Start looking for alternative "add on" for depakote, one with better efficacy. <u>DUE#2 Zyprexa/Olanzapine - 5/17/11</u> Objective: To evaluate appropriate use and monitoring Type of data collection: Retrospective Planned study size: 18 Source of data elements: Patient charts, laboratory legers, and MOSES/DISCUS	

Criteria and Indicators	Compliance (%)
Justification for Drug Being Prescribed	
Schizophrenia/Bipolar	39
Process Indicators	
Age<65	83
<20mg total daily dose	44
Initial CPK	17
Initial blood sugar	72
Initial weight	83
Initial fasting lipids	56
Initial EKG	50
CMP & ANC	55
Prolactin	33
Initial insulin free and total	22
BP and vitals	100
Outcome Indicators	
Decreased aggression/SIB	39/17
Decreased combative behavior	25
Other Indicators or Criteria	
MOSES/DISCUS	78
<6 weeks duration	0
Psychiatry consult in last 6 months	72

#	Provision	Assessment of Status	Compliance
		Results of data analysis: • Only 7 of 18 patients had appropriate indications for use. • Most of the elderly patients were excluded as is appropriate. • Many patients were receiving more than the 20 mg per day maximum allowed • Most of the process indicators were in noncompliance range • Only blood pressure and vital signs came in at 100% compliance Conclusion: • Very few patients were meeting outcome criteria. Recommendations: • After six weeks of daily dosing, if patient not showing marked improvement, drug should be tapered and discontinued • Psychiatry should evaluate all those on olanzapine for longer than six weeks and decide on continuing or not. <u>DUE#3- Med Room Audits</u> Nine medication rooms were inspected for compliance with 19 individual monitoring elements. Noncompliance was noted for: • Clean, well lighted, cool, free from traffic • Presence of conversion tables, poison charts, lists of prescribers, poison control center phone numbers listed. • Medication refrigerator temperature logged daily with no food inside refrigerators. • External use medications are stored separately from internal medications. The discussion section included the following comments: " This report clearly shows we are willing to put up with the status quo. Only 11% of medications mobile carts successful separated external medications from internal medications. The … rightly states this is a major source of medication errors. An in-service should be conducted reminded dispensing personnel of this potential error. Only 44% of medication rooms had the required notices posted showing conversion tables, poison control center telephone numbers. When seconds count, we should be better prepared." Recommendations: • A team be formed to visit each nurse case manager to periodically to remind them of the above and to encourage them to raise their sensitivity to these elements	

#	Provision	Assessment of Status	Compliance
		Additional Discussion The DUEs on Depakote and Zyprexa documented several similar findings including: • Deficient documentation of indications or improper indications. • Low compliance with laboratory monitoring for the use of these two drugs. • A lack of follow-up by psychiatry. • A lack of adequate clinical outcomes based on the chosen outcome indicators. The monitoring team noted several concerns related to the DUEs: • The reports submitted were handwritten with strikethroughs, side notes, and "run-on" information that was difficult to review. • The adequacy of the sample size was unknown since there was no documentation of the total number of individuals receiving the drugs. • Recommendations were reviewed at P&T for the Depakote DUE as well as the medication room audits. The olanzapine DUE had not been presented at the time of the onsite review. In general, recommendations resulting from DUEs should produce a corrective action plan that outlines the actions to be taken, the persons responsible for those actions, and the timelines for completion. Corrective actions plans or documentation of a follow-up to create such plans were not present in the P&T meeting minutes.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility had a procedure in place for collecting data related to medication variances. There were discrepancies in meeting agenda and minute dates as discussed in the summary. There was a Medication Variance Error Committee meeting agenda dated 1/13/11, but minutes were provided for a January 2010 meeting. This issue presented a challenge for the monitoring team's review of additional documents. During the November 2010 onsite review, the matter of overages and shortages was discussed. The facility had prioritized issues that needed to be addressed. The issue of overages and shortages was surfaced during the PIT meeting and it was reported that, in the near future, nursing administration would be addressing this issue. The monitoring team made a recommendation that this be considered an urgent issue due to the fact that each overage or shortage represented a potential medication variance. A document entitled Medication Variance Data Analysis from April 2011 to April 2011 was provided to the monitoring team. Data were extracted and summarized in the following table.	Noncompliance

#	Provision	Assessment of Status	Compliance

Medication Variances 2010 - 2011					
Error Type	Nov	Dec	Jan	Feb	Mar
Omission	3	1	2	1	3
Wrong drug	1	6	1	1	4
Wrong dose	1		1	1	1
Wrong time	1	1	1	--	
Wrong patient	--	1		1	1
Prescribing	--	--	1	--	--
Dispensing	--	--	--	2	--
Other	--	2	1	--	--
Total	6	11	7	6	9

Wrong medication errors accounted for 33% of the reported variances. Wrong patient and wrong dose errors represented 18% of variances. Look-alike, sound-alike drugs were frequently involved in the wrong drug errors. Approximately 15% of the wrong drug errors involved clonazepam, lorazepam, and diazepam. Corrective actions correctly included retraining the nurses involved. Systems changes related to look-alike sound-alike drugs were not clearly evident.

Several issues related to medication variances were documented in meeting minutes and discussed with the staff during various meetings with the monitoring team:

- Nurses becoming confused and giving medication to wrong patient because the two med drawers on the medication cart were next to each other.
- Setting up of medications for the 8 am med pass that another nurse would complete.
- Setting up crushed meds in cup left in drawers (also noted in medication room audit).
- Inadequate staffing or staff pulled into unfamiliar areas.
- Blanks continued to be found on MARS where nurses should sign.

Several interventions had occurred to decrease these types of errors:

- The medication administration and transcription polices were revised.
- Multiple mechanisms to correctly identify individuals were implemented for medication passes.
- Process was implemented for the nurse going off duty to review the MAR prior to the nurse coming on duty. The two nurses would assist with reminding each other to sign the MAR.
- A workgroup was established to review the medication administration times.
- Production of a skit on medication variances was to be used for training nurses.

A concerning discussion was contained in the January 2011 minutes related to providing charcoal in the homes because ipecac syrup production was discontinued in 2010. The

#	Provision	Assessment of Status	Compliance
		use of ipecac to induce emesis in overdose victims has, for many years, been regarded as having an unfavorable risk benefit/analysis profile. United States Poison control centers reported its use in less than .03% of patients in 2009 compared to 15% in 1985. The facility should not use ipecac and should contact the local poison control center each and every time an overdose is suspected. Additionally, increased efforts should be directed to preventing the medication errors that result in overdoses. Another matter of great concern was the fact that the agency had made minimal progress in addressing the issue of overages and shortages. An overage and shortage form and spreadsheet were developed and implemented in February 2011. Minutes from the Medication Variance PIT noted that the spreadsheet and forms did not contain the same data. Furthermore, there was a significant amount of data missing due to constraints of pharmacy staff. Assistance in data entry was to be provided to the pharmacy. The medication error report and recommendations of P&T minutes (3/30/11) documented that the pharmacy director reported that spreadsheet contained 400 to 500 entries. The PIT minutes on 3/31/11 documented that there was a total of 172 entries. This represented entries for 2/11/11 to 2/17/11 and 3/19/11to 3/24/11. Minutes from the PIT meeting 5/19/11 documented 37 entries for 5/9/11 to 5/17/11. The monitoring team attended the Medication Variance Performance Improvement Team meeting. It was acknowledged that greater effort would need to be placed on this problem. Reconciliation at the time of delivery would need to be completed in order to provide more accurate data. Nurses on homes 508 and 510 had been trained on the process of receiving medication form the pharmacy to ensure that count are correct prior to validation of the count sheets.	

Recommendations:

1. All pharmacy staff should receive training on the WORx software and its applications.

2. The pharmacy must document all interactions between the pharmacists and the clinicians. The SPI Forms and notes extracts are a suitable solution when used correctly.

3. The pharmacy should develop a specific procedure for contacting clinicians when there is a drug interaction based on the level of the drug interaction. The procedure should specify the requirements for the physician and pharmacist when there is a severe drug interaction.

4. The facility will need to determine how to provide the pharmacy with access to laboratory information since the need for laboratory testing must be considered as part of the prospective review.

5. The medical director and pharmacy department will need to determine what drugs require lab monitoring and prioritize which will be

included in the prospective review.

6. The facility should develop a policy for completion of QDRRs. The policy should outline the process, timelines and requirements for monitoring labs and other pertinent clinical data. The requirements should not set standards that are not congruent with the facility's lab matrix. Consideration should be given to adding a section related to the anticholinergic burden in order to ensure the appropriate monitoring for this drug class.

7. A policy for completion of DUEs should be developed. It should specify requirements for completion, such as determination of calendar, drugs for review, and sample size selection. It should also specify requirements for corrective action plans such as the specification of action steps, responsible parties and timelines.

8. A tracking system should be implemented to ensure that action is taken for those recommendations that the physician has agreed to.

9. The medical director should work with the medical staff to ensure that the MOSES and DISCUS forms are being appropriately reviewed and completed.

10. The ADR policy should be revised to include a threshold for intense case analysis. One requirement should be that any ADR associated with hospitalization require an intense case analysis or review of the circumstances surrounding the adverse event. When deficiencies are noted, a corrective action plan should be developed that provides action steps, responsible persons, and timelines for completion.

11. The facility should provide additional training and emphasize the importance of the adverse drug reaction reporting and monitoring system. This training should be mandatory for all staff who have clinical contact with the individuals including physicians, dentists, nurses, respiratory therapists, and habilitation therapists.

12. The facility should consider revising the policies for completion of the MOSES and DISCUS assessments and provide specific timelines for review, completion, and return by the medical staff.

13. The medical director should provide guidance to the medical staff on the requirements for physician review and completion of the MOSES and DISCUS assessments.

14. The facility should address all deficiencies found in the medication room audits with formal corrective action plans.

15. Poison Control Center numbers should be highly visible and the facility should draft a policy related to contacting the centers given the great concern expressed by various staff regarding drug overdoses and the use of charcoal.

16. The facility must consider the issue of medication overages and shortages a priority as each represents a medication error until reconciliation occurs. One key step is to ensure that the medication counts are correct at the time of delivery. The agency must ensure that this occurs or subsequent data will be unreliable.

17. The facility must address other areas related to medication variances. All variances that occur within the medication use system must be reported including those attributed to physicians, APRNs, pharmacist and nurses. This data is needed to gain a foothold on the medication variance problems such that appropriate analysis can be conducted and corrective actions implemented.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o PMNT Members 3/16/11 and attached CVs o PNMT Continuing Education Sessions 4/8/11 o SGSSLC Organizational Charts o Staffing data (4/22/11) o Section O Presentation Book and POI o Health Risk Assessment tool and risk guidelines o Risk lists for osteoporosis, falls, choking, aspiration, skin integrity, weight loss/gain, constipation, dehydration, Client List as of 3/31/11 o Admissions Activity 10/1/10 – 3/31/11 o Separation Activity 10/1/10 – 3/31/11 o PNM Needs list o No PNM Needs list o Maintenance Log o PNM spreadsheet o List of individuals with pain, chronic and acute o List of individuals with GERD o List of individuals with dysphagia o List of individuals with poor oral hygiene 4/25/11 o List of individuals with chronic dehydration o List of individuals with unplanned weight loss o List of individuals with BMI greater than 30 4/4/11 o List of individuals with BMI less than 20 4/4/11 o List of individuals who require mealtime assistance 4/20/11 o List of individuals receiving modified textures 4/14/11 o Downgraded Textures o Current Skin Breakdown for the past year o Pneumonia Tracking 1/1/10 4/20/11 o Active Pressure Ulcers o SGSSLC Non-Injury Fall Data 4/10 – 3/11 o Falls list 4/18/11 o Fractures list 4/20/11 o List of individuals with Diagnosis of Pneumonia – Textures, consistency and MBSS 4/13/11 o List of individuals who receive enteral nutrition o Individuals who were non-ambulatory or assisted ambulation 4/8/11

	o Individuals with Primary Mobility Wheelchair 4/4/11 o Individuals who Use Transport Chairs 4/6/11 o Individuals with Orthopedic Devices and Braces 4/6/11 o List of individuals with swallow studies 4/20/11 o List of hospitalizations/ER visits/infirmary admissions o Choking incidents and interventions 4/15/11 o Incident reports, and follow-up documentation related to choking events for the following: • Individual #46, Individual #314, Individual #271, Individual #104, Individual #344, Individual #116 and Individual #186 o Section O QA/Rehabilitation Therapy audits February and March 2011 o PNM Monitoring form templates (7) o Proposed PNM monitoring tools and database format 4/17/11 o Completed PNMP Monitoring Forms submitted o Completed Mealtime Monitoring Drills o Mealtime Monitoring schedules o Murdoch Center Program Library o NEO training curriculum for PNM o Physical Nutritional Management Refresher Course I Learn Curriculum o PNMPC competency training curriculum materials, pre- and post-tests o PNMPC training notebooks o PNMP template o Dining Plan template o PNMPs submitted o Education and Training Rosters submitted for Dining Plans and PNMPs o PNMP Monitoring 2011 spreadsheet o PNMT Evaluation, PNMT Meeting Review and PNMT Summary templates o PNMT Summaries (2/8/11, 2/18/11, 2/24/11, 3/4/11, 3/11/11, 3/18/11, 3/24/11, o PNMP Clinic process guidelines, monitoring forms and documentation o PSPs, PSPAs, PNMT Evaluations, Action Plans and documentation for the following: • Individual #78, Individual #18, Individual #38, Individual #344, Individual #7, Individual #2, and Individual #122 o Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plan, Annual Physician Summary, Health Status tab, MBSS studies and reports, hospital summaries, current medication list, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab, Nutrition tab and Dental tab for the following: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o Information from Individual Notebook including PNMP tab for the following individuals:

	• Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o PNMPs for last 12 months, Dining Plans for last 12 months and Monitoring forms completed in the last six months for the following individuals: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR Habilitation Therapies Director o OTs, PTs, and SLPs o PNMP Coordinators o Sally Smith, LD, MBA o Various supervisors and direct support staff o Health Risk Assessment meetings with two PSTs o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o PNM Clinic o PSP meetings
	Facility Self-Assessment: SGSSLC's self-assessment rated noncompliance for all items of this provision. Systems continued to be revised and refined (PNMT process) or were in the process of development (monitoring and staff training). This self-assessment was consistent with the monitoring team's assessment of noncompliance. The POI may be more useful if there were also action steps listed designed to achieve compliance with the status of completion and evidence to illustrate this included in the plan. The current format merely listed activities, but did not present an understanding of the steps and strategies required to meet the provisions with timelines of completion. This kind of format would offer more of a roadmap for all staff and a means to direct their focus, effort, and energy.

	Summary of Monitor's Assessment: There was a full complement of core PNMT members with a soon to be dedicated RN. The other team members were not, and could not be, dedicated team members given the current staffing levels for OT, PT, SLPs, and the single dietitian. One dietitian was insufficient to address the nutritional needs for 245 individuals as well as take on the responsibilities of the PNMT role. The clinicians are to be commended for moving forward with the process with the understanding that this is a work in progress and that they will learn as they go. There were some noted improvements related to mealtimes in several of the homes and the Performance Improvement Team approach to addressing system issues appeared to be effective as well as the focused commitment to the training of the PNMPCs. There were some noted issues related to staff having difficulty with cues to slow individuals down or to take smaller bites and the current SPOs to address this did not provide sufficient activity analysis to break down the activity into component parts or learning objectives. Newly developed training and monitoring systems will require ongoing assessment during subsequent compliance reviews.

#	Provision	Assessment of Status	Compliance
01	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary,	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** SGSSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) on 2/8/11 during the first meeting on that date and with the evaluation of one individual identified at risk secondary to pneumonia. The PNMT continued to meet weekly with a total of seven individuals reviewed and monitored by the team as of 5/2/11. 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 core members of the newly established Physical Nutritional Management Team (PNMT) included the following, per the documentation submitted: • PNMT Coordinator: Dana Johnston, OTR • Cindy Bolen, PT • Judy Perkins, PT • Susan Holler, MS, CCC-SLP • Charis Worden, OTR • Sally Smith, LD, MBA • Chey McCrae, RN, Nurse Hospital Liaison • Dr. Joel Bessman, MD • Scott Lindsey, APRN, MSN, FNP	Noncompliance

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	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.	Adjunct members included the QMRPs, nurse case managers, home managers, direct support staff, and other PST members for the individuals reviewed during the PNMT meeting. Evidence of current licenses was not submitted though license numbers were identified. Experience documented per the CVs submitted indicated that each of the currently identified clinicians had experience with individuals who had developmental disabilities and a varied clinical background. The only documented continuing education for the current PNMT members in the last six months was for Charis Worden, OTR (Understanding Personality Disorders, 3/17/11). **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT met weekly to assess and review individuals at risk for PNM concerns. Meetings were documented in the PNMT Meeting Review form. Assessments were completed using the PNMT Evaluation form. Each team member was responsible to bring information to the team meeting for discussion. Analysis of team findings and the development of action plans were completed during each meeting. The review meeting was documented in the integrated progress notes in the individual's active record and a PNMT summary was also submitted to document the meeting discussions, actions and status updates. The interval of subsequent reviews was established in the action plan developed by the team. PNMT assessments to date included the following; • Individual #122, Individual #78, Individual #7, Individual #344, Individual #38, Individual #2, Individual #164, Individual #18, Individual #273 PNMT assessments were not received though action plans were submitted for five of these individuals. Also, meeting documentation from 4/1/11 to 5/20/11 was reviewed and it was noted that follow-up for issues or recommendations made in one meeting was inconsistent in subsequent meetings. Some examples included: • Individual #7: 4/1/11 recommendation for review of falls to identify trends. No evidence that this had been completed as of 5/20/11. • Individual #38: 4/1/11 recommendation for medication review by Pharm.D. due to excessive number of medications for an extended time. No evidence that this had been completed as of 5/20/11. • Individual #344: 4/1/11 recommendation for mealtime monitoring for correct liquid consistency. Also implementation of aspiration trigger sheet with review	

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		in four weeks. Subsequent review by PNMT on 4/29/11. Aspiration trigger sheet reviewed, but no evidence of mealtime monitoring documented through 5/20/11. His individual action plan indicated that this had been completed with no issues noted however. • Individual #78: 4/8/11 recommendations for consult by the dietitian to create alternate meals to address meal refusals and nursing to provide retraining for direct support and nursing staff regarding actions in the event of meal refusals. Subsequent follow-up on 4/29/11 reported fewer meal refusals, though there was no documentation that the previous recommendations had been completed. • Individual #164: 4/8/11 recommendations for review of dentures for appropriate fit and PT evaluation of positioning due to lateral leaning and reduced head control with fatigue. No evidence of completion of these recommendations, though on 5/13/11 it was documented that she had started a strengthening program with PT. There was no rationale for intervention provided. One of the purposes of this group was to identify supports, services, or interventions to address issues related to referral to the PNMT or other concerns noted via comprehensive assessment. It would be critical to carefully track all issues through to completion with thorough documentation of findings.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess	**Standard: A process is in place that identifies individuals with PNM concerns.** Per a list submitted for this onsite review, there were 190 individuals identified with PNM needs at SGSSLC or 77.6%% of the current census (245). Each of these was provided a PNMP. A new policy and process used to establish health risk levels had recently been implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were working to integrate this into the new PSP process initiated in the Fall 2010. The PSTs will require ongoing clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. Meetings related to the risk assessment process with two PSTs were conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The statewide system to identify and manage individuals at risk was outlined in policy #006.1, At Risk Individuals, with an implementation date of 1/1/11. This policy was intended to identify individuals who were at risk for illness or injury as well as to identify	Noncompliance

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	each individual having physical and nutritional management problems to identify the causes of such problems.	actions and supports to mitigate the risks. The PST was to initiate assessment upon change in status for any individual to examine the existing support plans to ensure the appropriate measures were in place. The PNMT was defined as follows per this policy: "A team of specialists with knowledge and expertise in the development of Physical Nutritional Management Plans who meet to provide comprehensive assessment and determine appropriate intervention for persons whose identified health status places them at highest risk for potential or actual injury and/or illness. Members of the PNMT include the following disciplines: registered nurse, physical therapist, occupational therapist, dietician, speech pathologist and others as needed. All core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. As requested the team shall include primary care providers, nursing case managers, therapists, psychologists, QMRPs, home supervisors, facility support services staff and others as needed." The PST was to refer individuals at high risk to the PNMT who were not stable and for whom the PST required assistance in developing a plan. The PNMT was to begin assessment within five working days of referral to determine possible causes for the change in status, to analyze assessment findings, integrate recommendations, and to propose an action plan with measurable goals and outcomes. There were a number of individuals with multiple PNM-related risk factors or issues who potentially would benefit from the coordinated, comprehensive supports and services of the PNMT. • There were 190 (78% of the current census) individuals identified with PNM needs and were provided a PNMP. • There were no (0%) individuals with chronic dehydration in the last year. • There was one (>1%) individual with fecal impaction in the last year. • There were four (2%) individuals with skin breakdown in the last year. • There were 22 (9%) individuals with chronic pain in the last year. • There were 29 (11%) individuals with poor oral hygiene in the last six months. • There were 12 (5%) individuals who sustained an injury resulting in a fracture in the last year. Two of these individuals were either non-ambulatory or required assisted ambulation to some degree. • There were 15 (6%) individuals with 22 incidences of skin breakdown in the past year. One of these was active at the time of this review (Individual #17). • There were eight (3%) individuals whose diet had been downgraded in the last year. • There were 52 (21%) individuals who were obese with BMIs 30 or over with 11	

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		of these with a BMI over 40. • There were 18 (7%) individuals with a BMI less than 20, with 2 of these with a BMI under 18 (underweight). • There were two (>1%) individuals with unplanned weight loss (Individual #18 and Individual #265). These individuals had lost more than 10% of their weight in six months' time. • There were seven (3%) individuals who had experienced a choking event in the last 12 months, one of whom had experienced two such events (Individual #104). There were 12 individuals listed as HIGH risk for choking. • There were 128 (52%) individuals who required assistance at mealtime. • There were 99 (40%) individuals with modified diet textures and 21 (9%) with thickened liquids. • There were eight (3%) individuals who were enterally nourished; one was deceased at the time of this review. • There were approximately 19 (8%) individuals with a diagnosis of pneumonia in the last year, six (32%) of which was aspiration pneumonia. There were 11 individuals who were at risk for aspiration per the list submitted dated 4/20/11. There were two individuals who had an incidence of aspiration pneumonia in the last year, but were listed as MEDIUM risk for aspiration (Individual #127 and Individual #373). Individual #248 was listed with aspiration pneumonia on 10/12/10 yet she was identified at LOW risk for aspiration. Individual #15 was reported to have aspiration pneumonia on 1/24/11, but she had no risk rating listed. • There were 39 (16 %) individuals identified as non-ambulatory or requiring assistance for ambulation. • There were 25 (10%) individuals who used a wheelchair as a primary means of mobility. • There were 22 (9%) individuals who used assistive equipment for ambulation including walkers or gait belts. • There were 15 (6%) individuals who used transport wheelchairs as needed. • There were 78 (32%) individuals with upper or lower extremity orthotics, orthopedic shoes or braces. • There were approximately 157/87 (64%/36%) individuals who had experienced approximately 728/220 falls in the last year/three months. Twenty-two of these were either non-ambulatory or required assistance for ambulation. There were 133 individuals who experienced a slip, trip, or fall resulting in an injury with 12 of those reported as serious. Individual #186 was listed with two serious injuries due to falls on 9/12/10 and 10/15/10. Three of those with serious injuries (Individual #345, Individual #189 and Individual #288) used a walker and/or a gait belt for assisted ambulation. Approximately 54 of the total incidents	

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		occurred in the bathing or toileting area. There were 41 individuals who had five or more falls in a 12-month period. A number of individuals had 10 or more of falls during that time, many of those with injury. For example: Individual #186 (26), Individual #26 (15), Individual #379 (12), Individual #318 (20), Individual #294 (16), Individual #31 (14), Individual #197 (12), Individual #198 (27), Individual #85 (35), Individual #3 (12), Individual #7 (47), Individual #288 (42), Individual #202 (11), Individual #126 (10), Individual #78 (14), and Individual #334 (15). Six of these individuals were either non-ambulatory or required assistance for ambulation (Individual #7, Individual #288, Individual #202, Individual #126, Individual #78 and Individual #334). • Of those listed with a LOW risk for falls, there were at least 17 who had experienced five or more falls in the last year. A number of these had experienced 10 or more falls and included: Individual #3 (12), Individual #202 (11), Individual #7 (47), and Individual #126 (10). As stated above Individual #202, Individual #7 and Individual #126 each used a walker and/or gait belt for assisted ambulation. There were 19 individuals listed at MEDIUM risk for falls. Five of these individuals had experienced 10 or more falls in the last year: Individual #26 (15), Individual #104 (12), Individual #78 (14), Individual #334 (15), and Individual #197 (12). Only seven individuals were listed at HIGH risk for falls and included the following: Individual #186 (26), Individual #66 (0), Individual #385 (5), Individual #318 (20), Individual #122 (0), Individual #90 (0) and Individual #238 (2). A number of individuals were not included on the list dated 4/20/11 of fall risk ratings yet had experienced a number of falls in the last year: Individual #316 (7), Individual #271 (11), Individual #161 (6), Individual #379 (12), Individual #288 (42), Individual #382 (7), Individual #294 (16), Individual #31, (14), Individual #258 (8), Individual #198 (27), and Individual #85 (35). • There were 12 individuals listed at HIGH risk for osteoporosis who had experienced falls in the last year. Some of these had experienced falls in the last year including: Individual #318 (20 falls, no fall risk rating), Individual #384 (4 falls, LOW fall risk) and Individual #180 (3 falls, LOW fall risk). There were 19 others listed with a MEDIUM risk for osteoporosis and had experienced a number of falls in the last year including: Individual #26 (15 falls with MEDIUM fall risk), Individual #25 (five falls and MEDIUM fall risk), Individual #222 (three falls, LOW fall risk) and Individual #85 (35 falls, no fall risk rating). • 22 (9%) individuals were listed with chronic pain. • 10 individuals had a total of 12 fractures in the last year. Two of these were non-ambulatory or required assistance for ambulation (Individual #255 and Individual #122). Individual #122's fracture was reported to have occurred during a lift or transfer.	

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		The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The process for risk assessment and the PNMT had been implemented only in the last six months. Further review will be necessary as these two systems evolve during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team hopes that these issues will be resolved as the new systems are reviewed and refined.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**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 190 individuals identified with PNM needs and all (100%) had PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, risks, specialized equipment, mobility, transfers, handling, positioning, bathing, dining plan, adaptive mealtime equipment, diet, and communication. Oral hygiene or medication administration were not consistently noted. The plans were dated and most were current within the last 12 months with the exception of 11 plans submitted. The monitoring team selected 20 individuals for a record sample (included in the above list of documents reviewed). Records were submitted for each of the 20 requested and included the PNMPs for each. It appeared that the PNMPs were generally of a standardized format. The PNMPs submitted for each of the 20 individuals for whom individual records were submitted were reviewed with findings as follows: • PNMPs were submitted for 19 of 20 individuals included in the sample. A dining plan only was submitted for Individual #76. Thus, the sample was considered to be 19 for the purposes of this review. • PNMPs for 19 of 19 individuals in the sample (100%) were current within the last 12 months. • In 19 of 19 of PNMPs reviewed (100%), mobility was addressed. • In 19 of 19 PNMPs reviewed (100%), positioning was addressed. • In 9 of 9 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility, included some positioning instructions for the wheelchair. • In 19 of 19 PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 19 of 19 PNMPs reviewed (100%), the PNMP listed bathing instructions and listed equipment when needed. In 17 of 17 PNMPs reviewed (100%), toileting instructions were identified. One listed only "requires assistance" (Individual	Noncompliance

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		#161). • In 19/19 PNMPs reviewed (100%), for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 19 of 19 PNMPs reviewed (100%), instructions related to mealtime were included. • Six of 19 individuals (32%) received enteral nutrition. This was clearly stated in their PNMPs. • In 19 of 19 PNMPs reviewed (100%), dining position for meals or enteral nutrition was provided. • In 19 of 19 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally with statements related to enteral nutrition though there were no instructions for nothing by mouth for those with non-oral intake. Only Individual #217 received pleasure feedings by mouth, only by medical staff however. • In eight of 13 PNMPs for individuals who received liquids orally (62%), the liquid consistency was clearly identified. Individual #76's dining plan listed thin liquids, but PNMPs for five individuals who received oral intake did not list the liquid consistency (Individual #7, Individual #265, Individual #151, Individual #345, and Individual #202). • In 12 of the 13 PNMPs for individuals who ate orally (92%), dining equipment was specified in the adaptive equipment section. There was a statement that individuals did not use adaptive eating equipment or used regular utensils in three cases (Individual #345, Individual #151 and Individual #265). • In two of 19 PNMPs reviewed (10%), a heading for medication administration was included in the plan. Information for the other plans was included under other headings, though none were consistent. The texture for medication administration or that medication was administered via tube was generally included under adaptive equipment/diet heading. Only one plan indicated that no special equipment was required for medication administration (Individual #345) , but it was not clearly stated what was to be used in the other cases. Other strategies for medication administration such as position or head alignment were documented in some of the plans but also under various headings. Most of those who received enteral nutrition were also provided pictures and written instructions related to the appropriate positioning for medication administration except in the case of Individual #122. • In one of 19 PNMPs reviewed (1%), a heading for oral hygiene or oral care was included. Reference to oral care was noted in each of the other plans but under various headings and the detail of information also varied. By report, the therapists had met with the dental department staff to problem-solve acceptable	

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		positioning to be used for examinations and other dental interventions. Instructions regarding positioning were noted in 10 of the plans included in the sample. A primary intent of addressing oral hygiene in the PNMP was to ensure appropriate position and, most importantly, proper alignment during oral hygiene/tooth brushing activities conducted by the direct support professionals several times daily. Another critical issue is related to whether the individual required slickened liquids or special techniques to assist with swallow/breathe synchrony. This is critical to ensure effective oral hygiene in a manner that is safe for those at risk for aspiration. There were no written instructions or pictorial support to direct staff in oral hygiene strategies and techniques. • 19 of 19 PNMPs (100%) reviewed included a heading related to communication. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Ten of the 20 PSPs submitted for the individuals included in the sample selected by the monitoring team were of the new format. PSP meeting attendance by PNM professionals was as follows: • Medical: 0/10 in attendance per the signature sheet. Reference to physician attendance was noted in the PSP, but there was no signature by the MD • Dental: 1/10 in attendance • Nursing: 10/10 in attendance • Habilitation Therapies: 4/10 in attendance (PT three times and OT once) • Nutrition: 0/10 in attendance • Communication: 0/10 in attendance (one of these was SLP responsible for swallowing issues and one was the SLP responsible for communication) It would not be possible to achieve adequate integration with the clear limitations in PNM-related professional participation in the PST meetings when these plans were developed. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. Documentation of the discussion of risk during the PSP meeting was included with Medical and did not consistently reflect an interdisciplinary approach to discussion, risk identification, and intervention. For example, Individual #7 was identified at low risk for falls, yet there were 47 falls documented in the last 12 months. There was no evidence that this was even discussed during her meeting. Under OT/PT, it was reported that there had been a referral for a wheelchair assessment due to an increase in the number of falls.	

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		There was no statement as to the outcome of this. There was no evidence of an interdisciplinary discussion of health risks (Individual #265, Individual #76, Individual #203 and Individual #202). Only Individual #202's PSP was held after 1/1/11 and the implementation of the new health risk assessment process. Based on the meetings held between two PSTs and the monitoring team during the week of this review, it was evident that continued supports were necessary to ensure that the PSTs understood and considered the interrelationship between the risk issues the individual had and considered the effectiveness of the supports the PNMP provided in mitigating risks to an individual's health and safety. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** As stated, above poor attendance at PSP meetings and the lack of integration in the PSP negatively impacted the ability to develop the PNMPs in a comprehensive and collaborative manner. There was no evidence of interdisciplinary PST discussion of the elements of the plan, its effectiveness, or need for modification. For example, in the case of Individual #66, the PST agreed that all supports should continue, however, there was no representation from therapies at the meeting so all discussion was based only on the written report submitted. Continued assessment of this element will be required during the next review. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians though, as stated above, there was inconsistent review by the PST in relation to identified risk and the efficacy of the interventions implemented. In some cases (e.g., Individual #7), the full OT/PT assessment was cut and pasted into the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. The assessment information listed only 10 non-serious falls in the last year. Further, the OT/PT assessment indicated that her risk for injury was moderate, but that it was recommended it be increased to HIGH based on her gait assessment. As stated above, her health risk for fall was documented as LOW as of 2/17/11. There was no physician, OT, PT, SLP, or dietitian at her meeting. There were seven individuals identified with eight incidents of choking during the last 12 months (Individual #46, Individual #314, Individual #271, Individual #104 (2 incidents), Individual #344, Individual #116, and Individual #186). Incident reports and all follow-up documentation and monitoring for these events was requested and received by the	

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		monitoring team. There was no evidence of follow-up assessment by Habilitation therapists in the documentation reviewed for Individual #186, Individual #344, Individual #271, or Individual #116. Individual #116 and Individual #186 were listed at LOW risk for choking. Individual #46 and Individual #271 were listed as MEDIUM risk for choking. Individual #104, Individual #314 and Individual #344 were listed as HIGH risk for choking. An assessment for Individual #314 was conducted on the same date as his choking incident (7/30/10). Recommendations included modifications to his dining plan to incorporate verbal reminders for safe bite size and a visual cue to assist him in recognizing safe bite size. The corrective action plan indicated that these modifications should be completed by 8/20/10, three weeks following this event. This timeline did not reflect the urgency of this issue and the necessary changes should have been made immediately with appropriate staff training. As of 8/6/10, an email from the QA Auditor indicated that the recommended changes had not yet been made to his dining plan. A subsequent email on 8/16/10, 8/23/10, 9/3/10, and 9/22/10 indicated again that these recommendations were not yet completed. A response on 9/22/10 from Dena Johnston, OTR, indicated that the plan had previously been revised. The attached dining plan was dated 9/14/10, one and a half months after this serious incident. Documentation for a choking event for Individual #104 on 12/14/10 was submitted as requested. This event occurred when he was eating unsupervised by staff. Fortunately, a staff person assigned to another individual who required 2:1 supervision happened to walk by the dining room, look in, and notice that Individual #104 was choking. The Heimlich was performed. His dining plan in place at that time required that staff provide reminders to eat slowly and take small bites, remind him to chew and swallow before taking another bite, and to monitor Individual #104 for food stealing. No one had witnessed this event and, as such, his dining plan had not been implemented as prescribed. The analysis of findings from the incident report indicated that Individual #104 had moved to 509A on or about 11/18/10 but that staff had not been trained on his PNMP. His diet order at the time of this event was all ground foods and honey-thickened liquids. There was no evidence that any staff was able to confirm that he had received the correct food texture and liquid consistency at the meal when the choking incident occurred. In addition, the nurse did not conduct a comprehensive assessment of his status following this serious, life-threatening event. A consultation by Dena Johnston, OTR, recommended that his dining plan be modified to assist staff in educating him as to safe diet texture and safe bite size. This consult indicated that his dining plan and adaptive equipment were not available to him in his new home. Additionally, it was recommended that staff sit with him to provide reminders and training opportunities in safe eating. These recommendations were to be implemented by 12/30/10. The only revised dining	

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		plan submitted with this documentation was dated 2/12/11, over two months following this serious incident. It was not clear that his dining plan had been previous revised per the corrective action plan associated with the incident report submitted. Documentation for a subsequent choking event on 2/10/11 cited a PNMP dated 12/17/10. Documentation of the recommended changes described above was noted in this PNMP. It was determined that Individual #104 choked on chips he had purchased in a vending machine at the gym. It appeared again that Individual #104 was eating without staff supervision and on this occasion, it was likely food not consistent with his current diet order. The Heimlich was performed and he was given water, though it was not clear that this was thickened to a honey consistency as prescribed creating further risk of choking and/or aspiration. The action plan outlined that an MBSS would be scheduled to assess the status of dysphagia and the appropriate food texture and liquid consistency with a completion date of 2/25/11. Referral to speech was also indicated to address communication issues related to his understanding of the risks associated with not complying with his prescribed diet order. Additionally, staff were to be trained on his dining plan by 3/1/11. Staff training for his modified dining plan was documented on 2/23/11 nearly two weeks after this second serious event.	
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 with limited input by other PST members as described above. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright, described the angle of recline, seatbelt use and the type of transfer to be used. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation, but not always specified in the PNMPs. Dining Plans were noted to be available in the dining areas, though prompts were required in several homes. Staff were observed to read the plan when asked a question, though reference to the plan before beginning the meal was inconsistent. In some cases where an error was noted by the monitoring team, the staff was asked to read the plan. They were also inconsistently able to recognize the error observed.	Noncompliance

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		Based on observations of individuals during meals across a variety of homes, a number of errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #198: No dining plan was available on the table for her and, then as noticed, for none of the other individuals in the dining area. Staff had to be prompted to put them out. They reported that they had been instructed not to put the plans out on the table until the individual was sitting at the table. There was a concern, however, that this policy made it impossible for staff to review the plan prior to the individual beginning their meal and as a result risked errors in the service of the meal. For example, in the case of Individual #198, her plan indicated that she should receive diced bread and chopped meat. On this date, all of her foods were chopped. When asked about this the staff responded that she did not understand why the plan stated that when "she always gets all chopped." • Individual #186: Her plan indicated that she should receive all chopped foods, yet she was served all ground foods. • Individual #18: The assigned staff person was observed being rough and disrespectful of Individual #18 during his meal. Individual #18 was refusing some bites of food and was attempting to clear his throat and cough. The staff appeared to be more concerned about wiping his mouth off than the fact that he was trying to clear or cough and Individual #18 was resisting. The home manager present cued the staff to be more gentle when he wiped his mouth off, but this was ignored. The staff person was asked what he was supposed to do when coughing occurred during the meal and he indicated at first that he did not know. When prompted further he indicated that he was to report it to the nurse. He had to be cued to do so at that time. The nurse checked vital signs and determined that Individual #18 was stable. Individual #18 was listed at HIGH risk for aspiration and choking. This incident was reported by the monitoring team to facility management. • Individual #345: She was on a weight reduction diet and the diet book outlined specific foods she should have for her meal. Several items on the list had not been sent for her from the kitchen, yet staff had not reported this or made any attempt to obtain those foods, so she received less food than permitted per her current diet order. Staff reported that at times when they called the kitchen, no one answered so they often did not call. • In 510A, the monitoring team requested to look at the diet book. The staff indicated that it was missing and was likely in one of the individual's room. She reported that the book had been in the dining area that morning at breakfast. Later it was learned by the monitoring team that the book actually had been reported missing by the PNMPC the day before.	

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		• Also in 510A it was noted that there were 15 individuals in the home with insufficient staffing during a meal to ensure that the prompts and cues necessary per the dining plans were provided. This was complicated by the fact that there were two individuals with 1:1 supervision and one with 2:1 supervision related to behavioral needs. It would be critical that careful review of the dining plans be consistently done to ensure that each individual was supported as needed for safe and appropriate mealtime supports. • Individual #134: He was observed during his PSP meeting when he was offered a fruit gel cup with a maroon spoon. His dining plan indicated that he should receive all ground foods, yet the pieces of fruit offered were much larger. Of further concern was that he ate it quickly without intervention or sufficient cues to slow down. • In 509B three out of six men in the dining room received the incorrect bread texture. Also, the kitchen only sent regular salad and green beans, yet one individual was to receive chopped foods per his dining plan. They were all standing over the individuals throughout the meal and when asked about this they reported that they had been given inconsistent feedback regarding this issue. The Habilitation Therapy Director indicated that she would follow-up to get clarification. The staff were honest about their errors and were extremely open as they were coached to make corrections by the Habilitation Therapy Director. The staff were also noted to interact very effectively with individuals. The majority of these errors were related to diet texture and receiving the correct food items from the kitchen. Further staff training and communication with the kitchen staff regarding these issues was needed. Clarification regarding the dining plans not present in 510A before the meal started was immediately addressed by the Habilitation Therapy Director and training had occurred by the following day. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** As described above, there were a number of errors in implementation, suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served. In addition, staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. See examples in section P.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** Improvements to staff training were noted by the monitoring team. Per the	Noncompliance

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	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.	documentation submitted, staff training for New Employee Orientation related to PNM included the PNMP, Dining Plan, repositioning in the wheelchair, positioning and repositioning (supine, semi-sidelying, and supported sitting), body mechanics, lifting and transfers (stand pivot, two person, mechanical lift), diet modifications and restrictions, diet, food textures and liquid consistencies, thickened liquids, basic swallowing anatomy and physiology, issues associated with aspiration, choking and GERD, dysphagia triggers, use of the PNMP, sighted guide techniques, adaptive equipment and monitoring. A tremendous amount of content was to be presented with the intent of establishing competency in only a day and a half. Though by report, there were related skills-based checklists and/or written or verbal tests used to establish competence, these were not submitted for review. The curriculum materials submitted referred only to the demonstration and competency assessment for lifting with no evidence of similar assessment for other PNM content presented. An Employee Agreement was included for staff signature to acknowledge their roles and responsibilities in the delivery of PNM-related supports. Their skills-based performance was monitored by the therapists and PNMPCs as an aspect of the monitoring system. Mealtime Monitoring Drills were to be completed on each staff on a monthly basis, however, there were only 31 drills submitted for individuals included in the sample and clearly this would not represent monitoring for each staff monthly from January 2011 through April 2011. There did not appear to be any tracking of the frequency of monitoring for specific staff in order to ensure continued compliance and competency. There were only 21 PNMP monitoring forms completed by therapists for individuals in the sample for the last year. Clearly, the consistency of this system was not well established at the time of this review. Based on observations during rounds with the OT, PTs, and Habilitation Therapy Director, it was evident that staff were not able to recognize the physical cues that individuals were not properly aligned in their seating device, though they were positioned in sitting. Their heads were well below their headrest, there were large gaps behind their hips in the seat, the seatbelt would not fasten, and/or they were leaning forward or to the side. A number of individuals required repositioning in their day program area. It was noted, however, that the PNMPC was extremely knowledgeable and confident about the specifics of each seating system and demonstrated the ability to recognize and correct errors in alignment and support. Further, the training had not been effective for staff who failed to recognize the need to correct errors in food texture as described above. Based on review of the training sheets submitted, it appeared that the individual-specific training that was provided related to mealtime was tested via a verbal response rather than return demonstration. The introduction of the annual refresher courses should begin to impact these concerns for existing staff as well as reinforce learning for new employees. **Standard: Competency-based training focuses on the acquisition of skills or**	

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		knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable. Completed competency-based training checklists were not submitted as used for NEO staff training in the area of PNM. By report and per the curriculum materials submitted, inservice training for direct support staff required verbal, written, and/or return demonstration. Checklists must be sufficiently discrete so as to ensure proper evaluation of their abilities to demonstrate and apply specific skills necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. As described above, staff were not consistently able to demonstrate competence in the implementation of the PNMPs and Dining Plans. **Standard: All foundational trainings are updated annually.** A PNM refresher class to be held annually for direct support staff had been developed and an ilearn course was also in development at the time of this review. The monitoring team looks forward to seeing how these are implemented in subsequent reviews. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Tools and checklists used to establish competency and documentation for staff trained to implement PNMPs and Dining Plans for five individuals were submitted as requested. This consisted of training rosters signed by participants. A description of the knowledge or skill trained was documented on the roster which appeared to imply competency, though this was not clearly stated. As stated above, each of these appeared to require only a verbal response rather than a skills-based competency established via return demonstration. **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 consistently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not generally 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. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate	

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		implementation of supports designed to mitigate PNM risks. Further assessment of this will be needed in subsequent reviews. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals who were at high risk or for pulled/float staff. Training for changes to plans was conducted by therapists, PNMPCs, and in some cases, by home managers. Competency had not been clearly established via this system to date.	
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 formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication). The training for PNMPCs outlined the monitoring process for their use with detailed guidelines and significant information in other content areas was provided in a competency-based format. This training was newly developed yet there was clear evidence of improvement in the confidence and skill levels of the PNMPCs observed during this onsite review. The newly developed system was to involve a transformation of the existing PNM Clinic. Elements of the revised clinic format were as follows: • Annual review and assessment to occur two months prior to the PSP. • At that time the PNMPs will be reviewed for effectiveness using the monitoring results and specific individual health risk indicators. New review tools will be used to guide the process. • Progress related to therapy goals (health and skill acquisition) will be reviewed to determine if these plans successfully meth the individual's needs • All will be incorporated into the annual assessment or update. • The PST will establish a monitoring schedule based on their PNM risk set at the annual PSP or revised at subsequent PSPAs as indicated • The PNM Clinic team will meet monthly to review the findings of the monitoring to address system issues and program issues identified and ensure timely follow-up • PNM Clinic Summaries will continue to be generated to reflect attendance, discussion, actions and recommendations from these meetings with more immediate documentation in the integrated progress notes.	Noncompliance

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		Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. At that time, additional follow-up or training was provided as well as follow-up as indicated in addition to annual re-validation. A database developed to track PNM monitoring would also track the completion of validation checks with the PNMPCs. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring forms had been developed to address implementation of the PNMP, mealtime, lifting and transfers, and wheelchair and bed positioning. There was no mechanism to ensure that monitoring occurred during bathing, medication administration, or oral care. The monitoring schedules continued to be under development with the intent to base frequency on health risk indicators. Mealtime monitoring by the PST had been initiated in several homes and was to include the QMRPs, psychology, home managers, and nurses in addition to the habilitation therapists and PNMPCs, but a process of corrective action was to be further developed. The therapists reviewed individuals in PNM Clinic for program effectiveness with frequency based on risk levels though this had just been initiated on 5/1/11. As stated above, the PNM Clinic therapists would examine the monitoring results on a monthly basis to ensure that they had followed up on issues identified. In addition, the therapy clinicians were working to integrate a recommended monitoring schedule into their annual assessments with discussion of this during the annual PSP meetings. Though there was no formal system as yet to document data collected during the monitoring conducted and no analysis of findings to effect system change or direct the focus of staff training, there were plans to do this over the next several months. There was no oversight to track and trend compliance with the intended frequency and scope of the monitoring conducted. Per the Habilitation Services Director, this was to be in place over the next six months. 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. However, as stated above, the training modules for the PNMPCs included most of this information in a clear, competency-based format. **Standard: All members of the PNM team conduct monitoring.** The PNMT did not specifically conduct monitoring at this time. The PNMT met monthly, however, with the purpose being review of health status and the implementation and effectiveness of interventions recommended by the team.	

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		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 system implemented to address monitoring by the PNMT at the time of this onsite review. There was no mechanism to analyze the information obtained by the PNMPCs though the PNM Clinic therapists had recently initiated a monthly meeting to review the monitoring sheets completed to track individual-specific issues through to resolution. Eventually, a system to track and trend concerns noted in homes or across the facility was also to be implemented. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when an individual was determined to be at risk of harm and that the monitor would notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves did not provide a mechanism to document these actions or to document follow-up. There was also no means to document whether retraining was required.	
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 new health risk assessment process was introduced in January 2011 and the PSTs continued to face challenges in order to fully implement this process. Discussions with two PSTs were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. Further review during the next onsite visit will be necessary to determine the effectiveness of each of these systems. **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 at least on an annual basis, though more frequent routine, proactive review of the plans was conducted by the clinicians during the PNM Clinic that was held to provide quarterly, semi-annually, or other reviews as indicated with frequency based on health risk level. In the case that an individual participated in direct therapy, progress notes were written, though very few individuals received this as discussed in section P below. The system continued to be refined so as to ensure assessment of the effectiveness of the plans on a regular basis in addition to the PNMP and dining plan monitoring conducted by the PNMPCs and soon also other PST members.	Noncompliance

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O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**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 enteral nutrition, though one of these was recently deceased. Six of these individuals had been included in the sample reviewed by the monitoring team. There was a new system as an aspect of the At Risk Individuals policy that provided a format for the annual review of those who received enteral nutrition by the PST using the Aspiration Pneumonia/Enteral Nutrition Evaluation. Evaluations completed for individuals in the sample were requested by the monitoring team. These assessments were noted for five of the six individuals in the sample. As this process had just recently been implemented, further review will be conducted by the monitoring team in the future. **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 in the selected sample had been provided a PNMP that included the same elements described above. **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.** There was no protocol outlined for this process. Individual #217 received oral intake per her enteral nutrition evaluation dated 1/21/11. There was no discussion of her success with this at the time of that evaluation other than to document that nursing was to monitor her respiratory status closely and that her breakfast serving had been increased to three-quarters of a cup. She otherwise received one-quarter to one-half a cup, five times a day. She did not have a dining plan and her PNMP indicated only that she should be upright during intake and remain upright for a minimum of 45 minutes after. There were no utensils specified and it stated that she could have ½ cup of pureed foods daily, assisted only by medical staff. Guidelines for pace or bite size were not outlined as would be expected. There was an inconsistency in the amount and frequency reported in her evaluation with the PNMP dated 11/12/10. A transition to oral intake was attempted for Individual #203, though the date was unclear per her enteral nutrition evaluation dated 3/22/11. It stated that the last attempt had been in July 2009 though there was also a reference to reinstatement sometime after a MBSS on 3/31/10. Following an ileus with associated decline in medical status, oral intake was discontinued. The rationale for not resuming oral intake was not clearly stated	Noncompliance

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		though there was reference to less agitation with enteral eating rather than oral intake and that it was "not in her best interest due to health issues" to resume oral eating. There were no data presented to substantiate these conclusions. There was also insufficient rationale for continued enteral intake in the enteral nutrition evaluation dated 3/30/11 for Individual #66. There was insufficient data presented in the enteral nutrition evaluation dated 1/21/11 to justify discontinuing oral intake for Individual #98 in September 2010. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** One aspect of the new At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nursing case manager based on information provided by the PCP, nursing, habilitation therapists, dietitian, pharmacist, and other members of the PST. As stated above, five of the eight individuals reviewed had completed assessments. The assessments completed for the five individuals identified above followed the approved format, though they varied in consistency and as stated above did not provide sufficient data to support conclusions presented in the evaluation. Further assessment will be necessary by the monitoring team in the future to assess the quality of these assessments. **Standard: Individuals who are at an increased PNM risk are provided with 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. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. Consider an increase in nutritional staff. One dietitian for the facility and assignment to the PNMT was insufficient to adequately meet the needs of all individuals living at SGSSLC (245 individuals).

2. Identify and address risk issues consistently in the focus of the PNMP, dining plans and assessments. Clinical justification for supports should

be stated with a clear link to the health risk indicators identified by all PST members.

3. Conduct self-audits of Dining Plans and PNMPs to look at clarity, consistency of format, and content. Reviews should include a review of the flow of implementation throughout the day to ensure optimal compliance.

4. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct chart review and history. Evaluations must be based on new data or information in order to yield a new perspective to address specific issues that drove the referral to the team.

5. Ensure improved attendance at the PSPs and PSPAs by Habilitation Therapies and Nutrition Services staff. Attendance by the PNMT will also become critical as they begin to conduct assessments and develop intervention plans.

6. Ensure that competency-based training is skills-based whenever indicated. Staff generally learn better by learning and trainers get a better idea of the effectiveness of their training through return demonstration rather than mere verbal responses. Verbal responses do not suffice in the case that the staff need to perform a specific skill.

7. Proceed with implementation of the trend analysis of all monitoring data. Review findings and make system adjustments. It is critical to establish a mechanism to review the overall trends and findings to drive staff training in the homes and other settings in which the PNMP is implemented. This review is an important quality improvement element.

8. Use a collaborative approach to assist the PSTs for improved activity analysis in the development of SPOs for teaching individuals to slow down or take smaller bites. Integrate strategies and prompts like taking a drink, using a napkin, or putting the utensil down for individuals who do not respond to verbal cues. Provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect.

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:** Documents Reviewed: o Rehabilitation Therapy Staff Information list o OT/PT Continuing Education Sessions 4/11/11 o SGSSLC Organizational Charts o Staffing data (4/22/11) o Section P Presentation Book and POI o Health Risk Assessment tool and risk guidelines o Risk lists for osteoporosis, falls, choking, aspiration, skin integrity, o Client List as of 3/31/11 o Admissions Activity 10/1/10 – 3/31/11 o Separation Activity 10/1/10 – 3/31/11 o PNM Needs list o No PNM Needs list o Maintenance Log o PNM spreadsheet o List of individuals with pain, chronic and acute o List of individuals with GERD o List of individuals with dysphagia o Current Skin Breakdown for the past year o Pneumonia Tracking 1/1/10 4/20/11 o Active Pressure Ulcers o SGSSLC Non-Injury Fall Data 4/10 – 3/11 o Falls list 4/18/11 o Fractures list 4/20/11 o List of individuals with Diagnosis of Pneumonia – Textures, consistency and MBSS 4/13/11 o List of individuals who receive enteral nutrition o Individuals who were non-ambulatory or assisted ambulation 4/8/11 o Individuals with Primary Mobility Wheelchair 4/4/11 o Individuals who Use Transport Chairs 4/6/11 o Individuals with Orthopedic Devices and Braces 4/6/11 o Individuals receiving direct OT/PT o List of hospitalizations/ER visits o Section P QA/Rehabilitation Therapy audits February and March 2011 o PNM Monitoring form templates (7) o Proposed PNM monitoring tools and database format 4/17/11 o Completed PNMP Monitoring Forms submitted

	o Murdoch Center Program Library o NEO training curriculum for PNM o Physical Nutritional Management Refresher Course iLearn Curriculum o PNMPC competency training curriculum materials, pre- and post-tests o PNMPC training notebooks o PNMP template o PNMPs submitted o PNMP Monitoring 2011 spreadsheet o OT/PT Master Plan (4/18/11) o OT/PT Assessment and OT/PT Assessment Update templates o PNMP Clinic process guidelines, monitoring forms and documentation o PSPs, PSPAs, consults, integrated progress notes, documentation related to OT/PT treatment for: o Individual #169, Individual #26, Individual #14, Individual #318, and Individual #78 o OT/PT evaluations and PSPs: • Individual #334, Individual #206, Individual #302, Individual #128, Individual #247, Individual #126, Individual #80, Individual #29, Individual #94, Individual #14, Individual #291, Individual #90, Individual #318, Individual #273, Individual #143, and Individual #367. o Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plan, Annual Physician Summary, Health Status tab, MBSS studies and reports, hospital summaries, current medication list, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab, Nutrition tab and Dental tab for the following: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o Information from Individual Notebook including PNMP tab for the following individuals: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o PNMPs for last 12 months, Dining Plans for last 12 months and Monitoring forms completed in the last six months for the following individuals: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265 and Individual #15.

	Interviews and Meetings Held: o Dena Johnston, OTR Habilitation Therapies Director o OTs and PTs o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o OT/PT Clinic o Observation rounds with OTs and PTs for positioning
	Facility Self-Assessment: SGSSLC's self-assessment identified noncompliance for all items in this provision. The self-assessment was consistent with the monitoring team's assessment of noncompliance for each aspect of this provision. Comments stated actions taken that were determined to be related to each provision item, but there was no clearly stated plan to achieve compliance with progress tracked by completion of each specific action step. Some of the activities documented as completed during the last six months included the following: • SGSSLC continued in their attempts to recruit therapy clinicians. • The OT/PT Assessment format was revised slightly to address positioning for oral care and medication administration. Efforts to include objective measurable goals continued. A Master Plan was developed to identify assessment schedules based on PNM risks. • Efforts to better integrate the PNMP into the PSP process. There has been progress in incorporating the PNMPs into the risk action plans to address identified issues. • Development of the PNMPC training modules were designed to build their knowledge base and skills. • Monitoring drills were initiated for lifting/transferring • Development of a monitoring tool to review progress and effectiveness of the PNMP and other supports based on health risk indicators Much work has been noted yet the current POI format appeared to merely document completion of tasks rather than serve as a well outlined plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps similar to that used for POI to address actions on recommendations from previous compliance reviews.

	Summary of Monitor's Assessment: Staffing levels continued to be very low, though a tremendous amount of work was evident by the small core group of therapy clinicians. Assessments were improving with efforts to begin to link the health risk assessment process to the OT/PT assessment process and in the development of the PNMP. The focus continued to be primarily on health risk and measurable goals developed were generally related to those risk indicators identified for an individual. Efforts to address functional skill acquisition were noted, but generally recommendations shifted to the PST rather than also the identification of potentials and need for motor skill acquisition or increased independence in activities of daily living requiring the design and implementation of training objectives directed by the therapists as well. These meaningful and functional learning opportunities must be recognized as equally important as physical health concerns and that independence, engagement and participation are also critical to positive health outcomes for individuals. Though the assessment format continued to be refined, and there were obvious attempts to move toward more functional analysis to create a foundation for interventions and strategies, the analysis of findings continued to need improvement. The comparative analysis of health and functional status from the previous year and of the data reported to provide a sound foundation and rationale for the recommendations for interventions and supports will require additional focus and refinement. There were few intervention plans, (none were SPOs in the PSP) and measurable goals were not consistently established with performance criteria clearly outlined, though there was a noted improvement in this area. Follow-up was likely addressed but inconsistency of documentation was noted. There continued to ongoing concerns related to positioning and alignment of individuals in wheelchairs. Direct support staff did not demonstrate sufficient knowledge and skills to implement plans appropriately. There was significant progress noted however with regard to the knowledge, skills, and confidence of the PNMPCs. It was anticipated that their monitoring and training efforts will begin to impact the competency and performance of the direct support staff in the implementation of the PNMPs over the next six months. A new system of monitoring and refresher training content should have good payoff if well implemented over the next few months.

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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	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** Dena Johnston, OTR, continued to be the Rehabilitation Therapy Director. OT and PT staffing levels were essentially unchanged from the previous onsite review. Current staffing included two full time PTs, no PTAs, one full time OTR, and no COTAs. There was one unfilled position for PT and two for OT. There were no OT or PT technicians. There	Noncompliance

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	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.	were nine Physical Nutritional Management Coordinators, one of whom was the designated lead (Louis Bailey). Fabrication of seating systems continued to occur onsite with one orthopedic equipment technician who served as fabricator and conducted maintenance work on equipment. A list was submitted of continuing education for Charis Worden, OTR, only (Understanding Personality Disorders on 3/17/11). There were no contact hours listed. No other continuing education was listed for the other clinicians. Regardless of experience, it is critical that all therapy clinicians routinely participate in continuing education and clinical instruction routinely in order to remain current with regard to assessment and intervention. Based on a list of PNM needs submitted, 190 individuals or 77.6% of the current census (245) were identified as requiring PNM supports and were provided a PNMP. Based on the reported census and identified PNM needs, as currently staffed, the PT caseload was approximately 122.5 each for the full-time PTs considering the general census or 95 each for the those reported with PNM needs. The OT caseload size was considerably higher at 1:245 for the general census, or 1:190 for those reported with PNM needs. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with no additional supports available from the therapy assistants or aides. Annual assessments/updates were completed by OT and PT collaboratively. Some of those who did not have established PNM needs required occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the current staffing levels for OTs and PTs. OT/PT assessments were included in the request for 20 individual records. There were 20/20 assessments submitted and listed above. Documentation for each of the 20 individuals included in the sample selected by the monitoring team (listed above) was pulled directly from the active record as requested and there were generally multiple evaluations for each. The assessment for Individual #78 was incomplete with only the first page submitted. Review was limited to the most current evaluation submitted, though two of these were 13-15 years old and, as such, could not be considered an appropriate representation of their current status Individual #384 and Individual #210. Additional most current assessment samples from each therapist were also requested and 20 were submitted, though three were duplicated in the individual sample selected by the monitoring team. The total number of assessments included for review was 34.	

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		Based on review of the assessments submitted, there were at least 21 of the 34 (62%) individuals with identified concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics and dining supports. A very limited number of these individuals were provided with OT or PT services beyond the PNMP (Individual #345, Individual #14, Individual #318, Individual #78). Only Individual #318's assessment had a recommendation related to direct services. Only two others (for whom assessments were not requested) participated in direct therapy (Individual #169 and Individual #26). **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed as a more discrete measure of status rather than screenings, for most individuals. The assessments submitted were completed by both OT and PT. As stated above, there were 34 assessments included for review. Of these, 15 were identified as assessments, 15 as assessment updates, two were evaluation updates (Individual #278 and Individual #98), one was a comprehensive assessment (Individual #128), and one was a CLDP assessment update (Individual #334). Assessments submitted that were not current within the last 12 months included the following: • Individual #210 (7/1/96) • Individual #384 (8/31/98) • Individual #38 (4/27/10) • Individual #344 (5/6/10) • Individual #278 (3/16/10) • Individual #98 (4/20/10) No more current assessments were submitted for these individuals. None of the updates referred to a previous comprehensive assessment that was being updated or a previous update. Some documented a comparison of the individual's status with the previous year (Individual #76), however, though it was not clearly stated that an assessment or update had been completed at that time. The rationale for a comprehensive assessment for Individual #128 was not stated in the report dated 3/15/11. His previous OT/PT assessment had been completed on 5/16/07, but was not referenced in this current assessment. He was described at high risk for choking and medium aspiration risk. He had been seen by OT and PT during the previous year related to reports of coughing, decreased range of motion, and skin integrity concerns. He was seated in a wheelchair and had a PNMP for alternate positioning. It was not clear that he had received an update	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>since 2007.

An OT/PT Master Plan was submitted and described as “under construction.” The plan was intended to provide PSTs information related to the assessment schedule for each individual at SGSSLC. The plan identified the most current assessment date and a proposed date for the subsequent assessment update. There was a plan to track the timeliness of these using the Master Plan. By report, the current evaluation schedule was to be determined based on risk at the time of the annual PSP/assessment. An individual considered to be at low risk and had no supports would receive a screening every five years. The screening was not developed at the time of this review. An individual considered at medium risk would receive an assessment every three years with interim updates specific to the services the individual received. An individual at high risk would receive assessment annually. This schedule would be adjusted with changes in the individual’s physical nutritional health status. The plan submitted was dated 4/18/11 and listed 249 individuals. Current assessment/updates dates listed were as follows:

<table>
<tr><th>Year</th><th>Current Assessments</th><th>Assessment Updates</th></tr>
<tr><td>No date specified</td><td>3</td><td></td></tr>
<tr><td>1995</td><td>7</td><td></td></tr>
<tr><td>1996</td><td>4</td><td></td></tr>
<tr><td>1997</td><td>6</td><td></td></tr>
<tr><td>1998</td><td>20</td><td></td></tr>
<tr><td>1999</td><td>16</td><td></td></tr>
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<tr><td>2001</td><td>10</td><td>1</td></tr>
<tr><td>2002</td><td>9</td><td></td></tr>
<tr><td>2003</td><td>4</td><td></td></tr>
<tr><td>2004</td><td>18</td><td></td></tr>
<tr><td>2005</td><td>11</td><td></td></tr>
<tr><td>2006</td><td>16</td><td></td></tr>
<tr><td>2007</td><td>48</td><td></td></tr>
<tr><td>2008</td><td>25</td><td></td></tr>
<tr><td>2009</td><td>17</td><td></td></tr>
<tr><td>2010</td><td>13</td><td></td></tr>
<tr><td>2011</td><td>4</td><td>33</td></tr>
<tr><td>2012</td><td>1</td><td></td></tr>
</table></td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		In review of the Master Plan, it was not clear why some individuals had received an update or assessment in 2011 after a number of years since their previous OT/PT assessment (Individual #44, 3/6/07, and Individual #302, 5/26/06). Some individuals had received a more recent assessment, yet this was not listed in the Master Plan. Some examples included Individual #273, 1/25/11; Individual #66, 1/27/11; Individual #367, 3/29/11; Individual #90, 2/8/11; and Individual #304, 2/3/11. No proposed re-assessment date was identified for any of these individuals. Others had received an update since the previous assessment listed in the plan but this also was not reflected including Individual #76, 12/10/10; Individual #203, 8/10/10; Individual #265, 10/6/10; Individual #98, 4/20/10; Individual #278, 3/16/10; and Individual #14, 3/7/11. It also did not appear that the proposed assessment dates were consistently related to risk levels or the provision of supports and services. For example: • Individual #94 had not received an OT/PT assessment since 4/4/03, received an update on 3/15/11, and was proposed to receive a subsequent assessment by 3/17/12. She was identified at low risk for most indicators on the Integrated Risk Rating Form (undated) and at medium risk for weight, cardiac disease, polypharmacy, and challenging behavior. Her current assessment did not outline any OT/PT supports or services and did not indicate a need for annual reassessment. It was not clear why she required annual assessment. • Individual #318 had not received an OT/PT assessment since 3/27/98, but received an update on 1/18/11 with no proposed date of reassessment. He was identified at low risk for most indicators on the Integrated Risk Rating Form (2/16/11) and at medium risk for choking, aspiration, challenging behavior, and fractures. He was listed at high risk for falls and osteoporosis and participated in PT though had not been scheduled to receive an annual update or assessment. • Individual #128 had not received an OT/PT assessment since 5/16/07, but received a comprehensive assessment on 3/15/11. He was identified at high for choking and medium risk for aspiration, weight, cardiac disease, constipation/bowel impaction, infections, challenging behaviors, and urinary tract infections, yet he was not scheduled for an annual update or assessment per the Master Plan. As described in Section O above, there would likely be a need for the PSTs to reconsider the risk levels they had assigned for a number of individuals to more accurately reflect actual risk. These changes would likely impact the current OT/PT Master Plan. In addition, this approach would not be an effective method to establish a schedule for those who would benefit from OT or PT therapy intervention for skill acquisition to increase function and independence.	

#	Provision	Assessment of Status	Compliance
		Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. An assessment format was submitted that appeared to be more comprehensive if the content was appropriate and complete, though there were a number of areas not sufficiently addressed and are described in this standard. A summary was offered with recommendations and rehabilitation therapy goals. Health risk issues were not addressed via a heading in the template, though these were generally noted in various sections throughout the reports reviewed. Recommendations for supports were not always directly linked to the specific health risks identified by the PSTs, nor were they clearly linked to the specific findings of the therapy clinicians. There continued to be no focus on skill acquisition via functional outcomes and training objectives addressed by the therapy clinicians. An assessment update format was also submitted that was slightly different than the full assessment and focused slightly more on what had occurred during the previous year, including their health status as well as a review of the supports and services provided. There was no aspect of the assessment to address the focus or effectiveness of direct services provided or to review progress on SPOs implemented by direct support or day program staff but designed and reviewed by the professional therapy staff. Of the assessments submitted, only one was titled a comprehensive assessment (Individual #128). As stated above, there was no rationale documented in the report for this comprehensive assessment. His previous OT/PT assessment had been nearly four years earlier on 5/16/07. All other individuals for whom assessments were submitted and reviewed had received an OT/PT assessment or update, though some were not considered to be current based on the proposed assessment schedule (Individual #210, Individual #38, Individual #384, Individual #278, and Individual #98). As previous assessments were not referenced in the current assessments a reader would not be able to discern when a previous assessment had been completed. There was no clear evidence that all individuals had a comprehensive assessment that met current standards with regard to format and content as most had been completed prior to the effective date of the Settlement Agreement. An annual update of status would be an acceptable process if the baseline assessment was sufficiently comprehensive. Generally, there would be a reference to the baseline assessment and a copy of that assessment and subsequent updates would be available in the active individual record until a subsequent comprehensive assessment was completed. While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard is not acceptable when there are urgent issues with potential for further injury or health and safety risks. There did not appear to be a	

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		standard for additional comprehensive assessment when new issues were identified or referred by the PST, however, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period via a consult or brief update. Most of these appeared to have been completed in a timely manner. There was no formal system to track these or other specific referrals generated by the PST or via PNMP monitoring through to resolution. **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.** As stated above, there was no consistent practice to ensure that a comprehensive evaluation was conducted every three years with annual interim updates for those receiving direct or indirect supports and services. The new Master Plan, however, was intended to ensure that the assessment schedule was to also be based on risk level in addition to the provision of supports and services. For example, an individual considered to be at high risk was to receive an annual assessment. Individuals at medium risk were to receive a comprehensive assessment every three years with interim updates annually. This was not yet implemented as evidenced by Individual #278, Individual #38, and Individual #98 who had updates that were just over 12 months at the time of this review, though they were at high risk in PNM-related areas and received PNM supports. A current assessment should have been completed and in their individual record but was not. The following individuals were also identified at high risk for PNM-related issues and received supports and services: • Individual #66, Individual #210, Individual #7, Individual #344, Individual #18, Individual #384, Individual #109, Individual #217 Two of these (Individual #210 and Individual #384) did not have current OT/PT assessments with the previous assessments dated in 1996 and 1998 respectively. In addition, there was no evidence that a comprehensive evaluation was conducted for an individual with a change in status, but rather an issue-specific consult was to be documented by report. Sufficient follow-up was not consistent. For example: • Individual #210 had been hospitalized on 2/2/11 for aspiration pneumonia following a seizure with vomiting. He was discharged with a downgraded diet and thickened liquids with a MBSS to be ordered after recovery. As stated above he had not received an OT/PT assessment since 1996, with no evidence of updates since that time in his individual record or in the Master Plan. There were no consults or updates documented in his individual record following his	

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		discharge on 2/7/11. A nursing note recommended that his head of bed be elevated at 30 degrees at all times, if tolerated, and suction tooth brushing. Though gurgling and coughing had been reported on his aspiration trigger sheet by nursing in a note on 2/23/11 there was no documented OT/PT consult until 3/9/11 in response to a PNMPC request related to his posture during meals, though staff had reported changes in his posture since an increase in seizure activity in February. On that date, OT recommended a follow-up in one week to see if there was any improvement in his posture after an increase in Keppra on 3/3/11. He returned to the emergency room on 3/17/11 and a note on 3/18/11 documented that the OT deferred a mealtime observation due to Individual #318 being in the infirmary. It was not clear why the OT did not attempt to observe him during this or his previous infirmary admission as mealtimes occurred during those times. He was discharged on 3/21 to home. The OT observed lunch, but wanted to observe him again using a back cushion to see if that improved his posture because the seat depth of his chair was too long and his feet were not fully supported on the floor. There was no further review by the OT documented. There had been no increase in monitoring by the PNMPCs. He was not reviewed by the PNMT. There was no addendum to his PSP other than one related to the initiation of suction tooth brushing on 2/10/11. The response to Individual #318's change in status was inadequate. A list submitted identified six individuals who had received direct OT or PT services in the last six months. The following individuals participated in PT: • Individual #78 for strengthening and gait training • Individual #318 for lower extremity strengthening, balance and coordination • Individual #14 for left knee pain • Individual #26 for safe walking and lower extremity strengthening • Individual #345 for increased function of her right upper extremity secondary to a fall The following one individual participated in OT: • Individual #169 for range of motion post distal radius fracture and subsequent surgery Assessments for Individual #318, Individual #14, and Individual #345 were included in the sample for review. Only Individual #318 had been recommended for direct services in his assessment. Further review of assessments for those in therapy is indicated in future reviews by the monitoring team. The assessments inconsistently contained most of these new headings, though fine motor	

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		skills or upper extremity functions were not addressed in half of the assessments reviewed. In the case that there was a heading for this area, the content was often not sufficiently comprehensive. For example, in the case of Individual #98, her grasp patterns were listed, but there was an insufficient description of her reach, release, and manipulative skills. It was reported that she used both hands together in bilateral activities, but none were given in example. It was not known if this referred to bilateral skills (both hands doing the same thing as in catching or throwing a ball) or bimanual skills (one hand stabilizing an object while the other manipulated as in removing the lid from a jar). The only functional example was holding a crayon adaptively to color, though this might not be clearly understood by other team members. With more specific examples of what an individual can or cannot do provides a better foundation for the development of skill acquisition programs (SPOs) in the home and day program activities. The clinicians did not generally document functional examples of systems level findings, such as range of motion, strength, and muscle tone. The new format submitted provided a statement to this effect in in order to prompt the therapists to do this. Observation of activities outside of the clinic setting was not documented. This limited the clinicians' ability to identify potential for skill acquisition and therapy consultation. The assessments rarely discussed postural control or alignment in any position other than during standing or ambulation. A description of sitting skills in other settings or a discussion of transitions to and from sitting was also not discussed. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified and interventions, primarily the PNMP, were not specifically linked to these ratings. As stated above approximately 62% of the assessments reviewed described individuals with significant movement disorders and limitations in self-care and/or functional skills. The following information was also noted based on the documents submitted and these	

#	Provision	Assessment of Status	Compliance
		individuals would likely require supports and interventions by OT and/or PT beyond only a PNMP. There were: • 190 (78% of the current census) individuals identified with PNM needs per the list submitted. • 39 (16 %) individuals identified as non-ambulatory or requiring assistance for ambulation. • 18 individuals required a gait belt or transfer belt for assisted mobility. • 9 individuals used assistive equipment for mobility such as a walker. • 25 (10%) individuals who used a wheelchair as a primary means of mobility. • 15 (6%) individuals who used transport wheelchairs as needed. • 64 (26%) individuals with upper or lower extremity orthotics and/or braces • 10 (4%) individuals sustained an injury resulting in a fracture. Two of these individuals were either non-ambulatory or required assisted ambulation to some degree. One occurred during a lift or transfer for Individual #122. • 61 (25%) individuals had experienced falls in the last three months. Approximately 12 of these incidents occurred in the bathing or toileting area. There were three individuals who experienced a slip, trip or fall resulting in a serious injury. There were 22 individuals who had more than one fall and 5 of these were either non-ambulatory or required assistance for ambulation. For example: Individual #7 (9 falls), Individual #34 (2), Individual #288 (6), Individual #202 (3) and Individual #189 (3). Only Individual #189 was identified at medium risk for falls, all others were listed as low risk. • One (7%) individual had an incident of pressure ulcer in the last year. • 12 (5%) individuals were listed at high risk for osteoporosis, including Individual #318 who had experienced four falls in the last three months and Individual #384 who had fallen on 3/24/11 resulting in a serious injury. Refinement of the PSP and Health Risk Assessment processes are refined over the next year, they will likely further impact the OT/PT assessments over the next year. **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)** As stated above, the assessments generally addressed range of motion and movement	

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		skills, such as transfers and ambulation. Other functional skills were not consistently addressed, particularly in the area of fine motor skills and activities of daily living. The description of self-care typically only stated that they were dependent on staff or were independent. There was no description for those who had some level of participation, such as raising their arm during dressing, for example, to provide a foundation for skill acquisition. There was no evidence that these activities were observed by the therapists. **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.** One individual who had not been previously identified with PNM needs, Individual #169, experienced a fracture of his distal radius, requiring surgery after he fell on the ice on 2/1/11. His cast was removed on 3/17/11 and there was an order for OT/PT and daily range of motion with orthopedic follow-up in four weeks. An OT evaluation was documented in a progress note with instructions for edema management and written home program instructions were provided. There was no PSP addendum noted to integrate these instructions and goals for therapy into his PSP. Direct OT was initiated on 2/22/11. Documentation was inconsistent with notes on 3/31/11, 4/1/11, and 4/14/11. These did not document frequency of the therapy provided and reported progress did not address all of the stated goals. Some of these were not functional or in measurable terms as described above. There was no further documentation as to Individual #169's status by the OT. On 5/27/11 a nursing note reported having received an email reporting complaints of wrist pain and that he was not able to complete his exercises. There was no evidence that the OT had addressed this. Comprehensive assessments were not provided upon a change in status, but rather OT or PT consults were noted for some individuals in the Integrated Progress Notes. The date of referral was not consistently documented, so it was not possible to determine the timeliness of these consults. While this would be appropriate in many cases, such as Individual #169, a more comprehensive consult should have been completed. There was no evidence that the OT actually evaluated his functional status as a baseline prior to beginning direct therapy nor was there documentation of his upper extremity function prior to the fracture to assist in the establishment of functional goals. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments reviewed did not typically recommend further specialized evaluations for wheelchair seating or for other issues though recommendations to the PST for further medical review or assessment were noted for some, however. Generally, referrals by the	

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		PST or PNMPCs related to concerns or problems with the wheelchairs or seating were made and the individual was scheduled for the PNM Clinic. Each individual with PNM needs was scheduled at a regular interval based on need in this clinic, when the therapists typically conducted a thorough review. Maintenance checks were also completed at that time. The annual assessments typically provided a thorough description of the seating system components for individuals, and consistently addressed whether the system was appropriate as to fit, function, and condition. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** The assessment format offered a list of diagnoses, and past and present medical concerns were described. There was generally a brief reference to recent health events, with special consults or diagnostics reported less frequently. The current health risk ratings were not reported though, in some cases, the clinicians provided a statement to justify a specific risk rating such as for choking or aspiration. In some cases, there was a reference to a health issue elsewhere in the report, but there was no specific review of health events, special consults, or diagnostics conducted during the previous year. References to the PST risk assessment and ratings were not noted and, in some cases, the issues were not addressed adequately in the assessments and supports. The concept of presenting risk as used in the revised NEO training would be an excellent framework for appropriate analysis and justification for the supports and interventions. Efforts to identify the rationale for some supports were noted. There was no comprehensive analysis of findings that included both health and medical concerns with a description of functional skill abilities and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. There was a new PSP and risk assessment process that should result in changes in the way this is addressed in the clinical evaluations completed by OT and PT. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	

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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.** Plans were limited to the PNMP that was reviewed at the time of the annual PSP and were updated as needed due to a change in status. There was evidence that the majority of the plans were reviewed and updated as needed during the quarterly PNMP clinic, at the time of the annual staffing and at other times related to program changes. Changes were identified by a symbol to alert staff to a change from the previous version. The majority of the plans reviewed were current within the last 12 months with the exception of 11 plans. A number of these documented only the risk of reflux, back brace, foot orthotics or orthopedic shoes, or mattress for fully independent individuals. It would appear that these items could be addressed in another manner without the documentation and review required of a PNMP. There were no SPOs or activity plans developed to outline direct therapy and interventions were not integrated into the PSP. Most of the interventions were not written clearly as skill acquisition plans with functional measurable goals and objectives. While there were some stated goals these focused on system changes in range of motion or strength, but were not related to a functional outcome as described above. **Standard: Within 30 days of development of the plan, it was implemented.** As there were very limited interventions provided beyond 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, per the progress notes reviewed. However, there were some cases described above where there was no documentary evidence that therapy supports and services had been provided or that appropriate follow-up and monitoring had been conducted. Documentation by the clinicians was consistent in most cases though improvements in consistent reference to established measurable goals to justify continued intervention or the need for termination were indicated. Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with measurable and functional goals and outcomes. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. While documentation was included in the integrated progress notes section, these were not a consistent aspect of documentation for quarterly PSP reviews by the QMRP. **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**	Noncompliance

#	Provision	Assessment of Status	Compliance
		and functional outcomes. There was inconsistent analysis of findings in the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions as described above. There was a general rationale identified on the plan itself rather than the specific supports in the statements of focus, however, these statements were not always consistent with the risks identified by the PST. The new format and process for the development of the PSP had potential for improved integration of the PNMP, though this was not evident PSPs reviewed as listed above. PSP Addendums were not consistently developed to address modifications to PNMPs and other therapy interventions for individuals as described above. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited related to promoting independence and skill acquisition. The few interventions in place were generally well documented (exceptions discussed above), however, the scope of service was limited to a handful of individuals only. Justification for continued therapy or discharge was not well justified as a result. SPOs for skill acquisition were just beginning to be developed though this was via recommendations for the PST rather than SPOs designed, implemented, or monitored by OT or PT. The examples identified in the presentation book were as follows: • Individual #104: The only recommendation for skill acquisition was identified as choosing a snack from options that were appropriate for his diet order and prescribed texture. It was stated that by offering him more choices that were appropriate he would learn what he could safely eat. There were no measurable goals for this and OT/PT would not be involved in this activity. There were no other recommendations for skill acquisition for Individual #104. Indirect supports were identified such as a shoe lift to address his leg length discrepancy and an AFO on the right to promote dorsiflexion during gait. Direct PT intervention was not discussed with regard to possible benefits to address these identified concerns or to justify why direct therapy would not be effective or appropriate. • Individual #80: Recommendations included PST consult with the dietitian to create healthy eating habits goal. There were no measurable goals for this and OT/PT would not be involved in this activity. Though he was reported to have lost 14 pounds, it was documented that he continued to be 60 pounds over his ideal weight range and was noncompliant with his diet. There was no discussion	

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		of the possible benefit of an exercise program or OT/PT intervention. Other examples submitted included progress notes for intervention included: • Individual #78 for safe and more frequent walking in his home, walking 100 feet with the assistance of the PT with minimal signs of fatigue, and a 10% increased in his lower extremity strength. Walking 100 feet was a measurable functional goal and was tracked for progress in each of two subsequent progress notes by the clinician. His baseline was reported as 25 to 50 feet in a note on 1/28/11 and his reported performance was 25 feet in February 2011 and 35 feet in March 2011. Regarding the other two goals, walking in his home was not stated in measurable terms and 10% increase in strength was not stated in functional terms. The duration and frequency of intervention was documented as two times weekly for four weeks. • Individual #169: The goals were generally measureable, but functional outcome was not stated in measurable terms. For example, range of motion standards were outlined, such as achieve forearm supination to 20 degrees, but function was stated merely as he would more effectively and functionally use his left hand in daily activities. There was no evidence that the clinician had observed his hand use in the home to establish the baseline by which to judge improvement nor was his functional skill status prior to the fracture reported. As such it was not possible to establish specific functional goals for Individual #169. PNMPs included staff instructions or precautions in the areas of movement and mobility, transfers, handling, positioning, bathing, communication, diet order, mealtime equipment, and instructions. Assistive equipment was included, as well. The plans were written in first person, for example, "I can sit in any chair for activities" or "help me reposition every two hours." Instructions for medication administration were noted for 19/20 individuals included in the sample, though this was generally stated under adaptive equipment/diet. There was a statement as to the texture required such as crushed medications or via PEG tube, but no special instructions for presentation or utensils were outlined for any individual. Only in two cases was there a specific section for medication administration making the information easy to locate in the plan (Individual #66 and Individual #98). Instructions related to bathing were noted in all of the plans included in the sample. Oral hygiene instructions were included under the dining plan heading. In several cases, positioning for dental interventions was noted in the plan and was an excellent addition to the PNMP. Risks were listed and appeared to be consistent with the health risk system in place at the facility. The positioning focus appeared to provide a rationale for the provision of the physical supports described in each plan.	

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		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 inconsistently provided a rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. Positioning instructions with pictures were provided for staff reference as an adjunct to the PNMP with details for alignment and support for bed (Individual #66 and Individual #122), wheelchair seating (Individual #203 and Individual #217), walker use (Individual #78) and gait belts (Individual #98 and Individual #217) but not for braces or orthotics (Individual #66 and Individual #109). A standing home program for Individual #217 with a description of how to place her in the Easy Stand was noted in her individual book though there were no pictures to reinforce staff understanding and compliance. These plans were generally present in the individual books and were each current within the last 12 months. The pictures noted were large, in color and generally clear with useful highlights for staff as cues or reminders of the critical components of the prescribed supports, however, the inconsistencies noted above had the potential to confuse staff. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans, and measurable goals were not consistently established with performance criteria clearly outlined. Documentation was consistent and, in some cases, described progress, but without a clear baseline and/or a specific measurable goal, continued intervention was not well justified. As a result, the decision to continue therapy or discharge was not supported. It was likely that there was an adequate justification for many of the supports and services provided, but they were not always well documented. **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.** In the case that an individual received direct therapy, documentation was noted monthly in most cases, though the frequency of intervention was not consistently reported. Documentation for direct services was included in the integrated progress note section. Reviews of the PNMP were conducted at a predetermined interval, such as quarterly or semi-annually, upon referral, or based on the findings of monitoring. There was evidence	

#	Provision	Assessment of Status	Compliance
		of the therapists addressing some issues identified through monitoring or referral, yet documentation of follow-up through to resolution was inconsistent. As described above, there were some oversights in documentation, though it appeared likely that the support or service had been provided.	
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, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standard of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair. However, the PNMPCs appeared to be very knowledgeable about the equipment and how an individual should be positioned. It is critical that they confidently and consistently apply their knowledge and skills in their interactions with direct support staff to ensure appropriate implementation of all aspects of the PNMP and other supports. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The PNM aspect of NEO training for direct support staff had been revised and improved since the previous review. It was clearly outlined and comprehensive, though there was a tremendous amount of information to be presented in only a day and a half to cover physical and nutritional supports. Though by report, it was competency-based, the checklists used to establish this were not submitted with the instructional materials. In addition, a refresher course to be provided to all direct support staff had also been developed as well as a contract with staff to document a commitment to the implementation of the supports necessary for individuals with PNM needs. These were positive steps in the provision of appropriate and effective staff training and to ensure continued staff competencies. Individual-specific training was also reported to be competency-based. Licensed therapy staff provided inservice training to direct support staff and to PNMPCs. The training sheets submitted were primarily related to dining plans so it was not clear if this process was also used to train physical management aspects of the PNMPs. The training sheets submitted had a description of the procedures to be used and the type of competency, either verbal or demonstration of specific skills. The staff participating in the training	Noncompliance

#	Provision	Assessment of Status	Compliance
		signed the sheet though there was no indication that their signature signified competence. The only training that required demonstration among the samples submitted were two related to the implementation of communication systems. The newly developed PNMPC training included a section on training others and how to establish competence. This will provide these staff with improved skills needed for effective training of direct support staff. The training was developed to establish competency for the PNMPCs across all aspects of the content necessary for their role as monitors and trainers. There was a mentoring system also developed that allowed for the opportunity for each PNMPC to spend time with staff within and outside the therapy department and to understand how their role is integrated with the roles of all staff facility wide. The system provided the mentor with content for discussion and specific activities for participation, such as attendance at certain meetings. Additionally, there was a checklist that served as a means for the PNMPC to reflect his or her learning and understanding as a result of these opportunities. **Standard: Staff verbalizes rationale for interventions.** Staff had been provided with coaching and drills to ensure that they were consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was also not included in the PNMP related to specific strategies. This is an important aspect of staff training as well as monitoring and coaching. The focus of the PNMP highlighted the overall risk issue for the individual as a rationale for the plan, but detail as to why a specific strategy was used was not consistently indicated on the PNMP. As described above, however, there were significant risk issues for individuals that were not listed in the PNMP.	
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	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** Monitoring by the PNMPCs was routinely conducted to review the availability of equipment, the condition, and to document any associated problems with the equipment or its use. This aspect of monitoring did not address fit or function because this would be beyond the scope of the PNMPCs as paraprofessionals or non-licensed staff. Assessment, and review of equipment and the PNMP, were conducted by the therapists on an annual basis in the PNM Clinic with review at least on a quarterly basis for those considered to be at highest risk or with significant PNM needs. Others were reviewed semiannually or annually as indicated. This was to be determined by the therapy team and the PST and was to be included in the assessments. Maintenance tasks were generally identified and completed when possible during these reviews. Additional maintenance	Noncompliance

#	Provision	Assessment of Status	Compliance
	nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	requests were addressed via work orders. There was a data base submitted used to track all maintenance activities. Assessments were conducted as needed for new seating systems or for modifications to existing systems. It did not appear, however, that specific wheelchair assessment reports were produced by the therapists. There were no assessments conducted during the week of this onsite review. The monitoring team will need to observe this in future reviews. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** There were only 21 PNMP monitoring sheets submitted that were completed in the last 12 months. Each was completed by the therapy clinicians and none by the PNMPCs. It was presumed that the request for monitoring sheets was misunderstood and that this did not represent all the monitoring of PNMPs completed. There were a number of sample tools submitted, but none of the completed tools were included in the document request materials. These tools were to be completed for each individual per an individual monitoring schedule established by the PST at the annual meeting. The frequency of monitoring would also be recorded in the OT/PT Master Plan. Immediate issues were to be addressed at the time of the monitoring. By report, this system was implemented on 5/1/11. The monitoring team will clarify this request for future reviews. Though the therapists were certainly able to review the effectiveness of the PNMPs and whether it appropriately addressed the individual's needs, the form used did not provide a format to document any findings. One clinician used emails to communicate her findings on the monitoring forms. There was no method to track these findings or to analyze them at the time of this review. By report, there was a plan for the PNM clinic team to review the completed monitoring tools on a monthly basis to ensure that problems were addressed appropriately and in a timely manner. This team planned to review also for system and program issues with recommendations for further analysis, consultation, or assessment. **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, though procedures were established and only recently implemented on 5/1/11. This was to involve a transformation of the existing PNM Clinic. Elements of the revised clinic format were as follows: • Annual review and assessment to occur two months prior to the PSP. • At that time the PNMPs will be reviewed for effectiveness using the monitoring	

#	Provision	Assessment of Status	Compliance
		results and specific individual health risk indicators. New review tools will be used to guide the process. • Progress related to therapy goals (health and skill acquisition will be reviewed to determine if these plans successfully meth the individual's needs • All will be incorporated into the annual assessment or update. • The PST will establish a monitoring schedule based on their PNM risk set at the annual PSP or revised at subsequent PSPAs as indicated • The PNM Clinic team will meet monthly to review the findings of the monitoring to address system issues and program issues identified and ensure timely follow-up • PNM Clinic Summaries will continue to be generated to reflect attendance, discussion, actions and recommendations from these meetings with more immediate documentation in the integrated progress notes. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. At that time, additional follow-up or training was provided as well as follow-up as indicated in addition to annual re-validation. A database developed to track PNM monitoring would also track the completion of validation checks with the PNMPCs. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored as an aspect of the individual-specific monitoring conducted by PNMPCs with staff names listed on the monitoring forms. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** There were no intervention plans provided other than the PNMP. Review of PNMPs was as described 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.** There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. The systems in place for improving the current staff training should address this though a system to ensure that staff	

#	Provision	Assessment of Status	Compliance
		assignments to competent direct support staff should be considered. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no standardized method to document action on findings from the PNMP monitoring through to problem resolution. There was no mechanism to track findings, problems or resolution at the time of this review. Further assessment of this element is indicated in future reviews by the monitoring team. **Standard: Data collection method is validated by the program's author(s).** There were no SPOs requiring data collection or validation of implementation and documentation.	

Recommendations:

1. Clarify specific PNM risks used to establish the frequency of monitoring and assessment. Consider that an individual considered to be at medium risk in a greater number of areas may require more frequent review similar to an individual who was high risk in one area or two areas. This determination will likely need to be highly individualized based on careful analysis of the assessment information.

2. The health risk system continued to evolve and the Master Plan will need to be updated to reflect new thinking by the PSTs as they become more skilled in the analysis and assignment of risk as well as in the development of useful action plans.

3. Consider audits of consults and progress notes to examine for consistency and content across clinicians. Ensure that there is a clear mechanism and documentation trail to close the loop on open issues or concerns and track actions through to completion.

4. Consider a reference to the baseline/comprehensive assessment and updates in subsequent updates. In other words, the therapist should clearly cite the date of the previous assessment in the current one. It may make sense to maintain the comprehensive assessment with the subsequent updates in the active record until a new comprehensive was completed. Clear statements as to when the next assessment or update was to be completed should be included in the recommendations.

5. Consider the use of a similar format used to present risk in the revised NEO training. This may provide a framework of how to design more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, services and interventions were indicated. These should then be listed as recommendations. Consider changing the name of the summary to analysis as this section should be more than a mere summary of the data.

6. Address skill acquisition in the OT/PT assessment. More discreet task analysis and observation generally will yield greater specificity, laying a better foundation for potentials for learning and the design of implementation programs and plans. Provide functional descriptions of skills rather than general statements to describe motor skills. Specific examples will be more useful to therapists and other team members. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with the SLPs and/or psychology. A temporary shift in focus from assessment to action and implementation to address the intense need for active treatment may be necessary. Working with the home and day program environments on a day to day basis rather than merely referring or making recommendations promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition.

7. Integrate direct and indirect supports into the PSP through the development of SOPs that include measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures as well as functional health status indicators are used to justify initiation, continuation and/or termination of interventions.

8. Consider the strategy of rounds with PNMPCs to conduct drills for additional training for PNMPCs and to assist staff in recognizing when realignment is indicated.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SGSSLC Policy #: Desensitization and Intervention Policy for Dental Services, 8/11/10 o SGSSLC Policy: Dental Care – Toothbrushes, 5/18/10, 4/11 o SGSSLC Oral Care For Individuals With Dysphagia, 1/11/10 o SGSSLC Policy: New Employee Oral Care Training, 2/10/10 o SGSSLC Policy Annual Examinations, 3/1/10 o SGSSLC Policy Dental Appointment tracking, 3/5/10 o SGSSLC Policy Emergency Dental Treatment, 2/23/10 o SGSSLC Policy Medical/Dental Restraint and Sedation Minimum Guidelines, 9/9/05 • SGSSLC Dental Data (11/10 – 4/11) o Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Dental records for the individuals listed in Section L o List of Pretreatment sedations, Dosages, Route and Plans o Desensitization plans for the following individuals: • Individual #18, Individual #17, Individual #, 217 Individual #130, Individual #198 Interviews and Meetings Held: o Tom Anderson, DDS, Dental Director o Belinda Lendermon, RDH o Rebecca McKown, MD, Medical Director Observations Conducted: o Dental department o Dental clinic o Multidisciplinary POI Meeting o Informal observation of oral hygiene being completed in home areas
	Facility Self-Assessment: The facility rated itself in compliance with provision Q1 and noncompliant with provision Q2 in the POI. Although the monitoring team clearly saw evidence of continued improvement in the department since the November 2010 onsite review, the department will need to present additional data to show substantial compliance. The implementation of the suction toothbrushes occurred two months prior to the onsite visit, so follow-up assessments had not occurred. The monitoring team must disagree with the rating of compliance.

	With regards to provision Q2, once again progress was noted, but fell short of achieving substantial compliance. Data for the full six months ere not available to substantiate substantial compliance with annual assessments, and failed appointments appeared to be increasing in spite of greater efforts. The monitoring team must therefore concur with the rating of noncompliance
	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 Tuesdays and Thursdays. The full time hygienist did not routinely provide any direct clinical care. There were three operatories, two of which were fully equipped. Progress was noted in the processes related to the provision of dental services. The use of suction toothbrushes was implemented and desensitization plans were being implemented. There was a plan to begin a pretreatment notification process that involved dental clinic, psychology, and the psychiatry departments. Suction toothbrushes were implemented just two months prior to the onsite review, so data related to the impact of this service were not available. Likewise, four desensitization plans appeared to have been signed off on in March 2011 and April 2011. One appeared to have been implemented in January 2011. Status reports on progress made with these plans were not provided. The one individual included in the record sample had no discussion of a potential desensitization plan mentioned in the annual medical assessment done just prior to the start date. Failed appointments were barriers to dental treatment. Strategies to decrease failed appointments were evident in the documents, such as IPNs and PSP addendums. Desensitization plans, as discussed above, had been developed for a small percentage of those who were considered. In spite of these efforts, the last two months of data showed an increase from 25% to 35 % in failed appointments. That increase was without explanation. Annual assessments, with the exception of January 2011, appeared to mostly be timely. Documentation of the six months from the last visit was not provided.

#	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	Dental clinic was conducted five days a week. Two operatories were used. The dentist and hygienists saw individuals separately. The department implemented a new software program in November 2010. It allowed data tracking related to visits, attendance, and annual exams. Multiple spreadsheets and reports were submitted to the monitoring team. The data collection period was November 2010 through mid-April 2011. After tallying data and accounting for refusals and other missed appointments, the number of completed visits was approximated as follows:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Preventive visits - 320 • Annual visits - 124 • Restorative visits – 60 • Emergency visits - 9 Record reviews indicated that the individuals were receiving routine dental care on a regular basis. All of the individuals had frequent oral hygiene assessments. Oral hygiene ratings data for November 2010 to April 2011 indicated that 67% of individuals had good oral hygiene, 23% had fair oral hygiene, and 10 % had poor hygiene. This was an improvement from data reviewed at the last onsite review when oral hygiene ratings were 51% good, 15% fair, and 34% poor. The use of suction toothbrushes was implemented in March 2011 and approximately 30 individuals were involved in this program. The dental department and nursing services developed the policy jointly. The integrated records contained documentation of the procedures completed by nursing. The dental clinic contacted the OT/PTs on a monthly basis to identify individuals who needed to be added to the list. The PSTs met to determine if the recommendation were to be implemented. When implemented, documentation of toothbrushing and any problems was required to be in the IPN. Follow-up was completed monthly to determine if the there were any issues, ensure adequate documentation, and assess overall progress. Baseline hygiene ratings were recorded and the facility was in the process of completing quarterly assessment on the individuals to determine if the suctioning toothbrushing procedures were improving clinical outcomes. The PSTs were responsible for working with the dental clinic to improve oral hygiene for any individuals who required improvement. The QMRPs developed PSP addendums related to tooth brushing. Examples of discussions included: • Individual #206– The PST discussed ways to improve the oral hygiene status, which was fair to poor in February 2011. The individual's toothbrushing program was revised. The QMRP will revise again, to add when informal teaching should take place, and when the staff should brush the teeth if the individual is unable to do so. • Individual #78 - The team met to discuss the need for a plan of care due to poor oral hygiene. The individual was currently receiving suction toothbrushing and oral care from nursing daily. The individual was seen in dental clinic and was to return ASAP for fillings. A training objective will be written to assist in getting good oral hygiene care and self care. • Individual #164 – The PST met to discuss poor oral hygiene ratings, what was being done, and what changes were needed to ensure oral care is received. The	

#	Provision	Assessment of Status	Compliance
		individual did have a training objective in place and was currently brushing all surfaces of teeth. Staff will inservice on this training objective and ensure that this process is being completed to a level to ensure that the teeth are free of food.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	<u>Policies and Procedures</u> The Dental Clinic maintained a comprehensive set of dental policies and procedures. The Dental Services Policy was based on state issued policy. Policies included areas such as staff training. All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn. <u>Annual Assessments</u> In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months and the date of previous annual assessment was requested. The documents provided contained a list of assessments beginning in January 2011 along with the dates of the previous assessment. This information did not allow determination of compliance during the six months since the last onsite review. It was noted that the first 10 appointments of 2011 did not meet compliance for timelines of the annual assessment. <u>Emergency Care</u> Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. A list of individuals receiving emergency dental care was reviewed. Nine individuals received emergency dental treatment over the past six months. Records indicated that appropriate treatment and pain relief were provided. <u>Dental Records</u> The dental staff was documenting in the integrated progress notes as required. The notes were being completed in the required SOAP format with signatures and dates. Additional information was found in the PSPs and various tracking records made available to the PSTs on the network drives. The PSTs were provided adequate information related to the oral health status of the individuals. The monitoring team had concern about the legibility of the progress notes particularly those that pertained to actual treatment interventions because they were difficult to understand. Interpretation due to poor legibility may prove challenging to members of the PSTs.	Noncompliance

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		Failed Appointments The document Attendance Tracking Sheet provided the following data for the past six months November 2010 to March 2011: • Total scheduled appointments • Total completed appointments • Total failed appointments On average, 71% of appointments were successfully completed during this time period. This was the same completion rate noted during the last onsite review. While the 29% failure rate is the same as during the last onsite review, the number of failed appointments increased in two consecutive months. A document containing failed appointments was sent to all units on a monthly basis. The expectation was to have the failed appointments discussed in the morning meetings. The QMRPs were required to submit to the dental clinic strategies to decrease failed appointments. Examples of PSP addendums related to dental clinic attendance addressing failed appointments were submitted. The following are examples of strategies used by the PSTs to increase participation in dental clinic. • Individual #365: The PST had identified the individual as refusing dental treatment on 10/15/10. The PST noted this appointment as an isolated incident. The individual did not routinely refuse, and received informal instruction on the home from staff to brush teeth. The PST planned to continue to monitor further refusals and should concern arise will plan a reinforcer to help the incentive for attendance. • Individual #382 had refused to go to three dental clinic appointments. Refusal to attend appointments was due to a behavioral problem. The team decided not to inform the Individual until 30 minutes before time to go. The individual will be informed of the potential to receive a planned reinforcer. • Individual #99 was a no show and no call for dental appointments. The individual was refusing a lot of classes and appointments and was seen by the psychiatrist who changed medications and there was a change in behavior. The PST felt that, since the medication was changed and the Individual wanted to do more, the refusals for appointments would decrease as well. • Individual #277 was a no call no show. The Individual was on a routine and was really good about going to appointments. The PST will ensure the staff let the	

Appointments	Nov	Dec	Jan	Feb	Mar
Scheduled	179	195	207	189	172
Completed	128	146	156	129	112
Failed	51 (28%)	49 (25%)	51 (25%)	60 (32%)	60 (35%)

#	Provision	Assessment of Status	Compliance
		individual know when there is an appointment. • Individual #197 did not show up for dental appointment and at times did not show up to dental appointments even after being reminded. The individual was on a reinforcer program to help attend all sessions and appointments, but would not comply. The PST was still working on another reinforcer to help comply with appointments. <u>Restraints</u> The facility's list of individuals who required pretreatment sedation included individuals who received TIVA and three individuals who received oral medications for dental procedures. That list differed from the dental clinic list, which documented that 10 individuals required restraint – 7 for TIVA and 3 oral medications. The facility's list indicated that only two of the individuals had plans in place to minimize the need for the use of pretreatment sedation medication. In response to the document request for an appointment schedule for those undergoing general anesthesia/conscious sedation, the dental clinic provided a list of individuals scheduled for TIVA in January 2011. It also provided two calendars, dated 4/1/11 and 4/13/11, that included multiple individuals for dental clinic. The purpose of the visits was not indicated on the calendar. A list of individuals who needed consideration for desensitization was provided. Of the 24 persons identified on the list, five had desensitization plans developed. Four of the plans were implemented one to two months prior to the onsite review, so data on progress was lacking. Interestingly, Individual #18 had a DNR order in place and most non-palliative measures had been cancelled. It appeared that, although a plan was developed and submitted to the monitoring team, the desensitization plan may not have actually been implemented. The documents reviewed also included a series of emails exchanged during April 2011 between various department members of the facility. The emails discussed requirements for desensitization programs. These emails generally indicated that, in April 2011, there was a lack of clarity related to requirements for the practice of	

Individual #	Begin Date	OT signature Date	Dietician Signature Date
18	1/7/11	3/2/11	3/22/11
17	1/7/11	--	1/7/11
217	4/22/11	4/20/11	4/20/11
130	1/10/11	4/20/11	4/20/11
198	4/22/11	4/20/11	4/20/11

#	Provision	Assessment of Status	Compliance
		systematic desensitization. The facility's policy was issued in 2005 based on state minimum guidelines. A document detailing the methods to develop cooperation for medical and dental procedures and to decrease the need for use of restraint and sedation was also included. It was also evident that there was some level of disconnect between the dental clinic and psychology based on the multiple email exchanges where the dental clinic was requesting to know if any other desensitization plans had been completed so they could be included in the document request. Again, this information exchange should be an ongoing process and not just in preparation for an onsite review.	

Recommendations:

1. The facility should continue its efforts related to the use of suction toothbrushes including adequate documentation of baseline assessments, status reports and quarterly outcomes.

2. The facility must address the issue of failed appointments particularly since increases were noted in the last two months of data provided.

3. Annual appointments must be provided in a timely manner. When that does not occur, as seen in early January 2011, an explanation must be provided.

4. Greater effort is needed in the areas of desensitization. There should be evidence that discussions occur year-long and not just one to two months prior to an onsite review. Ongoing discussions may result in increased development of plans.

5. The PSTs should monitor the desensitization plans and document effectiveness. If the plan is not effective, then reconsideration must be given to the process. The dental clinic should be frequently updated with regards to the status of desensitization plans.

6. The dental clinic should use the capabilities of the new dental software and spreadsheets for performance improvement. Longitudinal data should be plotted monthly, analyzed and trending noted. When progresses ceases or regresses, the dental clinic along with the assistance of the QA department should look for explanations and implement corrective actions.

7. Progress notes related to dental treatment performed by practitioners should be dictated so that PSTs and other readers can clearly understand the content of the notes including what treatment was completed, what treatment remains and the overall plan of care.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Rehabilitation Therapy Staff Information list o Speech Continuing Education Sessions 4/12/11 o SGSSLC Organizational Charts o Staffing data (4/22/11) o Section R Presentation Book and POI o Client List as of 3/31/11 o Admissions Activity 10/1/10 – 3/31/11 o Separation Activity 10/1/10 – 3/31/11 o PNMP Monitoring Form AAC template tool o Section R QA/Rehabilitation Therapy audits February 2011 and March 2011 o Completed PNMP Monitoring Form AAC tools submitted o Completed monthly communication dictionary audits o Murdoch Center Program Library o PNMPs submitted o Communication Master Plan (4/14/11, 4/19/11) o List of individuals with AAC systems or devices o List of individuals with PBSPs o Communication evaluations and PSPs: • Individual #166, Individual #104, Individual #236, Individual #2, Individual #253, Individual #192, Individual #328, Individual #376, Individual #134, Individual #287, Individual #27, Individual #159, and Individual #183 o Communication Evaluation template o Information from the Active Record including PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plan, Annual Physician Summary, Health Status tab, MBSS studies and reports, hospital summaries, current medication list, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab, Nutrition tab and Dental tab for the following: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o Information from Individual Notebook including PNMP tab for the following individuals: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384,

	Individual #278, Individual #151, Individual #265, and Individual #15. o PNMPs for last 12 months, Dining Plans for last 12 months and Monitoring forms completed in the last six months for the following individuals: • Individual #66, Individual #98, Individual #217, Individual #203, Individual #109, Individual #7, Individual #78, Individual #122, Individual #18, Individual #38, Individual #344, Individual #202, Individual #210, Individual #345, Individual #76, Individual #384, Individual #278, Individual #151, Individual #265, and Individual #15. o PSPs, PSPAs consults, SPOs, integrated progress notes, and other documentation related to speech treatment for Individual #265 and Individual #287 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR Habilitation Therapies Director o Susan Holler, MS, CCC-SLP o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: SGSSLC's self-assessment identified noncompliance for all items in this provision. The self-assessment was consistent with the monitoring team's assessment of noncompliance for each aspect of this provision. Comments stated actions taken that were supposedly related to each provision item, but there was no clearly stated plan to achieve compliance with progress tracked by completion of each specific action step. Activities documented as completed during the last six months included the following: • SGSSLC continued to recruit SLPs. A full time contract SLP was employed with Health Care Agency Providers though issues related to her benefits package was not resolved and she resigned after one month. A speech technician position was recruited and due to begin shortly after this review. • An SLP was a regular participant in the BSP Committee and reviewed training programs developed by the PSTs to ensure they were consistent with individual communication skills. • The Master Plan was made public to all PST members and set the priorities for completion of communication assessments • A training module related to communication and AAC was developed for PNMPCs. This was completed for all PNMPCs with competency checks, initiation of AAC monitoring with validation checks. This approach appeared to merely document completion of tasks rather than serve as well-outlined plan to direct focus, work products, and effort by staff. Action steps should be stated in measurable terms with

	timelines and evidence required to demonstrate completion of all interim steps.
	Summary of Monitor's Assessment: There was limited progress noted since the previous review, though it was evident that the speech clinicians were extremely busy with assessments and attempts to implement recommendations for communication-related supports. A number of very creative individual, though largely community, systems were in place or ready for implementation pending maintenance tasks, such as mounting in the living areas. The speech staff reported that not all individuals who needed AAC and other communication supports and services received them. There were three part time clinicians assigned to provide communication services with additional duties related to mealtimes and the newly established PNMT. This was a significant understaffing of a critical aspect of comprehensive supports and services that potentially impacted every individual living at SGSSLC. Everyone communicates in some way and many require interventions and supports to enhance or augment those efforts and many others would benefit from refinement and expansion for skill acquisition in the area of communication. The Master Plan had been refined and made available to the PSTs. One speech clinician participated regularly on the BSP Committee and the newly formed PNMT. To date, only 49 evaluations had been completed since June 2010 following the baseline review when the monitoring team indicated that all the assessments would likely need to be re-done because those reviewed would not be considered comprehensive as required by the Settlement Agreement. At least 19 of those completed to date had been new admission assessments. Only 12 of the completed assessments had been completed prior to the date estimated in the Master Plan. Despite the diligent efforts of the existing part time clinicians, SGSSLC would not likely be able to meet the provisions items of section R at the current staffing levels. The focus on assessment also made timely implementation of supports and services and, more importantly, greatly limited opportunities for effective staff training. The speech clinicians recognized the critical importance of modeling and coaching with direct support staff for competent and consistent implementation of communication-relates systems and programs. Staff did not demonstrate an understanding of how to capitalize on teachable moments to promote communication skill acquisition or how to integrate existing systems into the daily routine. A focus on engagement in functional activities designed to promote actual participation, making requests, choices and other communication-based activities, using assistive technology, was a critical priority. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.

#	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 part-time contract SLPs working at SGSSLC, (Susan Holler, MS, CCC-SLP, Susan Reeves, MS, CCC-SLP, and Erin Bristo, MS, CCC-SLP) equaling approximately 1.8 FTEs, per Dena Johnson, OTR, Director. Ms. Bristo and Ms. Reeves were listed as providing eight hours per week each and Ms. Holler was reported to work an average of 30 hours per week at the time of this review. A full time SLP had been hired through a staffing company in March 2011. She completed NEO, but resigned after one month because she was not immediately eligible for benefits. A speech assistant previously working at the facility desired part time employment, but this was not an option because a state employee and had recently resigned. An additional speech assistant employed at the time of the previous review had moved. A part-time speech assistant, Allison Steele, worked approximately five to eight hours during the school year (the list submitted indicated that she worked only four hours) and up to 15 hours during the summer months. License numbers were included on a list submitted, but copies of credentials were not submitted, so the current status of licensure for these clinicians was not verified at this time. CVs were not submitted for any current speech staff. Only one of the current staff had attended communication-related continuing education since the previous review (Susan Reeves, MS, CCC-SLP). Communication–related continuing education had been listed only for Susan Holler during the previous review period. There were two full time positions for SLPs currently and one position for a speech assistant unfilled. As stated above, the department Director was Dena Johnston, OTR. By report, there were ongoing efforts to recruit and hire SLPs for full time positions. By report, the state salaries were not competitive and it was not possible to accommodate part time employment and, as a result, the facility was dependent on contract staff. At this time, each of the current staff was part time only. Recognition of the priority for the communication needs of individuals living at SGSSLC was not reflected in the current staffing allocation and assignment. **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.** Each individual had been previously screened and ranked based on need for AAC and	Noncompliance

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		documented in the Master Plan with a Priority rating of 1 (most needy) through 5 (most independent). The schedule for the completion of comprehensive communication assessments was based on these priorities. The plan submitted in the document request was dated 4/14/11. Based on the Master Plan submitted, there were 37 individuals identified as Priority 1, 29 individuals as Priority 2, 41 individuals as Priority 3, 97 individuals as Priority 4, and 42 individuals as Priority 5. There were 29 of 37 individuals identified as Priority 1 with a communication assessment current within the last 12 months. Eight had previous assessment dates listed approximately two years earlier, but were not considered to be comprehensive as required by the Settlement Agreement. Seven of these had been scheduled for a comprehensive communication assessment by 4/30/11 and one by 12/31/10. There was no evidence that these had yet been completed. There were 3 of 29 individuals identified as Priority 2 with a communication assessment current within the last 12 months. Individual #239 had received her communication assessment in 38 days of her admission, outside the required 30 days. Individual #236 had a proposed assessment completion target of 1/31/12, yet her assessment was documented as completed on 3/25/11. Individual #194 had received her assessment within the same month as the proposed date listed in the Master Plan. Each of these was completed in advance of the individuals listed as Priority 1. There was no key to the color codes included in the plan so it was not known if they had been newly admitted at that time. All others were scheduled to be provided an assessment prior to 9/30/11. There were 2 of 41 individuals identified as Priority 3 with a communication assessment current within the last 12 months. Individual #10 and Individual #309 had been newly admitted and their assessments had been completed within the 30-day time frame. All others in this category had assessments over one to two years old and were not considered to be comprehensive. Twelve of these were scheduled for completion prior to 12/31/11 and the others prior to 4/30/12. There were 11 of 97 individuals identified as Priority 4 with a communication assessment current within the last 12 months. Individual #376, Individual #258, Individual #166, Individual #196, Individual #347, Individual #175, Individual #99, Individual #341, Individual #73, Individual #106, and Individual #123 had been admitted during the last year and 10 of 11 assessments had been completed within the 30-day time frame. Individual #258's assessment was completed within 32 days, outside the required 30 days. All others in this category had assessments over one to two years	

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		old and were not comprehensive. Approximately 72 individuals were scheduled for assessments during 2012 and 14 scheduled during 2013. There were 4 of 42 individuals identified as Priority 5 with a communication assessment current within the last 12 months. Individual #117, Individual #298, Individual #23, and **I**ndividual #192 had been admitted during the last year and each had assessments completed within the 30-day time frame. All others in this category had assessments over one to two years old and were not comprehensive. All were scheduled for assessments during 2013, prior to September of that year. At least four of these appeared to be outside the timelines required in section R. To date, only 49 evaluations had been completed since June 2010 following the baseline review when the monitoring team indicated that all the assessments would likely need to be re-done because those reviewed would not be considered comprehensive as required by the Settlement Agreement. At least 19 of those completed to date had been new admission assessments. Only 12 of the completed assessments had been completed prior to the date estimated in the Master Plan. A different version of the Master Plan was submitted to reflect assessments completed since the previous review. This list identified 40 individuals (designated in pink) of various priority levels with assessment since the previous review, however, per the dates listed only 18 had actually been completed during that time period and 10 of these had been new admissions. Despite the diligent efforts of the existing part time clinicians, SGSSLC would not likely be able to meet the provisions outlined in section R of the Settlement Agreement, at the current staffing levels. A spreadsheet submitted and dated 4/19/11 listed approximately 217 individuals and included AAC equipment that had been provided. There was a wide variety of systems for 28 individuals. Some of these would not be considered individual communication-related AAC, such as a doorbell for Individual #345, environmental control devices for Individual #203 and Individual #27, and home programs for community devices for Individual #18, Individual #134, and Individual #253. Individuals in home 516 had social boards mounted at their doors to serve as communication starters as they displayed preferred items and interests. Some of these had single message switches included that conveyed a simple message. There were a number of community boards listed and located at all nursing stations and in 516 as well as location posters provided across the facility. Additional location posters, drink choice boards, and social boards were pending. In some cases, installation of plexiglass or provision of keys by maintenance were needed (Individual #183, Individual #39, Individual #201) and, in other cases, Velcro and a memory card for the camera were needed for implementation	

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		of these items. Records of 20 individuals were requested to include communication-related assessments and documentation. There were communication evaluations submitted for 12 of these individuals and brief annual reviews for six others. No communication related documentation was submitted for Individual #98 and Individual #122. It was presumed that these were not in the individual record. Per the Master Plan, Individual #122's last assessment was on 7/15/09 and she was designated as a Priority 3. There were instructions dated 5/17/11 for a Pocket Talker in her record, but this was not listed in the Master Plan; it turned out that it was listed on the rehab equipment list. Per the Master Plan, Individual #98's last communication assessment was on 6/8/09 and she was designated as Priority 3. Five communication assessments completed by each speech clinician were also requested and assessments for 13 additional individuals were submitted, though 4 were not in the current assessment format and were not considered to be comprehensive: Individual #278 (12/7/09), Individual #151 (3/4/09), Individual #384 (4/28/09), and Individual #38 (6/23/10). Of the assessments reviewed as submitted, at least 72% (18 of 25) indicated that the individuals presented with severe communication deficits. Two individuals (Individual #192 and Individual #117) were reported to be verbal with effective expressive and receptive communication skills. Three others presented with mild deficits, but were generally functional communicators (Individual #376, Individual #166, and Individual #151). Individual #38 and Individual #384 were identified with moderate deficits in expressive and receptive communication. Individual #384 was recommended for speech consultation to explore AAC. It appeared that 24 of the 25 individuals (96%) for whom assessments were reviewed had assessments that were current within the last two years. Individual #109's assessment was dated 12/18/08, though there was reference to an assessment completed on 1/21/10 in that report so it was likely dated in error. The format was fairly consistent with other more current assessments submitted. Of those identified with severe communication skill deficits, only one was recommended for specific communication supports and services designed to improve existing language and communication skills (Individual #287). All other recommendations included non-specific consultation by the SLP to address issues identified by the individual's PST. No direct services were recommended. However in each case the clinician provided strategies for staff to use to use to enhance existing skills rather than skill acquisition, though many of these were extensive, including scripts for routine activities for example. It was intended that these became integrated into the PSP.	

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		As of 4/13/11, per documentation submitted, there were no individuals at SGSSLC who received direct communication services. Per verbal report, there were several individuals involved in direct services, including Individual #287, Individual #66, and Individual #265. Evidence of formal training objectives was not noted for any of these individuals. Service objectives for AAC use was noted in Individual #66's PSP dated 3/30/11 but this only reflected staff responsibilities to provide access and opportunity for him, but did not reflect any active learning or skill acquisition on his part. Per the Communication Master Plan Database, there were approximately 66 (27%) individuals who were identified as Priority 1 or 2 with no, or limited, means to communicate effectively and who had potential to benefit from AAC. Per the Master Plan dated 4/13/11, approximately half of these had been provided some type of AAC system, though one individual (Individual #109) had a communication dictionary only, and a another (Individual #134) had only a home program for existing community devices. The others appeared to have a variety of no or low-tech systems, including communication books and boards and a handful of electronic message devices. There were no higher tech systems provided.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Standard: All individuals in need of AAC were identified as being in need of AAC.** As stated above, a Master Plan designed to prioritize completion of assessments was in place and the assessment format had been revised to be more comprehensive prior to the first compliance review in November 2010. At that time, the clinicians were in the process of conducting re-assessments of all individuals per the Master Plan. In the previous plan, there were 34 individuals who were identified at Priority 1 with a projected re-evaluation completion date prior 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. Of those with projected completion dates prior to the onsite review (approximately 19), only 53% had been completed on schedule. Seven individuals who were Priority 1 now had projected dates of 4/30/11. Since the previous review, there were 18 individuals with projected assessment completion dates prior to the time of this current onsite review and only half had been completed as of 4/14/11. For those listed as Priority 2 (29), the projected assessment dates had been pushed back significantly ranging from 5/31/11 through 9/30/11. Three had been completed already (Individual #194, Individual #239 and Individual #236). A more current Master Plan was not submitted, so it was not known how many additional assessments had been completed since 4/14/11 for individuals listed as either Priority 1 or 2. There were 37 individuals now listed as Priority 1, and 28 of those had	Noncompliance

#	Provision	Assessment of Status	Compliance
		been provided AAC supports. Three were listed with some type of AAC supports despite not having as assessment, and included Individual #111, Individual #325, and Individual #278. Of the 29 individuals who were identified as Priority 2, seven had AAC listed. Those listed as Priority 3, 4, and 5 represented the other 179 individuals living at SGSSLC as of 4/14/11. One of these, Individual #373, was listed with AAC (spiral pocket wallet communicator). He had not had a communication assessment since 7/29/09. As a Priority 3, his projected assessment date was 12/31/11. As all individuals had not yet received a comprehensive communication assessment, it was not known how many more individuals would benefit from AAC or other communication-related supports. At the current rate, it would not be possible to complete the assessments per the timelines established by the Master Plan or the Settlement Agreement. The limited staffing available to complete these assessments was further encumbered by the need to provide additional supports related to the implementation of existing systems (e.g., staff training, monitoring, and reassessment). **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** There had been eight admissions to SGSSLC in the previous six months according to the Admission Activity list (10/1/10 – 3/31/10). Per the Master Plan submitted, assessments had been completed for each of these individuals within 30 days of their admissions. By report, Susan Reeves, MS, CCC-SLP, was assigned to complete the bulk of the assessments for individuals who were newly admitted to SGSSLC. There was no evidence that assessments were proactively completed for individuals who had experienced a change in status. It was noted, however, that the Master Plan was adjusted to accommodate this as needed based on referral from the PST (Individual #104). His assessment was completed in April 2011 following a choking incident. A couple of others were reported due to behavioral issues, though it was not known to the monitoring team who these individuals were. **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.**	

#	Provision	Assessment of Status	Compliance
		The new communication assessment format generally addressed both verbal and nonverbal skills and expressive and receptive language skills. Each of the assessments in the new format had recommendations related to whether direct therapy or AAC was indicated. The recommendations provided typically addressed staff strategies to use or enhance existing skills but none were offered related to acquisition of new skills based on the assessments reviewed. In the case of Individual #328, he was described as not using words to communicate and that staff read his body language to anticipate his meaning. While he reciprocated interaction like handshakes or "high fives," he did not initiate social interaction with others, but rather touched himself or others inappropriately. He was independent with some skills, though his PSP (11/19/10) did not indicate his level of independence in self-care or dressing other than a training objective to brush his teeth. He enjoyed being around animals, participating in arts and crafts, and working simple puzzles. He did not have AAC other than a communication dictionary. He looked at books and pictures but, by report, did not use these as a communication tool. His communication deficits were attributed to autism. His replacement behaviors per psychology and his PBSP included communicating the need for a break or to leave an activity or program area, moving away from others rather than striking them and eating an edible item when attempting to eat a non-edible item. There was no mention of this in his communication assessment dated two months later on 1/7/11. Recommendations were limited to speech consult as needed to address the concerns of the PST. No direct therapy was recommended. Strategies provided were limited to staff being familiar with his communication dictionary and to encourage him to select Italian opera CDs, picture food and beverage choices, and use of a social story book. There was no apparent collaboration to address his communication-related behavior concerns. Implementation of these strategies appeared to be left to the PST for implementation and there was no evidence that these were SPOs developed and tracked by an SLP. There was insufficient involvement by the SLPs to ensure appropriate implementation of recommendations and suggestions. The three part-time clinicians had significantly broad responsibilities with participation in mealtime and communication concerns. In an effort to address this, the speech assistant, Allison Steele, assisted with data collection and recently Erin Bristo, MS, CCC-SLP, had been pulled off of completing assessments in order to provide training and to issue recommended equipment. **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.**	

#	Provision	Assessment of Status	Compliance
		Individuals were to be provided an assessment based on the Master Plan, per the prioritized schedule. The intended plan was to provide re-evaluation every three years for each individual with interim updates on an annual basis for those who received supports and services. The intent of the interim update was to review the individual's status and the relevance and appropriateness of the supports provided. Updates were not being completed consistently provided at this time and the projected date for re-evaluation was added to the Master Plan in the last month. As such, it was not possible to assess the consistency of re-assessment to review the adequacy of the supports provided. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** At the time of the document request it was reported that no individual participated in direct therapy and there were no training objectives written by the SLPs. At the time of this onsite review, Ms. Holler reported that she was working with Individual #265 in direct therapy as a result of a recommendation by an ENT and that this was in the PSP as a training objective. She was working on vocal strengthening due to bowed vocal cords. The Annual Physical Examination reported he also had Barrett's esophagus, reported heartburn, and a hoarse voice. He had been seen by a gastroenterologist for follow-up of the Barrett's esophagus on 1/25/11. A progress note on 2/4/11 by Scott Lindsey, FNP, indicated concurrence with the recommendation to see an ENT to evaluate his hoarse voice. A progress note on 4/8/11 reported the ENT consult and vocal cord atrophy, referral to the rehabilitation center for speech services and follow-up in four months. Apparently, it was determined that he was not able to attend speech therapy at the rehabilitation center secondary to concerns regarding pedophilia. He was reported to be seen one time weekly at SGSSLC and had been provided a home program. There was a progress note on 4/22/11 by Susan Reeves, MS, CCC-SLP documenting a comprehensive voice/speech/language assessment with report to follow. The individual record was requested for Individual #265 to include all speech assessments contained in the record. This current assessment was not submitted and there was no further documentation, PSP addendum or training objectives related to this direct service by SGSSLC speech clinicians. There was no evidence in his record that Individual #265 was receiving speech therapy as recommended. **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.** The five most current SLP assessments for each clinician with the related PSPs were	

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		requested by the monitoring team. Assessments for each of the three part-time clinicians responsible for communication services were submitted (listed in the documents reviewed above). Each of these was generally consistent with the assessment template submitted with the exception of a section titled "Team Integration." The format appeared to have been revised during March 2011. The Team Integration section was intended to describe the existing PBSP as well as documentation of conversations with others related to this plan or the PSP. Also to be included was a review of the SPOs, particularly those related to communication. This section was noted in only five of the assessments reviewed with completion dates since the previous monitoring review in November 2010 (13 total). Of the other eight assessments, seven were currently listed with PBSPs. There was no mention of the target behaviors or need for a PBSP in these assessments though at least 6 of 7 had PBSPs in place at the time of the assessment by the SLPs. Also, refer to the review of Individual #328 above. There was no clear analysis of the relationship of communication to behavioral concerns in the assessments reviewed. A list of individuals with PBSPs and replacement behaviors related to communication was requested, but the response was that they had not yet addressed this. Another list submitted identified Individuals with Behavioral Issues and Co-existing Severe Language Deficits and identified 52 individuals. Approximately 26 of the individuals listed did not have a current comprehensive communication assessment. There was no policy or assessment/screening to identify those who received behavioral supports and interventions, such as a PBSP, and would benefit from AAC or other communication-related interventions. The facility appeared to have made some progress in this area, however, by including a SLP on the BSP review committee. It was discussed that the process should not merely involve "review" of the BSP by the SLP, but rather collaboration related to assessment and analysis of associated communication and behavioral concerns as well as in the development and implementation of related training objectives. Additionally, collaborative development of a screening tool to guide effective placement in classes provided by psychology was noted related to each individual's ability to process language to ensure optimal participation and benefit. Further review of this area was indicated as they developed a consistent method to identify individuals who required communication-related behavioral supports and to provide appropriate communication supports to those with associated behavioral concerns. **Standard: Communication programs were integrated into the BSP as indicated.** There were PBSPs submitted for 12 of 26 individuals included in the sample reviewed.	

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		Three of these were identified as able to effective communicate and were rated a Priority 4 or 5 in the Master Plan (Individual #76, Individual #265, and Individual #78). Each had only an extremely brief annual review with no indication that they had a comprehensive communication assessment. These were listed as current assessments for Individual #76 and Individual #265 in the Master Plan though these had been completed in 12/15/09 and 10/27/09 respectively. The projected completion dates for a comprehensive assessment were 8/31/12 and 2/28/13 respectively. Individual #78's annual review was dated 5/27/09, though he was not included in the Master Plan. Two others were identified with mild to moderate communication issues (Individual #15 and Individual #151). Individual #15 had a brief annual review dated 7/29/09 and was identified as Priority 3. The projected date for a comprehensive assessment was 2/28/12. Individual #151 also had an annual review, dated 3/9/10 and he was identified as Priority 4. The projected date for his comprehensive assessment was 6/30/12. There did not appear to be an overt relationship between communication deficits and their behavioral manifestations in these cases. Individual #38 and Individual #202 were identified with moderate communication concerns and were considered Priority 2 and 3, respectively. • Individual #38 had a single page annual evaluation dated 4/27/10 and had a communication dictionary and spiral pocketbook. The dictionary was reported to be in good condition, but there was no analysis of whether it continued to be appropriate. It was reported that the spiral pocketbook was not available, so it was not reviewed. The speech clinician reported that, "negative behaviors may be exacerbated by decreased communicative function," but made no recommendations to further evaluate this, collaborate with psychology, or to provide more extensive communication supports. This would not be considered to be comprehensive. • Individual #202 had only an extremely brief annual review dated 1/13/10 and she was not scheduled for a comprehensive communication assessment until 1/31/12. A PBSP was submitted for Individual #98 as an aspect of her individual record, though there was no communication assessment available in her record. She was considered to be Priority 3 with the most current assessment dated 6/8/09. She was not projected to receive a comprehensive communication assessment until 11/30/11. There was no evidence that there had been consideration of or collaboration in the development of communication-related training objectives for these individuals. In the cases of Individual #384, Individual #203, Individual #344, Individual #18, and Individual #7, they were identified with severe communication deficits and likely related challenging behaviors. With the exception of Individual #384, they each had current	

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		comprehensive assessments, though there was no evidence that there had been any collaboration with psychology in the development of communication-related training objectives. Individual #384 had a brief annual review only dated 4/22/10. He was identified as Priority 2 with limited language skills, though was listed as Priority 3 in the Master Plan. The projected completion date for his comprehensive assessment was 11/30/11. It was stated that his negative behaviors were likely exacerbated by his decreased communicative function. **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. The Master Plan recorded completion of assessments. The plan was intended to prioritize those individuals who would most benefit from AAC devices or equipment. AAC provided to individuals was to be listed in the Master Plan as well. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or that established specific staff responsibilities. A Master Plan had been developed and was being implemented at the time of this review. As previously recommended, this plan had been shared with the PSTs to make them aware of the system used to schedule communication assessments and when they could anticipate this service.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The information contained in the PSPs related to communication was extremely inconsistent across the plans reviewed. Of the 35 PSPs submitted, only 18 were of the new format and the potential for improved descriptions was noted, but was not well implemented at this time. Only seven included any description of how the individual communicated (Individual #7, Individual #109, Individual #66, Individual #287, Individual #203, Individual #384, and Individual #117), though there was wide variation in the descriptions provided. Few included strategies for use by staff to enhance or expand existing communication skills. Other PSPs provided no description of communication skills or in some cases verbal skills were implied when the individuals' statements were documented (Individual #192, Individual #166 and Individual #265). There was no description included in the PSPs for Individual #76, Individual #236, Individual #345, and Individual #202. In most cases, it would be difficult for anyone who did not know the individual to understand how he or she communicated or how one best communicated with the individual from reading the PSP. Interestingly, in a number of cases, there was an indication in the community living section of the PSP that the	Noncompliance

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		individual required communication supports and services that were not provided to them at SGSSLC including: • Individual #151: There was no indication as to the manner in which Individual #151 communicated or the effectiveness of his existing skills. No SLP attended his PSP meeting. • Individual #203: It was documented that she would require access to monitor the effectiveness of her communication dictionary and to develop AAC devices for increased functional communication. Her most current communication assessments (10/10/10 and addendums dated 10/1/10 and 2/18/11) reported that the dictionary had been reviewed on 9/22/10 and was considered to be appropriate. There was no discussion of its effectiveness, however. Recommendations included staff instructions and direction to include strategies related to increasing effective communication through use of the communication dictionary, community augmentative display, and environmental control switches. Only the communication dictionary was referenced in her PSP. No SLP attended her annual meeting on 10/10/10. • Individual #328: His PSP indicated that he would require a SLP with experience working with AAC devices. There was no indication in his PSP that he required or had AAC. There was no description of his expressive or receptive communication skills contained in the document and there were no strategies for staff use as to how they might best serve as a communication partner for him. There was no SLP present at his annual PSP meeting on 11/19/10. **Standard: AAC devices were portable and functional in a variety of settings.** The majority of the AAC systems recommended were portable and intended to be functional in a variety of settings. During observations throughout the facility, there were no devices that were observed in use. As described above, there were a number of AAC systems recommended, but not yet issued or implemented. In one case an individual's picture wallet was on the table near him as he participated in an activity. When questioned, the direct support professional working with him stated that he did not use the wallet with the individual. During the observation, the individual stood and appeared to be attempting to communicate something, yet the staff did not recognize that as an opportunity to use the wallet to assist in determining what that was. Instead, he anticipated the individual's need to go to the bathroom and guided him there. The staff did not encourage use of the single message switch outside the bathroom provided for that purpose. As such, these devices were not functional, though this appeared to be a function of staff training rather than related to the devices in place.	

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		Standard: Communication programs and AAC devices were individualized and meaningful to the individual. The existing AAC systems, though few in number, appeared to be individualized and there was an obvious effort to make them meaningful as well. As stated above, staff training, modeling, and follow-up to promote compliance was more of an issue in the lack of implementation of the devices provided. **Standard: Staff were trained in the use of the AAC.** A number of additional and/or improved supports had been put in place over the last six months to address staff training. Instructional plans were included in the PNMP section of the individual books for staff reference for the following individuals included in the review sample and listed with AAC per the Master Plan: Individual #66 (3), Individual #217 (1), Individual #203 (1), Individual #7 (1), Individual #122 (1), Individual #18 (1), Individual #210 (1), Individual #345 (1), and Individual #278 (1). These plans provided a picture of the device or devices, the name and purpose of the AAC with instructions, and any additional equipment required. Communication dictionaries were also available in the individual books for those who required them. Additionally, the NEO curriculum was modified to incorporate effective communication strategies for staff use with individuals. The training material submitted appeared to be thorough, but it was not clear how much of the training was didactic only, rather than including opportunities for practice, modeling, and feedback. The post-test was multiple choice, though it was doubtful that the questions included would establish competency of staff as communication partners. Staff did not consistently demonstrate a good understanding of how to promote language or communication opportunities in the daily routine or during structured programming throughout the day based on observations by the monitoring team. The Communication section of the PNMPs provided information about how the individuals communicated, though less consistently provided instruction as to how staff could support or enhance both expressive and receptive language. Despite these efforts, direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. As stated above there appeared to be insufficient time devoted to hands-on training, modeling, and reinforcement of the appropriate implementation of communication supports of any kind, including AAC. This was likely a direct function of the inadequate number of speech	

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		staff, professional and adjunct. There were no formal communication programs and limited SLP support was available to ensure sufficient supports for appropriate and routine implementation of the recommendations addressed in the communication assessments completed to date. **Standard: Communication strategies/devices were implemented and used.** Though AAC systems were observed in many of the areas in which observations were conducted, none were observed being used throughout this onsite visit. Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful, such as during a meal. This was expressed also as a concern by Susan Holler, MS, CCC-SLP, that staff did not consistently implement the strategies or promote the use of AAC systems provided to individuals. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. **Standard: General AAC devices were available in common areas.** A number of community-use devices were available in the homes. These non-portable devices may be useful as a backup or extra system for individuals, but should not be used as a primary augmentative or alternative means of communication for an individual. None of these were observed in use during the onsite review by the monitoring team.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings	**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.** There were no policies related to a monitoring system for AAC. However, there were systems in place to conduct routine monitoring. For example, forms for homes 501, 502, 508, 509, 510, 512, and 516 that tracked availability of communication dictionaries and community posters and boards were to be completed monthly for each individual and community AAC system. Completed forms were submitted for December 2010 and January 2011 through March 2011, and through April 2011 for home 516. Compliance with these systems were as follows: • Communication Dictionaries: 78% • Location Posters: 50%	Noncompliance

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	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.	• Nursing Boards: 65% • Drink/Snack Boards: 89% • Social Boards: 60% Completed PNMP monitoring forms for AAC were also submitted (70 forms for 27 individuals completed primarily in March 2011, though some were not dated). Monitoring had been conducted by both speech clinicians and PNMPCs and was supposed to be completed weekly for each individual with an AAC device or system. Reported compliance for approximately 560 indicators was 94.5%. This was not consistent with the verbal reports by SGSSLC speech staff and observations by the monitoring team. It was indicated that the staff demonstrated use when requested as during the monitoring by PNMPCs or speech professionals, but did not routinely implement these systems with consistency throughout the day. The monitors documented the need for staff retraining in only two cases (Individual #278 and Individual #66). Only one of these had documented noncompliance with any element of the form. At the current time, analysis of these forms was not yet done by report. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** It appeared that monitoring occurred in the homes only at this time as alternate locations were not identified on the forms submitted. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** Special training had been provided to the PNMPCs specifically related to monitoring of AAC. The content materials were submitted for review by the monitoring team. There was no evidence of validation checks provided for PNMPCs. Internal audits of section R had been initiated and samples were submitted with the document request materials. Compliance with the elements was reviewed by the department director and the QA department staff. Inter-rater reliability scores were reported for each of these. Findings from reviews conducted in February 2011 and March 2011 were submitted. Compliance with 19 indicators included in the audit tool used ranged from 52% to 80%. The monitoring team noted, however, that in the case of Individual #150, he had not received a comprehensive assessment per the Master Plan submitted, but the auditors documented that he had an AAC system for which there was 100% compliance for availability, implementation, and effectiveness on 3/25/11. Interestingly, there was no evidence in the Master Plan submitted that he had any AAC system provided to him.	

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		It was reported that the audit system had not yet required any corrective action plans but there were plans for this in the future. Further assessment of this element will be necessary in future reviews.	

Recommendations:

1. Consider exploration of more flexible state employment agreements to permit part-time employment with benefits to potentially increase the pool of applicants for existing positions.

2. 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. Ensure all of these are integrated into the PSP process.

3. There is a need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with OT and PT and/or psychology.
    a. A temporary shift in focus from assessment to action/implementation may be necessary. Working with the home and day program environments on a day to day basis promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition.

4. Routine monitoring needs to include a review by professional staff as to the effectiveness of AAC systems, as well as formal and informal programming rather than only availability and condition of existing systems. Action plans should be developed in conjunction with the PSTs to address issues identified via monitoring. Performance Improvement Teams have been of proven benefit in the implementation of other activities needing improvement or implementation at SGSSLC. This may be an effective method to address the barriers and concerns related to communication programs and AAC.

5. 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:** Documents Reviewed: o Personal Support Plans for: • Individual #135, Individual #346, Individual #29, Individual #81, Individual #279, Individual #3, Individual #184, Individual #243, Individual #116, Individual #249, Individual #186, Individual #38, Individual #128, Individual #99, Individual #96, Individual #239, Individual #292 o Dental Desensitization Plans for: • Individual #386, Individual #217, Individual #130, Individual #198 o Skill Acquisition Plans for: • Individual #3, Individual #81, Individual #29, Individual #184, Individual #279, Individual #346, Individual #385, Individual #331, Individual #371, Individual #247, Individual #78, Individual #372, Individual #41, Individual #76, Individual #1, Individual #295, Individual #143, Individual #375, Individual #315, Individual #352, Individual #97, Individual #336, Individual #367, Individual #276, Individual #380, Individual #365, Individual #339, Individual #153, Individual #53 o Skill Acquisition Plan data for past 6 months for: • Individual #3, Individual #81, Individual #29, Individual #184, Individual #279, Individual #346, Individual #385, Individual #331 o QMRP Program Observation, 5/9/11 o Skill Acquisition Training program for QMRPs, undated o Community Integration Lesson Plan, (Dine-out Trips and Theater/Movies), 2/18/11 o Individual Support Observation and Interview, 6/5/08 o Home and Program Areas Active Treatment Monitoring Check List, 2/7/11 o Active Treatment Before and After Meals Monitoring Check List, 2/7/11 o List of individuals under age 22 and their school placement o SGSSLC observation tool of WISD classrooms, on SGSSLC campus and at WISD campus o ARD/IEPs, PSPs, and IEP progress reports: some of these documents for: • Individual #239, Individual #99, Individual #292 Interviews and Meetings Held: o Gary Flores, Director of Day Programs o Melissa Warren, TT IV Day Programs 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 WISD staff member, Lisa Easterly o SGSSLC staff working at the WISD facility classroom <u>Observations Conducted</u>: 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
	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, the monitoring team noted several improvements since the last review. These include: • Modifications to the skill acquisition training sheet/format • Expansion of the training methodology used at SGSSLC • Initiation of graphing of skill acquisition data • Development of a QMRP monitoring tool • Development of a data system to track and improve training of individuals in the community • Continued work with the local public school. The monitoring team believe that the primary barriers to these improvements translating into the acquisition of meaningful skills are: • Ensuring that SPOs are meaningful to each individual (e.g., based on documented need and preference) • Ensuring that the continuation, modification, or discontinuation of SPOs are the result of data-

	based decisions • Ensuring that the SPOs are implemented with integrity • Coordination of public school objectives with SPOs and/or informal activities at SGSSLC.

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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. Although there had been considerable progress since the last review, as indicated below, more work needs to be done to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision item. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition plans. These plans 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). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. The facility made continued progress in this area since the last review. The facility modified the SPO training sheet/format to include a rationale for the SPO. For example, Individual #371's SPO for sweeping his room included the statement "According to (Individual #371's) PSP, keeping a clean room is something that is important to him. Training is to increase (Individual #371's) independent living skills for when he resides in the community." The adding of a section to the SPO training sheet that required the rationale for choosing this particular objective is a direct way to ensure and document that SPOs are based on individual needs and preference. SGSSLC had just recently began training staff on this new SPO training sheet, and the monitoring team looks forward to review more of these plans during the next onsite review. Once identified, 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	Noncompliance

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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 In the last report, the SPOs at SGSSLC did not consistently contain the use of relevant discriminative stimuli, specific consequences for correct responses, or a plan for maintenance and generalization of skills. This was another area where the facility made improvements, by further modifying the SPO training sheet to ensure that all of the above components were included. The new SPO training sheet contained a space to list specific consequences for incorrect responses, and a space to discuss how to accomplish maintenance and generalization. All skill acquisition plans should include the above components demonstrated to be necessary for learning and skill development. Additionally, the new SPO training sheet for Individual #371 included clear discriminative stimuli for the task. As discussed above, these new SPO training sheets were only being piloted at the time of the onsite review, and will be examined more closely in the next review. Finally, as recommended in the last review, the training methodology at SGSSLC was expanded from the training of one step of a task analysis at a time, to other procedures shown to be effective in developing new behavioral repertoires such as forward and backward chaining. At the time of the onsite review, staff were being trained to use the new training methodology. <u>Desensitization skill acquisition</u> Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. Only four dental desensitization plans, however, had been developed since the last onsite review. As recommended in the baseline report, the plans were written by psychologists. It is recommended that dental desensitization plans be incorporated into the new SPO format. The plans represented forward chaining, and appeared to include many of the components of an effective training program described above, however, none of them included a plan for maintenance and generalization of skills. According to the dentistry department, many more individuals were waiting for dental desensitization plans to be	

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		written. The facility should ensure that dental desensitization plans are written for all individuals referred by the dentistry department. 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. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> SGSSLC included replacement behaviors in each PBSP. As discussed in K4 and K9, replacement behavior data were not consistently collected at the time of the onsite review. Additionally, there were no descriptions of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach the replacement behaviors. It is important that the occurrence of replacement behaviors be documented (i.e., data collection). Further, 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 above. <u>Communication and language skill acquisition</u> The monitoring team did not encounter any acquisition programs targeting the enhancement or establishment of communication and language skills. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs. <u>Service objective programming</u> Finally, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the QMRPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). <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. Engagement of individuals in the day programs and homes at the facility 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	

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		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 residence and day program are listed in the table below. Since the last review, the facility has made changes to improve active treatment. These improvements included the addition of staff to assist DCPs with active treatment, a plan to improve active treatment before and after meals, development of a new individual engagement tool, and the expansion of classes and services offered through day programming. As reported in the last review, the monitoring team was encouraged by the overall quantity of age appropriate and typical activities at SGSSLC. Consequently, in several homes visited, many of the individuals were out of the homes, engaging in activities (e.g., playing basketball, at the gym). Many of the remaining individuals were often engaged in other typical activities, such as listening to music, talking to friends, watching television, or playing video games. In the homes where individuals did not possess the skills to readily engage in independent activities, the ability to maintain individuals' attention and participation in activities varied. A particularly good group activity was found in Home 502, where a video was showing and the DCP was leading a discussion about the video. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 60%, a slight decrease from that observed during the last review (i.e., 63%) and the same as that observed during the baseline review. An engagement level of 75% is a typical target in a facility like SGSSLC, indicating that the engagement of the individuals at SGSSLC continued to have room to improve. Engagement Observations: Location / Engaged / Staff-to-individual ratio 509 A East — 1/1 — 1:1 509 A West — 2/2 — 1:2 509 B West — 1/1 — 1:1 509 B West — 0/3 — 1:3 509 B East — 1/3 — 1:3 512 A West — 1/4 — 0:4 512 A West — 1/5 — 2:5 512 A East — 0/1 — 1:1 516 West — 0/4 — 1 :4 502 — 4/5 — 1:5 510 A — 2/2 — 0:2	

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Imagination Program	2/2	0 :2
Vocational Workshop	7/9	2:9
Vocational Workshop	7/10	3:10
Vocational Workshop	7 /9	2:9
511 A	2/2	4:2
511 B East	2/3	2:3
511 B West	0/2	1:2
Suzy Crawford Center	6/7	4:7
Suzy Crawford Center	5/7	4:7

Educational Services

The monitoring team again looked at the status of the educational school services by talking with the director of residential services, observing the WISD classroom on the SGSSLC campus, talking with one of the WISD school staff, and reviewing documents. The WISD public school classroom was not observed during this review.

Three students attended graduation ceremonies that occurred during the week of the onsite review and received their diplomas. Seven other students graduated earlier this year. Eight students were to continue in educational services. Only one was remaining at the WISD public school campus, the other seven at the WISD classroom on the SGSSLC campus. It was unclear as to whether any other students would be attending school at the WISD campus building.

SGSSLC continued to be responsive to the monitoring team's recommendations and comments. It appeared that a good working relationship remained intact between SGSSLC and WISD. The SGSSLC residential director remained the liaison with the public school. Due to her many other responsibilities, SGSSLC might consider mentoring an additional administrator or manager to also play a role with the public school. The residential director reported that three meetings between SGSSLC and WISD were now scheduled to occur during each school year (August, January, and May) to discuss any issues, concerns, goals, progress, and so forth regarding the two organizations. This was a very good idea.

QMRPs, and sometimes the psychologists, participated in the annual ARD/IEP meetings. The residential director reported that there was increased discussion between SGSSLC and WISD regarding consistency in treatment and response to behavior disorders. Further, homework time was created in the residences. SGSSLC continued to need to work on there being some connection between the student's ARD/IEP objectives and their SPOs and/or informal activities at SGSSLC.

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		A classroom observation tool was developed by the QMRP Coordinator to be used by any administrator, manager, clinician, or QMRP who might visit the WISD or SGSSLC campus classrooms. It contained seven very relevant questions, including ones related to monitoring team comments in previous reports (e.g., engagement, inclusion, objectives in a measureable format). The tool was only recently created, so the facility did not yet have experience with its implementation. If it turns out to be helpful to both the facility and public school, it might be shared with other SSLCs. The monitoring team noted that the SGSSLC campus classroom was in need of painting, wall repair, floor repair, and perhaps other relatively minor improvements to make the environment more inviting and pleasant to the students and staff. Four issues observed during the baseline and/or previous review are discussed below: • Amount of student active participation in educational activities from day to day and over the entirety of the school year. o November 2010 review status: Eight students attended the SGSSLC campus school classroom. o May 2011 review status: Students at the WISD classroom on the SGSSLC campus appeared very engaged during the observation by the monitoring team. They completed an outdoor math-related activity; then they were working on computer-based programming. The Friday of the onsite review week, 5/27/11, was the last day of school until 8/23/11. That is, the students were to be out of school for 12 weeks (23% of the calendar year). A few of the students were to attend a three-week summer session that ran only two and a half hours per day for four days per week for these three weeks. SGSSLC should continue to work with WISD regarding appropriateness of extended school year services for those students who would be entitled to it. • Inclusion activities with other students o November 2010 review status: At the WISD campus, the SGSSLC students had little interaction and integration with the general population. Students at the SGSSLC campus classroom had no inclusion activities with typical students. o May 2011 review status: The residential director reported that she was beginning to address this with WISD and would work on this when the next school year began. At this time, it appeared that only one student would be at the WISD campus. Perhaps that would make it easier for WISD to include her in the general school population more often. There might also be opportunities for some, if not all, of the students at the on SGSSLC campus classroom to engage in activities at WISD.	

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		• 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. o November 2010 review status: The status of this issue remained the same. o May 2011 review status: Documents for two of three students reviewed contained the objectives for the ARD/IEP school year. The objectives covered a wide range of topic areas. The objectives described the academic skill/behavior, but without specific detail or understandable criterion (e.g., each objective had a percentage, such as 60%, but the reader had no way of knowing to what the 60% referred). • Grading numbers were not based on objective assessment, but rather on more subjective and intuitive processes that were unclear to the monitoring team. o November 2010 review status: There appeared to be a more structured manner in the determination of grading, however, it differed across the two classrooms. o May 2011 review status: Documents for only one of the three students included a progress report. The report, as was the case during the previous onsite review, stated progress with a code such as P1, P2, or P3, but the reader could not tell how this was determined.	
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, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was using both the Comprehensive Residential Assessment of Living Skills (CRA) and Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS was in the process of evaluating several assessments as an alternative to PALS. The monitoring team is supportive of the identification of an alternative to PALS, and looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology, etc.) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the PSP attempted to identify individual 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

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S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	SGSSLC was making progress on this provision item. More work, however, in the areas of integrity of the implementation, and the practicality and function of SPOs is needed before this item can be rated as being in substantial compliance. At the time of the onsite review, the facility began training QMRPs and DCPs in the graphing of daily SPO data monthly. QMRPs at SGSSLC summarized SPO data monthly, and presented those data at quarterly meetings. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., computer usage for Individual #346). Many other SPOs, however, indicated no improvements (e.g., money management for Individual #184, Toothbrushing for Individual #385) without any indication of a modification of the plan, retraining of staff, etc. Additionally, SPO data indicated that Individual #81's SPO for money management was achieved on 2/26/11. The objective, however, continued for at least one more month (data on this SPO was only available to the monitoring team until 3/31/11). Additionally, when DCPs were asked why Individual #372's SPO of asking for his cigarette pack was marked as "excused," each day for the last month, the monitoring team were told that Individual #372 had achieved this goal and has been carrying his own cigarettes for the last year. The implementation of graphed daily data is an encouraging development at SGSSLC, however, the above examples indicated that the QMRPs require additional tools to be able to ensure that decisions concerning the continuation, discontinuation, or modification of SPOs are based on outcome data. It is recommended that monthly SPO data be graphed so as to improve the QMRP's ability to evaluate the effectiveness of the plan. The skill acquisition plans at SGSSLC appeared practical and functional for some individuals (e.g., teaching Individual #81 to exercise), however, for many others it was not clear how or why these were practical without a specific rationale, as recommended in S1. The facility should ensure that SPOs are consistently practical and functional. As recommended in the last review, SGSSLC recently introduced integrity measures, conducted by the QMRPs, to ensure that SPOs were implemented as written. No integrity	Noncompliance

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		data were available to review during the onsite review. Future onsite reviews will examine these data. SPO data sheets were reviewed to evaluate if data were completed as scheduled. In two of the six SPO data sheets reviewed (33%) the data were absent (Individual #78's data was not completed for the entire month). These results suggested that SPO data were not reliable, however, treatment integrity measures need to be implemented and tracked to objectively determine if SPOs were implemented as written. It is recommended that the facility systematically monitor SPO data to ensure that is reliable. Finally, despite the improvements in this area since the last review, the monitoring team does not believe that SGSSLC will be able to achieve substantial compliance with this provision item until they restructure how skill acquisition programming is organized, implemented, and monitored at the facility.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SGSSLC enjoyed various recreational activities in the community. The facility had begun to make progress in providing and documenting the occurrence of training in the community. This process had recently begun and could not be fully evaluated at the time of the onsite review, and therefore this item was rated as being in noncompliance. The facility recently began recording training activities in the community. These activities included training specific SPOs (e.g., Individuals #367 and Individual #76 purchasing items in the community), general community skills (e.g., in a restaurant, theater, etc.), and recreational activities. It is recommended that these various training activities in community be separately recorded so that community training trends could be better tracked, and increased across the facility. At the time of the review, no individuals at SGSSLC worked in the community. This was the same as the number reported during the last onsite review.	Noncompliance

Recommendations:

1. Implement the new SPO training sheets for all individuals at SGSSLC, and ensure that a rationale (that includes needs and preferences) for the plan and all the components necessary for learning and skill development are included.

2. Dental desensitization plans should be incorporated into the new SPO format.

3. Ensure that dental desensitization plans are written for all individuals referred by the dentistry department.

4. Replacement behavior training procedures should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above.

5. The facility should expand the number of communication SPOs for individuals with communication needs.

6. Ensure that the continuation, modification, or discontinuation of SPOs are the result of data-based decisions.

7. Monthly SPO outcomes should be graphed to aid QMRP to evaluate the effectiveness of the individual SPOs.

8. It is recommended that the various training activities in community be separately recorded so that community training trends could be better tracked, and increased across the facility.

9. Explore and advocate for extended school year, when appropriate to do so.

10. Advocate for inclusion opportunities for students at the WISD campus.

11. Consider ways to incorporate ARD/IEP objectives into the student's activities and/or SPOs at SGSSLC.

12. Work on ensuring that ARD/IEP documentation includes (a) objectives that are understandable to SGSSLC staff (i.e., measureable terminology, clear criterion), and (b) progress reports that indicate how progress was determined.

13. Improve the SGSSLC classroom environment, such as wall repair and painting, floor repair, and general pleasantness of the setting.

The following are offered as additional suggestions to the facility:

14. The facility is encouraged to use the newly developed day programming, vocational services, and the many classes offered by the psychology department (see K8), as opportunities to teach and monitor meaningful SPOs.

15. Consider mentoring another SGSSLC administrator or clinician to participate in the residential director's liaison activities.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o DADS Obstacles Report for SSLCs, October 2010 o Organizational chart, undated o SGSSLC policy lists, 4/8/11 o List of typical meetings that occurred at SGSSLC o SGSSLC POI, 5/9/11 o SGSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 5/23/11 o Community Placement Report, through 3/31/11 o Half page listing of some information presented to senior management by the APC, 3/31/11 o List of individuals who were referred for placement and had been placed since last onsite review (10 individuals) o List of individuals who were referred for placement and had not yet been placed (27 individuals) o Individuals on the referral list for more than 180 days (12 individuals) o List of individuals who requested placement, but weren't referred, 3/21/11 (nine individuals since last onsite review, 21 individuals listed on Community Placement Report) o List of individuals who requested placement, but weren't referred solely due to LAR preference, 3/18/11 (five individuals) o List of rescinded referrals (three individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (no individuals) o List of alleged offenders (seven page list) o List of individuals discharged under alternate discharge procedures (no individuals) o Description of how facility assessed an individual for placement o List of all individuals at the facility, indicating that all had been assessed for placement, 3/18/11 o Documentation of APC attendance at two PSPs in April 2011 o One set of three completed self-monitoring tools for Individual #92 and Individual #88, 4/11 o Job descriptions for APC, PMM, and Residential Coordinator o Documentation of the following trainings related to referral and placement • Central office training for all APCs and PMMs from all SSLCs, 4/6/11 • Central office training of QMRPs at SGSSLC, 5/4/11 • APC and Residential Coordinator training of PST members for seven PSTs, 3/11 o Training by local MRAs, 12/10/10

	o Information sheets from each provider tour, 11/12/10 through 3/18/11 o Staff recordings of their experience during community provider tours, 11/10/10 through 3/10/11 o Blank checklist tool used by APC regarding assessment submissions for CLDP o List of all post move monitoring visits 11/10 through 5/26/11 o Completed self-monitoring forms related to most integrated setting practices o PSPs for: • Individual #287, Individual #232, Individual #313, Individual #44, Individual #331, Individual #94, Individual #247, Individual #32, Individual #12, Individual #59, Individual #126, Individual #276, Individual #367, Individual #151, Individual #389, Individual #236, Individual #90 o CLDPs for: • Individual #51, Individual #160, Individual #334, Individual #351, Individual #84 o Post move monitoring checklists conducted since last onsite review for: • Individual #84: 7-day • Individual #351: 7-day • Individual #334: 7-day, 45-day • Individual #160: 7-day, 45-day • Individual #51: 7-day, 45-day • Individual #195: 7-day, 45-day, 90-day • Individual #213: 7-day, 45-day, 90-day • Individual #281: 7-day, 45-day, 90-day • Individual #131: 7-day, 45-day, 90-day • Individual #219: 90-day • Post move monitoring conducted by another SSLC: Individual #102: 7-day, 45-day, 90-day o CLDP and completed PMM forms for one individual who died five months after moving to community: • Individual #107 <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor o Philip Baugh, Facility Director o Joy Patterson, Program Director, Michelle Settles, House Manager, D&S Residential o Ted Pluff, Program Director, Concho Resource Center o PST members for Individual #158 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 #158, Individual #169, Individual #134

	o Community group home or day program visit for: • Individual #351, Individual #51 o Many residences and day programs at SGSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, was revised and simplified compared to the POI presented during the previous onsite review. This was an improvement and should provide the admissions and placement department with guidance and direction. The monitoring team, however, learned that an updated and improved POI format has been recently created. Its goal is to more adequately describe actions taken and actions planned, directly in line with each provision item. This sounds like it will be a good improvement. As the APC completes his section of this new POI, the monitoring team recommends that the information provided in this section of the report be used. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the APC to use this report to guide him in setting forth a set of actions to work towards achieving substantial compliance with this provision. The POI primarily referred to the new CLDP processes and the new QA self-monitoring tools. Further, the POI indicated a self-rating of substantial compliance with two provision items. The monitoring team agreed with one of these ratings, T1h. The monitoring team did not agree with the self-rating of substantial compliance for T1g because the statewide report was still in draft format and did not contain information specific to SGSSLC. In addition, the monitoring team rated three provision items as being in substantial compliance that SGSSLC had self-rated as being in noncompliance (T1c2, T1c3, T1d). This represents an occurrence reliability percentage between the monitoring team and the facility of only 20%. With the APC, the monitoring team reviewed the department's presentation book. It was well prepared, organized, and contained a great deal of relevant information, including actions related to each provision item, and actions related to each recommendation from the previous monitoring report. 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 continued to engage in many activities to encourage and assist individuals to move to the most integrated setting. The specific numbers of individuals who were in the referral and placement process, however, remained low, given the size of the facility (i.e., 27 out of 425, that is 11%). • 10 individuals were placed in the community since the last onsite review • 27 individuals were on the active referral list. • The referrals of three individuals were rescinded since the last review.

	The monitoring team recommends that the department's data (including, but not limited to the above list) be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was what was noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. There was wide variability in the amount of information included in the PSPs within each subsection of the LOD. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). CLDPs were now being initiated at the time of referral. Thus, the CLDP became an evolving document to which information was to be added throughout the referral and placement process. The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report. The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, and safety issues. Although this was very important, requiring only the documentation of the inservicing of staff is insufficient. The required supports should list out those actions that the provider must take to satisfy the post move monitor that these supports are being provided. There were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. Examples are provided in section T1e below. DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence (see Facility Self-Assessment above). Post move monitoring had greatly improved since the last onsite review. Post move monitoring was completed within the required timelines, and followed the requirements of Appendix C of the Settlement

	Agreement. The PMM's reports were more detailed than last during the last review. Moreover, the PMM had taken a more assertive role, especially in one case described in T2a below. Detail regarding whether a support was being provided, the providers response and plan when a support was not being provided adequately, and more involvement of the PMM in other situations are required. Two post move monitorings were observed by the monitoring team. They were done in a professional manner. In order to achieve substantial compliance, every item on the list of supports needs to be directly observed (see T2b below) and PMM actions need to be taken when a support is not being provided adequately. The facility had just begun to hold PST meetings following each post move monitoring visit. A number of individuals had successful moves to the community and appeared to be enjoying active and happy lives.

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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.	Overall, SGSSLC continued to make progress towards meeting provision T of the Settlement Agreement, however, the amount of progress varied across the many items of this provision and, therefore, much work was still needed in order to achieve substantial compliance. Referral and placement activities continued to be overseen by Tim Welch, the Admissions and Placement Coordinator (APC). He continued to be assisted by Denise Copeland, the Post Move Monitor (PMM). In addition, James Reid, an experienced manager at SGSSLC, was now assigned to Mr. Welch and was assisting in the many tasks related to admissions, placement, and this provision of the Settlement Agreement. Recently, Mr. Welch also received approval for a new position, titled transition specialist. This would bring the department to a total of four staff. This appeared to be sufficient given the number of admissions, referrals, and placements. The specific numbers of individuals who were in the referral and placement process remained low, given the size of the facility (i.e., 27 out of 245, that is, 11%). Below are some specific numbers regarding the referral and placement process. Note that most are either stable or slightly improved from the previous onsite review. • 10 individuals were placed in the community since the last onsite review. This compared with 10 who had been placed at the time of the last review, and 17 at the time of the baseline review (however, this latter number was for a 10-month period). o About half of these 10 individuals were placed in San Angelo, and to only two residential providers: D&S Residential Services and Daybreak Services.	Noncompliance

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		o The APC reported that up to 4 individuals may move in the upcoming month and that the total number of moves may double by the time of the next onsite review. • 27 individuals were on the active referral list as of 5/23/11. This compared with 21 individuals who had been referred at the time of the last review, and 19 at the time of the baseline review. o About two-thirds of these were new referrals since the last onsite review. o 12 individuals had been on the referral list for more than 180 days. • 21 individuals were described as having requested placement, but were not referred. 9 of these 21 were new since the last onsite review. This compared with 44 individuals at the time of the previous review and 80 at the time of the baseline review. The change in number since the last two reviews may be due to a change in the way the APC collected the data. The APC should review this listing and ensure that all individuals who should be included, are included in this list. o Of these 21 individuals, the reason for lack of referral in 5 cases was that the MRA was not present. This should be corrected immediately. Moreover, this was listed as a recommendation in the previous report and in the baseline report when similar incidences were noted. This was reported as being addressed and completed in the POI for this item. o A facility review of each individual who requested placement, but was not referred (other than those for whom LAR preference was the sole reason) needs to occur. Lufkin SSLC had implemented this process and that might serve as a model for SGSSLC. It was called the "Placement Appeal Process" at Lufkin SSLC and is described in the April 2011 monitoring report for that facility. • 5 individuals were describe as having requested placement, but were not referred due solely to LAR preference. This compared to 8 at the time of the previous review. o The data for this category need to be gathered more accurately. This should be a list of individuals who would have been referred for placement but were not, solely due to LAR preference. This list should include not only those individuals who themselves requested referral, but those individuals who were not able to express themselves. This is a different list than the one described in the bullet immediately above, however, some names might appear on both lists. • 0 individuals were re-admitted to the facility after failed community placements since the previous review, however, one individual was being re-referred back to the facility (Individual #77). This compared with one individual at the time of	

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		the last onsite review. • The referrals of 3 individuals were rescinded since the last review. This compared with 5 at the time of the previous review and 4 at the time of the baseline review. For all three, the there seemed to be reasonable reasons for rescinding the referral, as described below: o Individual #114: serious incidents of self-injurious behavior and threats of suicide had occurred. Her medications were to be reviewed. Her LAR made the request for this rescinding and the PST, after discussion, concurred. o Individual #255: increased behaviors of harassing female peers, making harassing phone calls, inappropriate sexual contact, calling police while on group home visit, and harassing female peers while on group home visit had occurred. His LAR wanted his referral rescinded. After discussing, PST and MRA were also in agreement. The PSPA note indicated that the PST chose to refer him "to a more restrictive environment that may better serve his needs…." This, however, had not yet occurred. o Individual #247: he was referred on 1/20/11, however, beginning on 1/24/11, he exhibited almost daily serious behavior outbursts that included serious aggression towards staff that injured many staff, running away from the facility grounds, threatening to hurt himself, pulling the fire alarm, and making false allegations of abuse. Some incidents involved law enforcement and incarceration. His PST noted that his referral would be reviewed in six months, he was to begin participating in the new DBT program, and his medications would be reviewed. His LARs (parents) were in agreement. • 0 individuals were discharged under alternate discharge procedures (see section T4 below). This compared with 4 at the time of the previous review. • 1 individual had died since being placed since the last onsite review. Individual #107 moved on 8/31/11 and died 2/11/11. There did not appear to be any questions about his care in the community. Apparently, he was in poor health (e.g., smoking obesity, previous substance abuse) and had, coincidentally, been examined earlier that day by one of his physician specialists. The above data should be summarized and graphed every six months. Each of the above eight bullets should be graphed separately. The monitoring team recommends creating simple line graphs with one data point representing six months of data (preferably to coincide with the onsite reviews, that is, November-April and May-October). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team is available to help the facility create this	

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		graphic presentation prior to the next onsite review. In addition, the APC should do a review of every rescinded referral. Perhaps a thorough review might lead to changes in these processes for all, or some, individuals at SGSSLC. <u>Determinations of professionals</u> This provision item requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This is an activity that should occur during the annual PSP meeting and be documented in the written PSP. In the 17 PSPs listed above under Documents Reviewed, a statement at the end of the PSP narrative attempted to present the PST's decision regarding most integrated setting and referral. These were typically one or two sentences that provided insufficient detail regarding the opinions of professionals on this important matter. Perhaps the upcoming proposed revisions to the DADS policy on most integrated settings practices and the living options discussion will set the occasion for the incorporation of professional's determinations. The facility should ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. This provision item allows (and calls for) professional determination as separate from both the preference of the LAR and the opinion of the PST as a whole. <u>Preferences of individuals</u> SGSSLC appeared to work to honor the preferences of individuals. <u>Preferences of LARs and family members</u> SGSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. <u>Senior management</u> The APC reported that he had begun to inform senior management of the status of some of these data at the Quality Improvement Council meetings. The information presented to the monitoring team was a half-page listing of this information. This was insufficient. The monitoring tea recommends that the APC replicate the weekly report that was maintained by the Lufkin SSLC APC called "Weekly Admission, Inquiries, and Referrals Update." All of the data discussed throughout section T of this report should be incorporated into the facility's QA program.	

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T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1 and was dated 3/31/10. A revised state policy was in draft format. The Monitoring Panel had the opportunity to review this draft revised policy and submitted a set of comments to DADS separately from this report. In addition, the APC and PMM reported that they had the opportunity to also provide comments to state office. The new policy contained improvements from the previous version as well as more detail for PSTs. Once finalized and disseminated, SGSSLC will need to incorporate these revised policies, practices, and forms into its facility-specific policies. The facility-specific policy described in the previous report remained in place at SGSSLC Implementation of the new state policy and the updating of facility policies to make them in line with the new state policy will lead SGSSLC towards substantial compliance with this provision item.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's 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. The new statewide PSP policies and procedures were being implemented at SGSSLC. These policies and procedures were recently taught to the facility's PSP coordinators and the new procedures were put into place in late 2010. Four of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. At SGSSLC, PSP meetings were facilitated by QMRPs. In addition to attending PSP meetings, 17 recently completed PSP documents were reviewed (listed above in the Documents Reviewed list). The total sample included individuals representing different levels of referral for placement, ages, need for extensive supports, language abilities, medical needs, and family involvement. These 17 were chosen by SGSSLC, one for each of the residential homes. The new policy and procedures will require a more structured living options discussion	Noncompliance

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		to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this gets implemented correctly. To that end, the APC reported that he was attending PST meetings more frequently, and that PSTs were becoming more involved in tours of potential community living options and were going to visit homes before an individual moved. Furthermore, there were more frequent PST meetings once an individual was referred for placement. <u>Protections, Services, and Supports</u> The discussion about the ideal optimistic vision should focus on the components of an environment that would best (a) suit the needs and preferences of the individual, (b) ensure safety, and (c) provide adequate skill development and maintenance, and quality of life activities, such as leisure and recreation activities. The revised (but not yet finalized or disseminated) state policy included a more structured way of addressing the living options discussion (LOD) portion of the PSP meeting, both in the meeting and in the written document. Further, it separated the discussion of addressing the individual's preferences (which were derived from the PFA and discussed earlier at the PSP meeting) and the individual's needed supports and services (which were derived from assessments and discussed later at the PSP meeting during the LOD). The revised LOD will help ensure that the PST properly and fully considers an (a) optimistic living vision, (b) all aspects of supports and services, and (c) preferences. Further, the APC described recent activities that were designed to continue to move the facility towards these outcomes. These included • PSP guidelines that were created by the QMRP coordinator to ensure all necessary information was included in the PSP meeting and document, • PSP meetings were to be monitored by the QMRP coordinator and lead QMRPS, especially to help ensure that a meaningful discussion occurred, • Recent training for all QMRPs on facilitation of meetings, • Recent training by the state office for the APC and his staff, and • Recent training by the state office for QMRPs on LODs, and the referral and transition processes. SGSSLC was making continued progress towards achieving substantial compliance with this aspect of this provision item. The set of 17 PSPs reviewed were primarily from March 2011. Comments on these 17 PSPs are below: • The narrative section (i.e., everything prior to the action plans) ranged from less than two pages (e.g., Individual #287, Individual #367, Individual #331) to more	

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		than seven pages (e.g., Individual #90). There was wide variation in the amount of information included in the various sections of the document. • For example, Individual #126's narrative section was six pages long. This length, however, was due to the inclusion of information cut and pasted from other documents, such as unnecessary detailed descriptions of her medications. • The number of training objectives ranged from none (Individual #59) to three to four for most of the others. For most individuals, this included self-administration of medication and money management as two of the training objectives. • There was very little individualization on what skills were chosen to be addressed with training objectives. For example, Individual #247had a surprisingly limited list, especially given his possible re-referral to the community. Even though the lists were limited in number of training objectives, there were some examples of individualization, such as making healthy food choices (Individual #232) and laundry and cooking (Individual #94). The content and level of detail varied greatly across this set of PSPs. SGSSLC needs to provide more guidance to QMRPs and PSTs as to what should be included in the PSP meeting and PSP document. This guidance should help the QMRP to determine what level of detail to include in each section of the written PSP. Again, this will only be accomplished if the APC works closely with the QMRP department and the QA department. Self-monitoring tools were being used across the facility. Three were developed and being implemented for most integrated setting practices: one for the PSP written document, one for the CLDP document, and one for post move monitoring documents. Examples of completed self-monitoring tools were reviewed. One of these showed the comparison (i.e., inter-rater agreement) of two reviewers of a PSP document, the post move monitor and a QA staff member. The document indicated a very high rate of agreement (either 90% or 96%). Both observers, however, scored Yes to the item, "the transfer/referral is consistent with the determinations of professionals that community placement is appropriate," yet as indicated above, this was not evident in any of the PSPs reviewed due to the wording of the PSP document. Thus, the facility needs to ensure that self-monitoring is valid, that is, that it is measuring what it is intended to measure. High levels of agreement using the wrong criteria will result in an ineffective process. Moreover, monitoring of the PSP meeting itself (i.e., not just the PSP document) is also needed if all of the above is to be achieved.	

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		Obstacles to Movement There continued to be no coordinated plan or approach to identify and address obstacles to movement to the most integrated setting across the facility (also see T1g below). Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle (if one was identified) via an action plan as a service objective or training objective was not explicitly noted in most cases. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. It may be that use of this list will help PSTs to be more successful in identifying and addressing obstacles. It may be that PSTs will need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). The state's new system for determining and categorizing obstacles is likely to be helpful to PSTs. The new system should help PSTs to separate the defining of the supports and services the individual needs from the identification of obstacles that are preventing the individual receiving those supports and services in the most integrated setting. The below list of obstacles from this set of PSPs indicated that all types of characteristics, situations, and conditions were given as obstacles. Some reflected preferences, others reflected conditions of individuals, and others reflected the perceived capacity and competence of community providers. • Physical and verbal aggression (Individual #94) • Aggression, unauthorized departure, property destruction, self injury, and the creation of immense danger (Individual #247) • Challenging behaviors of aggression, fire setting, property destruction, suicidal behavior, and making unfounded allegations; she had set three fires in her bedroom (Individual #331) • Self-injurious behavior and poor hygiene (Individual #287) • Problem behaviors, participation in STEPP (attendance and active engagement), socialization, boundaries, and use of intimidation (Individual #232) • Dietary concerns and verbal aggression (Individual #12) • A licensed sex offender therapist with weekly appointments (Individual #276) • Limited language, and not much awareness of options (Individual #44) • Community safety, leaving supervision, high ammonia levels (Individual #59). This individual also stated that he did not want to move • Long-term relationship with another resident at SGSSLC, and need for accessibility in home, a ramp, orthopedic shoes, dysphagia-trained staff,	

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		mealtime equipment, and a speech pathologist (Individual #126) • He likes to walk around outside by himself, needs enhanced supervision, and doesn't attend work/day activities (Individual #367) • Not a US citizen (Individual #32) • No obstacles, however, there were concerns (Individual #313) As PSTs begin to define what supports are necessary to meet these needs, the discussion will likely become more centered upon what it is that the providers of community services will need to provide in order for the individual's placement to be successful, fulfilling, and long-term. To reiterate, obstacles, if there are any, will be identified later when PSTs attempt to arrange for the services/supports necessary to meet these needs and find that they are unavailable or cannot meet the individual's needs. It is important to note this distinction between needs and obstacles. Further, what were described as obstacles for most of the individuals in the above list was not consistent with any of the categories to be found in the state's new system for determining and categorizing obstacles. Please also see section F1e above for additional detailed discussion regarding assessment of preferences and needs, the optimistic living component of the PSP, skill training related to community living, obstacles, and referrals.	
	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 activities listed in the DADS policy. The facility had only just begun to address education of individuals and their families on an individual basis. This was due to the PSP template requiring a comment about the education of the individual and LAR, however, as exemplified in each of the 17 PSPs reviews, the PSP provided very little information and no details. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. The next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. The annual provider fair was discussed in the previous monitoring report; another fair had not occurred since the previous review. It did not appear, however, that any of the activities recommended in the previous monitoring report were being implemented, such as the determination of 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. Perhaps planning for the next provider fair could include these activities.	Noncompliance

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		There were numerous trainings over the past six months regarding most integrated setting practices, the CLDP, and referral, and transition policies, documents, and procedures. These trainings included: • State office did a training for all APCs and PMMs from all SSLCs together in Austin in April 2011 • State office did training at SGSSLC for all of the facility's QMRPs in May 2011 • SGSSLC's APC and residential coordinator did trainings of seven PSTs in March 2011. This was good to see and showed that the facility was taking steps to have the content of these trainings affect the functioning of the PSTs and their activities. • The local MRAs conducted training on 12/10/10 regarding the types of community services that were available. Four MRAs presented and 59 SGSSLC PST members attended. A Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) continued to be 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 facility took individuals on visits to community providers. The facility had made continued progress in organizing its system of planning, documenting, and reporting. The facility reported that nine tours occurred from mid-November 2010 through mid-March 2011, that is, about two per month, the same rate as reported during the last onsite review. Progress included that the tours now had the goal of going to three different providers, and the documentation listed the individuals who were scheduled and the staff. There was space at the end for one staff to make some comments. Comments, however, were of a general nature. As a result, a newly revised form was set up to prompt the writer to indicate the appropriateness of the sites, positive reactions from the participants, and negative reactions from the participants. A further improvement would be to report something about the response of each individual to the tour sites. There was still no tracking tool to determine how many individuals across the facility had been on tours, how many were scheduled, and how many needed to be scheduled. Also, there should be some analysis of individual's refusals to go on tours (there were many). Perhaps the individuals were being oppositional, perhaps they were indicating a preference to engage in a competing more preferred activity on campus (e.g., work), or	

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		perhaps they were making an appropriate personal decision. The APC should incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system, such as number of individuals who have gone on tours, number of providers visited, number of direct care staff who have gone on tour, and so forth (see section E above). Although not solely related to education about community placements and providers, the self-advocacy activities at SGSSLC can be another venue to educate individuals about community placement and the community placement process. Finally, the monitoring teams and DADS central office are working towards agreement on the specific criterion for this provision item. Once established, it will provide more specific direction to the APC and the facility regarding achieving substantial compliance.	
	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 reported that individuals were assessed by following the state's most integrated setting practices policy. In addition, the APC submitted a 31-page listing of each individual that included the headings "client's preference," "exact individual preference," "recommended movement," "reason not referred," and "other reason not referred." For almost all of the individuals, these last two columns were blank. 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 previous monitoring report, the facility will need guidance from DADS regarding this provision item. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether a well-conducted living options discussion, along with similarly well-done documentation in the written PSP would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at SGSSLC.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. The monitoring team had the opportunity to review this new CLDP form a few months	Noncompliance

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	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:	ago. These comments were presented in previous monitoring reports for this and other SSLCs. Many of these comments were taken into consideration and were reflected in the most recent draft proposed updates to the CLDP policy, practice, and forms. The monitoring teams have provided additional feedback and suggestions and it is expected that the new CLDP process and format will be disseminated and implemented sometime in the next few months.	
	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 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 monitoring team reviewed five of the most recently completed CLDPs (listed above under Documents Reviewed). Four of the five that were reviewed were done in the old style CLDP format; only the most recent (Individual #84) was done in the new style format. Generally, all of the individuals who were transitioned had care/service plans being implemented at the facility, such as BSPs, PNMPs, and Nursing Care Plans. None of the CLDPs (0%) adequately defined the facility staff's role in assisting community provider staff to learn about these plans and their implementation. That is, when such training and inservicing was referenced, the CLDP did not define what the training would consist of, what the facility's role would be in the training, or specifically what the expectations were with regard to the competency of the community provider staff in implementing the programs. None of the CLDPs described the need for collaboration between staff at SGSSLC and staff, consultants, or clinicians in the community. For example, it would be expected that clinical staff at SGSSLC would be responsible for sharing information and answering questions through face-to-face or telephone contact with their counterparts in the community. In none of the plans reviewed was this included as a requirement. Likewise, in none of the plans reviewed were expectations included for community provider staff or consultants to spend time at SGSSLC to get to know the individual, and/or to work with their counterparts to learn about the individual's routine and/or program. Again, for some individuals, this would be appropriate and expected. Further, many individuals would benefit from team members, particularly habilitation	Noncompliance

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		therapies staff or psychology, conducting an assessment of the environment, and making recommendations, as appropriate, prior to the time the individual transitions to a community home and/or day program/vocational site. This was not written into CLDPs as an essential support. The monitoring team, however, learned that lengthy trial visits to community providers had been arranged by the facility in some cases. This was also good to see and may also increase the likelihood of successful placements. For example, Individual #158 spent three weeks on a trial visit to the proposed residential and day providers, and the Director of Residential Services told the monitoring team about a woman from home 510 who also did an extended trial visit. Monitoring activities were identified in the CLDPs, including the role of the MRA Local Authority, as well as the role of facility staff in the post-move monitoring and follow-up process. The new CLDP process makes the CLDP into an "evolving document" that begins at the time of referral and "lives" until the individual is fully discharged from the facility, usually one year after moving to a more integrated setting. To support this, the APC set up each of the new CLDPs on the facility's shared computer file system so that multiple members of the PST could access it (some could make entries and updates to it, too). The monitoring team requested three of these CLDPs that were in-process, but they were not received. Therefore, this process will be reviewed during the next onsite review. The plan, however, to make the CLDP available to all PST members and to initiate it upon referral was a good one and should contribute to meeting the requirements of this provision. The APC reported that DADS central office was now conducting reviews of each of SGSSLC's CDLPs. The monitoring team requested, but did not receive copies of this feedback, however, if these were similar to those seen at other facilities, they should be helpful to the APC and the PMM. Central office might consider reviewing CLDPs at various stages of development, not only at the point that the individual moves.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP clearly indicated the staff responsible for certain actions and activities.	Substantial Compliance
	3. Be reviewed with the individual and, as	The CLDP contained evidence of individual and LAR review. This was also evident during observations of PSP meetings and discussions with two individuals who had	Substantial Compliance

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	appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	transitioned to the community.	
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.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The checklist of assessments was part of the new style CLDP and should help ensure meeting this provision's requirement. The checklist was used in the most recent CLDP (Individual #84). The APC reported that he reviewed all assessments and all assessment updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. The outcome of this, however, as indicated below in T1e, was inadequate because many important supports did not make it to the list of essential/nonessential supports for most individuals.	Substantial Compliance
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.	This provision item requires the identification of a set of individualized important supports that the PST determines are critical for the individual's success in his or her new placement. These are labeled as either essential supports (those that must be in place prior to the individual's move) or nonessential supports (those that must be put in place, but aren't required to be in place on the day of the move). The development of these lists of supports is one of the most important aspects of planning for each individual's move. The creation of the list of essential and nonessential supports provides the PST with the opportunity to ensure that the new provider provides the individual with all of the aspects of service and support that the PST deems necessary. PST members should never lose sight of their responsibility and opportunity, that is, that this is their chance to ensure that the individual gets what he or she needs and wants. Many PST members have, for many years, cared for, and cared deeply about, the individuals who are transitioning. They should not squander this opportunity to increase the likelihood of their individual's success at his or her new home. The lists of supports in the CLDPs were improved from the last onsite review, but remained inadequate and indicated problems in the planning of this aspect of each individual's transition. Problems in identifying essential and nonessential supports were identified in the baseline monitoring report and again the previous monitoring report.	Noncompliance

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		There are three components to a proper list of essential and nonessential supports.
		• First, the CLDP needs to include supports from a wide range of possible supports. This should come from the
		  o individual's personal preferences and interests,
		  o family members and LARs,
		  o written assessments and updates from PST members (i.e., needed services for health, safety, and skill development),
		  o other documents, such as the PSP and PSPAs, and
		  o discussion at PST meetings, with attendance as required.
		• Second, supports, both essential and nonessential, need to be described in adequate detail, using observable, measureable, and verifiable terminology. The wording must provide the facility, the receiving provider, and the post move monitor with adequate guidance regarding the provision and monitoring of each support.
		• Third, the way in which provision of the support is to be verified must be provided. The CLDP needs to specify what should be observed by the post move monitor (e.g., paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The facility might also note that it remains available, perhaps even on an on-call basis, for any questions the provider might have regarding any support.
		
		The monitoring team reviewed five CLDPs. Below are comments regarding these CLDPs as well as comment following attendance at the PSP meeting for one individual that occurred one week following his CLDP meeting (and therefore a couple of weeks prior to his upcoming move to the community). Unfortunately, a CLDP meeting was unable to be scheduled during the week of the onsite review. Consequently, the monitoring team was unable to observe the conduct of a CLDP meeting by the facility. The APC reported that he led these meetings and that each one was also attended by the PMM.
		• The lists of essential and nonessential supports was primarily filled with the scheduling of appointments and the arrangement for services. These are certainly important, but might have led to PSTs failing to focus on other important preferences and supports for the individual.
		• The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, and safety issues. Although this was very important, requiring only the documentation of the inservicing of staff and/or only the presence of the BSP or PNMP document is insufficient. The required supports should list out those actions that the provider must take to satisfy the post move monitor that these supports are being provided.
		• In some cases, nonessential supports included the continuation of the BSP,	

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		PNMP, etc., however, no details were provided, especially as to the most important aspects of these plans for that specific individual. • Thus, there were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. The monitoring team reviewed each of these cases and identified aspects that were surprisingly absent from the CLDP planning. • The monitoring team learned (via document review, observation in the community, and comments from individuals) that day programming options were often limited, boring, and meaningless. Integrated community paid work was extremely limited. Without meaningful day activities, the likelihood of failed placements goes up considerably, especially for the more capable individuals who are being referred for placement. Teams need to thoroughly consider the day and work activities of individuals as they develop lists of essential and nonessential supports. Individual #84: • He had a history of serious problem behaviors, including aggression towards a police officer and inappropriate sexual behaviors. He lived in seven different community homes, including the one he was moving back into. The CLDP noted this, but there were no specific supports included, other than a staff inservice on his BSP, the presence of a BSP in the home, and his continuation as a participant at SGSSLC's STEPP and Anger Management programs, though the only evidence required was an email (which the monitoring team assumed was to document that he was enrolled in the programs). There was no specification of what staff were to do each day to support his appropriate behavior in his new day and residential settings. • He had a history of GERD and skin infections. Neither was specifically addressed in the CLDP. • He had a preference to not get up in the morning before 8:00 am and he wanted to learn Spanish. Neither was in the CLDP list of supports. Individual #351: • She had a history of failed community placements and a history of severe aggression, serious property destruction, and suicidal behaviors. In one report, she was described as explosive, destructive, and causing injury to others. This history was not addressed in her listed supports.	

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		• She had stated that a paying job, keeping busy, going on outings, and cooking were important to her. Cooking was addressed as an nonessential support; that was good to see. On the other hand, the support related to getting a job only referred to contacting DARS, and the support related to activities gave no detail, criteria, or specific actions to be taken. • Coincidentally, the monitoring team attended her PSP meeting last year during which Individual #351 very clearly and very eloquently stated that keeping busy was not only her preference, but it was required if she was to be successful. Thus, it was disappointing to observe her at her current community day program and find that she was not working, not stimulated, and bored. This certainly increased the likelihood of behavior outbursts and psychiatric issues (although fortunately none had occurred at this time). • Exercise and addressing her BMI were noted as being important, but were not addressed in the list of supports. Individual #160: • He had an extensive history of sex offending noted in his record, including pedophilia and public exposure. Fortunately, his list of supports included numerous entries regarding male supervision, supervision while out of the home, participation in SGSSLC's STEPP program, and provision of other counseling. This was good to see and indicated that the PST took this history very seriously. • Staying busy was also noted as being important and was included as a nonessential support. There was, however, no indication of what activities, how often they should occur, or at what criterion. • A support noted that the provider should continue the BSP, but there was no indication of how to tell if it was being continued or what specific aspects needed to be implemented. • Work was noted as being very important to him, but this was not listed as a support, instead he attended a day activity program. Individual #334: • Her CLDP listed her many adaptive equipment needs and included a support requiring implementation/use of the equipment. This was good to see, however, there should be more detail as to what it is staff were to do and how they were to document it. • Similarly, her participation in outings and social activities should include some type of criterion or frequency to help guide the provider.	

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		Individual #51: • It was good to see that the setting up of a psychiatry appointment was listed as an essential support, thereby requiring it to be in place prior to his move. Often, providers have difficulty identifying a psychiatrist and making an appointment. By making it an essential support, the PST ensured it would be in place by the time he moved. • Similar to the other CLDPs, the list of supports focused primarily on inservice training rather than on implementation of BSP- and PNMP-related concerns. • The support for participation in activities did not provide sufficient evidence for post move monitoring • Similarly, the support for verbal prompts to complete daily living skills did not provide enough detail or description. Individual #158: • His CLDP meeting was held prior to the onsite review by the monitoring team, however, the monitoring team attended his PSP meeting and spoke with the PST following the meeting. • It appeared that two needs should have been addressed specifically in the list of supports: headaches and paid work.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. Implementation of these tools was just beginning at SGSSLC. The monitoring team's comments regarding these tools for this provision are above in section T1b1. The monitoring team recommends that the APC take a close look at these three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of the self-monitoring are adequate, and that the criterion for scoring appears to be valid. In addition to the implementation of self-monitoring, data from the referral and placement activities at SGSSLC should be submitted to and incorporated into the QA program at the facility (see section E above). Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QA department and to its senior management team. Examples include: • The bulleted items in T1a above • Individuals placed • Individuals referred	Noncompliance

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		• Obstacles to placement • Action plans related to obstacles • Educational activities • Number of providers, quality of providers	
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.	At the facility level, SGSSLC was not in compliance with this provision item. SGSSLC was not gathering relevant information regarding obstacles across the facility. SGSSLC was not analyzing information related to identified obstacles to individuals' movement to more integrated settings. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The proposed statewide obstacles report was described in the previous monitoring report for SGSSLC. As of the time of this review, it had not yet been issued and, therefore, the same comments from the previous monitoring report continued to be relevant and are not repeated here.	Noncompliance
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	The monitoring team was given a document titled "Community Placement Report." It was updated 3/31/11. This provision item was found to be in substantial compliance given the current contents as well as the facility and state's intention to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is	Substantial Compliance

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	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.	capable of expressing, a preference for referral. As noted above with regard to provision T1a, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The state indicated that at this time, its data system did not include this information, but it was working toward being able to produce these data in the near future.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether	SGSSLC was implementing the post move monitoring process. Post move monitoring was conducted by the post-move monitor (PMM), Denise Copeland. She continued to be organized, professional, and desirous of completing post move monitoring in an effective manner. Continued progress was demonstrated towards achieving substantial compliance with this provision item. The PMM and APC were responsive to the comments from the previous monitoring report in a number of ways: • The APC and the PMM now maintained a post-move monitoring schedule that listed each individual's name and the dates by which the three required post-	Noncompliance

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	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. • All (100%) of the post move monitoring visits occurred within the required timelines. • All (100%) of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. • More detail was included in the post move monitoring report, including a sentence or two for each support and a longer, more descriptive, paragraph at the end of the checklist describing the PMM's overall experience and impressions of the individual and his or her placement. These were very informative and helped the reader to understand the overall context of the details in the preceding pages. The monitoring team recommends that this be a standard part of all post move monitoring forms. • The post move monitor was more assertive in commenting on relevant and important aspect of the individual's living, work, or day situation, even if the item was not a specific support identified during the CLDP process. One example is worthy of additional description: o The PMM, during a pre-move site visit for Individual #160, noticed that children's playground equipment was in the neighbor's backyard. Due to the individual's history of sexual offending, the PMM intervened and raised this concern. As a result, the individual was placed in a different home, fortunately, with the same provider. This second home was staffed by staff who were trained and experienced in supporting individuals with this type of history. The monitoring team believes that it is not an overstatement to say that the PMM was responsible for perhaps averting a failed placement and/or the occurrence of some terrible tragedy. Moreover, the completed post move monitoring forms indicated that the individual was having a successful placement, that is, he was having an active and good life in the community, he was being supported appropriately, and he was happy. • The PMM added a description of how supports would be verified (i.e., evidence) to the post move monitoring form. In the future, the determination of evidence and criteria will become part of the CLDP process, that is, will be determined by the PST during the CLDP planning process with input (and requests for more specificity when needed) from the PMM. A recent change in state policy and practice required (a) each SSLC to post move monitor all of its own placements wherever they might be across the state, and (b) a PST meeting to occur following each post move monitoring visit. These two actions are likely to greatly help with addressing any problems and helping to ensure consistency in support provision. SGSSLC began implementing post move monitoring of all its placements a few	

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		months ago and began conducting PST meetings after post move monitoring only a few weeks prior to the onsite review (i.e., beginning with the placement of Individual #84). The SGSSLC PMM completed 21 post move monitoring visits across 10 individuals since the last onsite review. Many of these were conducted across two different days (i.e., one day for the residential site and one day for the day site). These were 100% of the required post move monitorings for this time period. Two additional post move monitoring visits for two individuals were completed during the week of the onsite review. Two of these were observed by the monitoring team (see T2b below). Areas in need of improvement for the next onsite review are described below. • Post move monitoring did not require the PMM to clearly indicate whether or not the support was in place. That is, there was no column to indicate Yes or No. As a result, it was difficult for the reader to determine if the PMM thought the support was being provided, even if there was a sentence or two describing some of the aspects of the provision of the support. A definitive yes/no should be provided for each support. • When a support is not being provided fully or at criterion, more detail is needed in the report, such as the provider's response and plan. This does not need to be lengthy; it can be done with just a couple of sentences. • It was great to see some of the assertive actions taken by the PMM as noted above. This needs to extend to other important areas of support for individuals, too. The PMM should be relentless in ensuring that supports are being provided as intended by the PST. Examples of where more action should have been taken are below. o Day programming and work activities were boring and meaningless for some individuals. Even if the individual and PST did not fully understand the amount of time it would take to find employment, the PMM should step up her activities when this support is not being provided. Individual #351 provided a salient example. Work and stimulating activities were noted as being very important to her success. At the 7-day post move monitoring, Individual #351 reported that she was already frustrated with her day program. When observed by the monitoring team during the onsite review, more than a month later, she was still without work and bored. This boredom and frustration could lead to behavior problems that could threaten her placement. o Further, also for Individual #351, there was indication that she hadn't had the opportunity for many leisure activities and that the she was not happy with her diet and the way her food was prepared. To the reader, this individual did not appear to be having an active and good life in the	

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		community. The PMM should indicate the responses of both the day and residential providers to these types of conditions. o The PMM noted that Individual #51's home was "… an older home and in need of some repairs…" and that the patio furniture was old and in need of repair or replacement. The monitoring team could not agree more and, moreover, noted these same observations when visiting the same home for another individual during the previous onsite review. Sitting on the patio was an important and preferred activity for this individual. Newer, cleaner, and better furniture should be provided for him. o Individual #51's medication pills were found hidden in his bedroom on more than one occasion, and his bed elevation was not being done correctly. More follow-up should have occurred for both of these supports. On the other hand, the post move monitoring of Individual #334 indicated that the PMM monitored whether PNM supports were being followed by using a detailed list provided by the facility. Further, the PMM monitored whether visual supports were being provided by using a list of sighted guide techniques. These lists were good examples of the type of criteria that could be included in future CLDPs when the PST is determining essential and nonessential supports and the type of evidence required to indicate their provision. Also, the post move monitoring reports for Individual #195 were very detailed and provided the reader with a good description of his transition, activities in his new placement, provision of his supports, and addressing of his concerns. He appeared to be having a very good life in the community. In summary, SGSSLC had made progress and is likely to achieve substantial compliance with this provision item in the near future.	
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	As noted above in section T2a, post-move monitoring visits were occurring at SGSSLC. The monitoring team had the opportunity to accompany the PMM on two post move monitoring visits, one to a day program for the 45-day review for Individual #351 and one to a residence for the 90-day review for Individual #51. The purpose of these visits was to learn about the post-move monitoring process, see the community home and day programs, meet the individuals, learn about transition and services, and see the status of some of the essential and nonessential supports. The monitoring team wishes to thank the PMM and the community agencies for making arrangements for this visit to occur.	Noncompliance

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	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.	Also attending the day program visit were the APC and the facility's QA staff member who was assigned to most integrated setting practices. Individual #351 attended the Concho Resource Center in San Angelo. It was a day habilitation program that also claimed to have work opportunities. The program director, Ted Fluff, described the program and was very responsive to the PMM and the monitoring team. Individual #351 was observed in a large room with approximately 30 other individuals and two staff (i.e., 1:15 ratio). After initial greetings, she joined the PMM, program director, day habilitation instructor, and monitoring team for the post move monitoring visit. She said she was "not doing much of nothing." She wanted a job; she said was used to working, like she did at SGSSLC. Apparently, during the transition planning, Individual #351 was told that it might take a while for a job to be identified for her and she had said she'd understood. Nevertheless, there was no job in sight any time soon. DARS had been contacted and the program was expecting that she'd have an assessment at some point and the program director thought she would be a good candidate for community employment. The program director said that they had an ironing job she could do, and that he thought her PST had recommended it. Individual #351, however, said she never was, and was not now, interested in that. It appeared to the monitoring team that many individuals (and perhaps PSTs) do not fully understand the impact of a long wait for employment, especially if it requires them to be in a day setting that is boring and below their capabilities for weeks and weeks. Consider that Individual #351 spent eight hours a day, five days per week, in a place that was not interesting, stimulating, or appropriate for her needs and desires, was not furnished or maintained very well, and that offered her few new opportunities. The program did not do individual community job placements, so Individual #351 had no other alternative, but to wait for DARS. The monitoring team learned, however, that another day habilitation program provider in San Angelo did help individuals look for community employment. Perhaps that would be a better day program for this individual. The program director and day habilitation instructor said that Individual #351 was doing great, responded to instructions and redirection, and was a pleasure to have in the program. The monitoring team hopes that Individual #351 can maintain this cooperativeness until appropriate day activities and employment can be established. Interestingly, the PMM did not look at the provision of any specific supports because the only support in the CLDP that were related to the day program was the training of new staff. The program did not have any new staff since Individual #351's transition, so there was nothing to specifically monitor. The inclusion of a support directly related to employment would have allowed the PMM to specifically address employment. Even so,	

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		as indicated in T2a above, the PMM is empowered to intervene, strongly if necessary, to ensure that each individual is receiving all needed and appropriate supports and services. The monitoring team also visited the home of Individual #51. Coincidentally, he lived in the same home as the individual whom the monitoring team visited during the previous onsite review. The provider was D&S Residential Services. The home had a new house manager. The house manager had only worked there for four months, however, she was an experienced manager and had many good idea for program improvements. The PMM met with the individual, the house manager, and the residential director to do the post move monitoring. The home remained worn and in need of repair and upgrades (see T2a above and the previous monitoring report). Individual #51's bedroom had three out of four light bulbs burned out, the rug was stained, his dresser was broken, the walls needed painting, and there were few wall hangings. His clothing in his closet, however, was neatly hung. The home's living room had light bulbs out, the kitchen cabinets needed repair and painting, the appliances were old, the refrigerator was missing a door handle (though the inside was clean and contained food), the dining room chairs were wobbly and mismatched, the curtains in the home were cheap and flimsy, and the curtain to the porch was stained. In the backyard were the same torn worn patio chairs described in the previous report. The PMM went through each of the items in the CLDP, one by one. For all items, she asked the provider to describe the status. For many items, she requested documentation. For some items, however, she did not actually go and observe their presence. Instead, she relied upon verbal reports from the provider staff (e.g., 1H regarding locked toxics, 1J regarding transportation). To meet substantial compliance with this provision item, every support must be directly observed, including those that were "in place" during the previous one or two post move monitoring visits.	
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	This item does not receive a rating.	

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	a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	There were no discharges during this review period that met the criteria for this provision item.	Not rated

Recommendations:

1. Implement updated DADS policy on most integrated setting practices, when it is disseminated.
2. Revise facility policies to be in line with the updated DADS policy.
3. Create a facility plan to address those referrals that are more than 180 days old.
4. Identify those individuals who have requested placement, but have not been referred.
5. Implement a process of review for each of these individuals who have requested placement, but have not been referred (e.g., Placement Appeal process).
6. Examine the status of individuals who would have been referred, but weren't, solely because of the absence of the MRA.
7. Identify those individuals who would have been referred except for the preference of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference but whose PSTs would otherwise have referred.
8. Ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. Professional determination is separate from both the preference of the individual, the LAR, and the opinion of the PST as a whole.
9. Implement the more-structured LOD as per the revised state policy (the APC will need to collaborate with the QMRP coordinator).
10. Create more consistency in amount of information included in the LOD sub-section of the written PSP.
11. Demonstrate individualization when skills are chosen for training objectives, especially for those who are referred for placement.
12. Identify and address obstacles to referral and to placement at an individual level.
13. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g.
14. Assess content and criterion for the three self-assessment tools being used for this provision.
15. Implement observational monitoring of PSP meeting LOD.
16. In the PSP, describe what activities were taken over the past year, and what activities were to be taken during the upcoming year, to educate the individual and/or his or her LAR regarding community placement.
17. Address the list/criteria regarding T1b2 to be generated by DADS central office in the next few months.

18. Summarize and graph all relevant data from the Admission and Placement department's activities (see list in T1a and T1f).

19. Include Admission and Placement data in the facility's QA program.

20. Provide Admission and Placement department data and information to senior management.

21. CLDP should describe how the facility and provider will collaborate so that the provider and staff can become knowledgeable about the individual's numerous plans.

22. Essential and nonessential supports chosen from a wide range, defined correctly, and evidence given.

23. Ensure essential and nonessential supports specifically include the individual's most important preferences and the most important supports and services noted by the PST.

24. Be very thoughtful about the day programming and employment aspects when planning for an individual's transition, especially the amount of time it may take for an appropriate day/employment arrangement to be put in place for the individual.

25. Improve post move monitoring process by including (a) a yes/no indication, (b) more detail when a support is not being provided adequately (e.g., include the provider's response and plan), and (c) more assertive action regarding aspects of support provision that are not adequate.

26. Observe the presence of every support when doing post move monitoring.

The following are offered as additional suggestions to the facility:

27. DADS should provide feedback and suggestions on the facility's CLDPs to the APC. In addition, 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 eventually being necessary. Also, consider reviewing CLDPs at various stages of the process because the CLDPs were now to be initiated at the time of referral.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o SGSSLC Plan of Improvement updated 5/9/11 o SGSSLC Policy: Informed Consent dated 5/10/2002 o Guardianship Committee Minutes 4/13/11 o Ethics Committee Minutes 1/20/11 and 1/26/11 o Human Rights Committee Minutes for the past six months o A sample of Determination for Need of Guardian Priority Tool completed for 63 individuals o Section U presentation book regarding progress towards compliance o List of individuals for whom an LAR had been obtained since 10/1/10 o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans and Rights Assessment for: • Individual #59, Individual #276, Individual #287, Individual #94, Individual #90, Individual #34, Individual #236, Individual #367, Individual #12, Individual #151, Individual #44, Individual #331, Individual #327, Individual #365, Individual #295, Individual #382, Individual #247, Individual #313, Individual #126, Individual #186, Individual #232, Individual #210 and Individual #226. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; o Michael Davila, QMRP Coordinator o Roy Smith, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 5/24/11 o Daily Incident Management Meeting 5/24/11 and 5/26/11 o Human Rights Committee Meeting o Annual PSP meetings for Individual #169 and Individual #134
	Facility Self-Assessment: The facility's POI indicated that the facility had assigned a rating of noncompliance to both items in this provision and were waiting on the new state policy to address consent and guardianship issues. 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 and training before taking most actions, the monitoring team reviewed a small sample of documents in order to be able to assess progress, if any, from the previous review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • The Rights Officer had met with the QMRPs regarding the determination of informed consent and pursuance of guardianship by family members. • A self-determination/self-advocacy course and a conflict resolution course were offered by the psychology department for individuals at the facility. • Local resources for obtaining advocates was explored • The Guardianship Committee continued to meet and discuss guardianship issues. • The Human Rights Committee continued to meet and review all restriction of rights.

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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	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. The facility did have a procedure in place for determining need for guardianship. They continued to use 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,	Noncompliance

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	potential guardianship resources.	At the last review, 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 • 46 were non-priority • 28 were priority I • 25 were priority II • 18 were priority III PSTs continued to assign a priority rating for guardianship at annual PST meetings. As of 3/31/11, 226 individuals had been rated for need of guardianship. The ratings were as follows: • 86 had guardians • 69 were non-priority • 29 were priority I • 28 were priority II • 14 were priority III In 23 PSPs reviewed, there were 17 individuals (74%) who did not have guardians. Determination for need for guardianship forms were completed on 12 of the individuals in the sample. The PST documented at least minimal individualized discussion regarding the need for guardianship in 22 of the 23 PSPs reviewed. • Individual #186 did not have an LAR or advocate. She had very little contact with her family. Her PSP indicated that she was in need of a guardian due to being high risk for abuse, neglect, or exploitation. The team noted that she had serious ongoing medical and psychiatric issues. The PSP indicated that the team had made a referral to the guardianship committee. She did not have a Determination for Need of Guardian Form and her name did not appear on the facility's priority for guardianship list. • Individual #126 did not have an LAR or advocate. Her PSP indicated that the team had made a referral to the Human Rights Officer for guardianship. She appeared on the facility priority for guardianship as a priority I. • Individual #236 did not have a guardian. Her PSP stated that the facility administrator gave informed consent in all areas for her. A referral was made to the guardianship coordinator for a guardian. She appeared on the facility's priority for guardianship list as a priority II. • The PSP for Individual #44 indicated that the team had completed a Determination for Need of Guardian Tool. Based on the assessment, she was referred to the Guardianship Committee and assigned priority I status.	

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		• Individual #59 did not have a guardian. His sister was minimally involved in his life. His PST had determined that he demonstrated minimal understanding of his rights. There was no discussion in his annual PSP regarding the need for guardianship. He appeared on the facility's priority guardianship list as a Priority II. • Individual #365's PSP indicated that he did not have a guardian. The team had completed the Determination for Need of Guardian Tool and he was not in need of a guardian. He agreed that he did not need a guardian at this time. • Individual #367 did not have a guardian. His PSP noted that the PST feels that he would benefit from a guardian to assist him in decision-making. The team had completed a Determination for Need of Guardian tool. He was listed as a Priority I for guardianship o the facility's need for guardianship list. • Individual #276's PSP indicated that he had no guardian, but advocated for himself, so did not need a guardian. • Individual #151 did not have a guardian. According to his PSP, he advocated effectively for himself and his mother also acted as an advocate on his behalf. He was listed as a priority III on the facility's need for guardianship list. • Individual #287's PSP indicated that the team had completed a Determination for the Need for Guardian tool and he was in need of a guardian. His Rights Assessment indicated that guardianship had lapsed. He was listed on the facility's priority guardianship list as "no need, has a guardian." His status needs to be updated on the facility list. • The PSP for Individual #94 stated that she did not have a guardian and was not in need of a guardian at this time. She was listed as "non-priority" on the need for guardianship list maintained by the facility. The HRC had approved restrictions on owning property, freedom of movement, and handling her money. • Individual #226's PST indicated that he did not have a guardian or advocate. He had restrictions on his right to give consent and managing his money. The team had determined that he did not need a guardian at this time. He was listed as "non-priority" on the facility's need for guardianship list. A Determination for the Need of Guardian tool was not completed for him. • The PSP for Individual #382 indicated that she did not have a guardian. The document stated that the Director of SGSSLC acted on her behalf and gives informed consent in all areas for her in order to protect her from exploitation. The team agreed that this guardianship was adequate and continued to benefit her. She was, however, referred to the guardianship committee and determined to be a priority I need for guardianship. • Individual #90's PSP indicated that the PST had completed the Need of Guardianship Tool and determined that she had a priority II need for	

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		guardianship. The PSP noted that she had severely impaired communication skills and many health issues that placed her at high risk. Her family did not routinely visit her, attend meetings, or advocate for her. Her right's assessment indicated that she could not give informed consent in any area of her life. She should have been rated as a priority I for guardianship. • Individual #34 did not have a guardian, but his PSP indicated that his mother served as an advocate on his behalf. The PST determined that he was not in need of a guardian because he was able to make decisions for himself while consulting with other team members. He had a psychiatric diagnosis of dementia. The team needs to further discuss his ability to give informed consent. • Individual #12 was competent with no legal guardian. The PST completed a Determination for Need for Guardianship tool and agreed that he did not need a guardian because he advocated for himself. The PSP summarized discussion in regards ability to give informed consent and make decisions about his life. This was the most thorough discussion found in the sample of PSPs regarding the need for guardianship. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The Guardianship Committee acknowledged this and was looking at ways to educate team members regarding making more accurate determinations. The facility is not yet in compliance with this provision.	
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	SGSSLC was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific policies to address consent and guardianship. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. According to documentation provided to the monitoring team, there were no individuals at the facility who had obtained a guardian since 10/1/10. The facility did have some rights protections in place including an assistant independent ombudsman housed at the facility and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met 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 monitoring team observed the	Noncompliance

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	LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	HRC meeting held the week of the monitoring visit. The committee engaged in thoughtful discussion of all rights presented to the HRC. Individuals were encouraged to come before the HRC to discuss any proposed restrictions. At the meeting observed, individuals were active participants in discussion around restrictions. They had the opportunity to express any concerns prior to approval by the HRC. There was also an active Guardianship Committee at the facility. The monitoring team met with the Guardianship Committee and the committee raised many valid questions regarding issues around guardianship and individual's ability to give informed consent. The Guardianship Committee needs to seek guidance from the State Office in answering complex questions regarding rights, consent, and guardianship for individuals at the facility. 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.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR.

2. 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.

3. Seek input from the state office regarding complex issue addressing rights, informed consent, and guardianship.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SGSSLC policy: Active Record Guidelines, updated 5/19/11, by Marsha Jones, URC o SGSSLC Organizational chart, undated o SGSSLC policy lists, 4/8/11 o List of typical meetings that occurred at SGSSLC o SGSSLC POI, 5/9/11 o SGSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 5/23/11 o SGSSLC tables of contents active records and individual notebooks, updated 5/17/11 o Table of contents for the master record, updated 3/21/11 o List of all staff responsible for management of unified records o List of all home secretaries o Description of how documents flowed from completion to filing in records o All About Me screen shots from electronic system o New employee orientation materials related to recordkeeping practices o Minutes from home secretaries monthly meetings, 11/10 through 4/11 o Two spreadsheets that tracked the status of state and facility policies for each provision of the Settlement Agreement o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o Variety of documents related to new policies and their dissemination throughout the facility o Description of the record auditing procedures o Blank auditing forms used, updated blank auditing forms to be used beginning 5/11 o 10 completed audits January 2011 through February 2011: • active records (two forms), • individual notebooks, • master records, • attendance signature sheet for follow-up meeting between URC and PST o Recordkeeping department completed self-monitoring spreadsheet, 12/10 through 4/11 o Email regarding individual notebooks from Becky McPherson to the SSLCs, 12/9/10 o State draft questionnaire on use of records (for V4) o Questions and answers regarding auditing and interviewing for this provision, from Becky McPherson to the SSLCs, dated 4/19/11 o Active records of many individuals who lived at SGSSLC during observations in residences o Review of active records and/or individual notebooks of:

	• Individual #130, Individual #159, Individual #66 o Review of master records of: • Individual #61, Individual #251 <u>Interviews and Meetings Held</u>: o Marsha Jones, Unified Records Coordinator o Meeting with all of the home secretaries o Juanita Brake, Director of Client Records Department o Ruby Heldenbrand, Settlement Agreement Clerk o Penny Bivens, Settlement Agreement Coordinator o Numerous staff and clinicians during observations in residences <u>Observations Conducted</u>: 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, was submitted to the monitoring team. The POI was revised since the last onsite review. The new version was shorter and appeared to be useful to the facility. The monitoring team, however, learned that an updated and improved POI format has been recently created. Its goal is to more adequately describe actions taken and actions planned, directly in line with each provision item. This sounds like it will be a good improvement. The current POI listed in the comments section the activities taken by the URC and the facility each month towards achieving substantial compliance. Continued progress was described, fairly accurately describing many of the actions taken at SGSSLC. The self-ratings were, as expected, noncompliance for all four provision items. The monitoring team agreed with these self-ratings, however, noted the progress that was made since the previous onsite review.
	Summary of Monitor's Assessment: Overall, SGSSLC had made continued progress towards achieving substantial compliance with the items of this provision. Moreover, the unified records coordinator was responsive to many of the recommendations and suggestions made in the previous monitoring report. 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. The new set of records followed the state's policy.

	The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. Areas for improvement included ensuring that all medical consultation documents were in the active record and that entries in the integrated progress notes were legible, with a legible signature, and with the clinician's credentials included. Individual notebooks were also in place for each individual. The facility had followed the state's new procedure of allowing the SSLC to determine how it wanted to handle individual notebooks. That is, the state no longer required individual notebooks, however, the requirement did remain that relevant information and data collection tools had to be readily available to direct care staff. SGSSLC chose to have individual notebooks for each individual, however, the notebooks would only follow some individuals all day (three homes) whereas the individual notebooks were to be kept in the records room in all of the other homes. As noted below, the facility will need to demonstrate that direct care staff do have information and data collection readily available to them. The master records continued to be maintained appropriately by the director of client records. A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. Two new spreadsheets were being used to manage and track the existence and development of both the state and the facility policies for each provision of the Settlement Agreement. State central office had recently taken a much more hands on approach in managing, directing, and supporting the facilities to have appropriate facility-specific policies for all Settlement Agreement provisions. The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of all three components of the unified record were conducted by the unified records coordinator. Items needing correction were noted in the comments column of the review tool. A systematic way to provide PST members with feedback on corrections that were needed (e.g., missing documents, out of date documents) was not yet in place. SGSSL had not yet taken any steps towards ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4. More guidance is expected from central office over the next few months. The recordkeeping department was not, but now should be, collecting data on its own performance and submitting those data to QA to be part of the facility's QA program.

#	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.	SGSSLC demonstrated continued improvement towards meeting substantial compliance with this provision item. Overall, the department had made a lot of progress since the last monitoring review. The DADS policy remained in effect. In addition, the SGSSLC facility-specific policy, called "Active Records Guidelines" was updated and approved on 5/19/11. The facility-specific policy addressed additional detail that was specific to the facility regarding recordkeeping practices, such as use of the individual notebooks. This policy was a succinctly written and appeared to be useful to facility staff. Every individual was reported to have unified record. The URC and the home secretaries were now focusing on maintaining these records. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record • Overflow files Tables of contents for the active records and individual notebooks were updated by DADS central office. SGSSLC, however, continued to adapt these, as appropriate, for their own facility. Facility-specific differences from the state standardized table of contents were indicated by using bold italic font. The URC obtained approval from DADS central office before adding any items. She did not get approval before deleting any items, though this should also be approved by central office. Recordkeeping activities continued to be managed primarily by the experienced and dedicated Unified Records Coordinator, Marsha Jones. In addition to her regular responsibilities, she worked to increase the quality of the conduct of recordkeeping throughout the facility in a number of ways, some of which are listed below: • The URC conducted a session of new employee orientation so that new staff would be trained on recordkeeping practices. • The URC showed the monitoring team the facility's computer-based "library" system that contained lots of information about each individual in the "All About Me" section. This was one way that for the URC to look for documents as part of her completion of auditing responsibilities (see V3 below). Moreover, this system played a role in sharing and coordination of data, reports, and information across the facility. • The monitoring team had the opportunity to meet with the group of home secretaries. At SGSSLC, they were responsible for the maintenance of the active records and individual notebooks. They were a lively and engaged group who	Noncompliance

#	Provision	Assessment of Status	Compliance
		appeared to be committed to doing their jobs correctly and professionally. Each secretary managed two homes. There were 18 homes on campus. Currently, two secretary positions were vacant. The URC met with the group of home secretaries each month beginning November 2010. This was a great idea and seemed to serve to improve communication and consistency. • The URC reported that she had an excellent working relationship with the QMRPs and the psychology department. Over the next few months, she planned to spend more time with the medical and nursing departments. • The URC was responsive to the comments and recommendations in the previous monitoring report (though, as would be expected, not all were yet implemented). The monitoring team recommends that the recordkeeping department begin to collect data on its own performance. To do so, the URC should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility. Examples include, but are not limited to: • Number of records reviewed per month • Average number of items that required correction per individual unified record • Number of incomplete corrections after a specified period of time (e.g., one month) These data should then be incorporated into the facility's QA program. <u>Active records</u> The new active records varied in size based upon the amount of information in the individual's record. Most records contained two or three three-inch binders. The active records were constructed following the order of sections from the state's table of contents. The home secretaries reported that they very much liked the new active record organization. The facility was going to be getting new binders for the active records and planned to create a four-binder active record for every individual. This created some confusion that the monitoring team was able to clarify during the onsite review. That is, individuals can have as many binders as necessary for their particular case. Thus, individuals might have two, three, or four binders. The important point is that the breaks between binders should be the same for all two-volume active records, three-volume active records, and so forth. Some aspects of the active records were addressed since the last onsite review. First, the use of three colored pens in the observation notes was reviewed and deemed acceptable	

#	Provision	Assessment of Status	Compliance
		by central office. Second, all binders were no longer required to be transported with the individual if only one binder was necessary. 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. For example, an RN casemanager reported to the monitoring team that the IPNs in the active records made it easy enough to get to everything he needed and it was easy to follow an individual's issues. Problems, however, were noted by the URC and by the monitoring team regarding legibility of signatures and the need for credentials to be included with the signature (e.g., RN). At the POI Interdisciplinary meetings, a physician noted that some of his reports were not making it into the active record. After some discussion, it appeared that the documents had a different header/title than other documents and that perhaps led to either misfiling or no filing. The URC should ensure that there is a system in place so that home secretaries know how to handle documents and reports for which the filing is unclear to them. The active records reviewed by the monitoring team were neat and well-organized. The state had improved the records by specifying (a) the minimum consent forms required and (b) more detail regarding what should be in the habilitation section. Similarly, the URC continued to struggle with: • determining what medical consultation documentation should be in each active record because these varied from individual to individual (e.g., cardiac, podiatry, vision). The monitoring team suggests that the URC find out if the facility's medical department keeps a list of these consultations and, if so, whether a copy can be obtained every month for their use during record audits. • determining what SPOs should be in the active record. She had been using the computer-based library, but it may be more expedient (and reliable) to look at the most recent PSP. <u>Individual notebooks</u> The DADS central office coordinator for recordkeeping practices sent a request for each SSLC to pick one of four individual notebook options. SGSSLC chose option #3, that is, to keep individual notebooks on the home unless the PST requests that the individual notebook go with the individual. The exception to this was for homes 516E, 516W, and 508A. For these three homes, the individual notebooks were to follow the individuals wherever they went. This appeared to be a good resolution to the question about individual notebooks raised during the previous onsite review.	

#	Provision	Assessment of Status	Compliance
		Further, the home secretaries reported that they really liked the individual notebooks because they did not have to interrupt ongoing programming. Further, staff worked in the individual notebooks and therefore spent less time filing in the active records, thereby keeping the active records neater and more organized. The individual notebooks reviewed by the monitoring team contained all of the required information. Data were, for the most part recorded through the previous shift. Even so, the monitoring team had a number of concerns about the ability of staff to accurately and reliably record important data if the individual notebooks were not available to them. For example, the monitoring team spoke with two direct care staff who were both employed for less than a year. They were energetic and engaged with the individuals. They both said that if they needed information they'd come back to the records room to look it up. When asked how they record data throughout the day if the individual notebooks are in the records room, one of the staff said she used a piece of paper. She then took a paper napkin out of her pocket. On it, written in pencil, was some information about the individual's day. The facility will need to demonstrate that data and information are accurately and reliably recorded. The monitoring team believes that this was also a requirement of DADS central office. SGSSLC should be prepared to discuss this during the next onsite review. <u>Master records</u> The master records continued to be managed by the director of client records. She reported that the psychiatrists, physicians, psychologists, and nurses often requested information. She handled all of the re-shelving of the master records if they were used by any of these clinicians. A standard table of contents was used for the SGSSLC master records. Two master records were reviewed, one for a more recent admission (Individual #61) and one for an individual who lived at the facility for many years (Individual #251). The master records appeared to be in satisfactory condition and maintained in a satisfactory manner. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	

#	Provision	Assessment of Status	Compliance
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. The facility-specific policies for each provision were at various stages of development at SGSSLC. The spreadsheet indicated who was responsible and the current status. For four of the policies, the spreadsheet noted "Do not operationalize." This did not seem to be in line with the guidance from central office and needs to be clarified and addressed, if needed. In addition, SGSSLC maintained a listing of all of its policies. It might be helpful to SGSSLC as it works towards meeting this provision item, to indicate which facility policies are meant to be the facility-specific policy for a specific Settlement Agreement provision. The monitoring team was very pleased to see the organized and systematic way that state office was going about managing facility-specific policies, that is, state office: • Required a facility-specific policy (or policies) for every Settlement Agreement provision • Required each facility-specific policy to be in line with the contents of the state policy • Required the facility to submit each facility-specific policy for approval • Provided feedback on the content of each facility-specific policy • Detailed these expectations in an email from the DADS SSLC director of operations, dated 3/15/11.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and	The SGSSLC URC had developed a system of reviewing the active records. Overall, the review system (called an "audit" by the facility) was going well and was likely to improve and become more consistent over the next few months. The audits utilized two forms for the active records and individual notebooks: the statewide tool of characteristics, and a version of the table of contents. The combined use of these two tools was a good way to conduct the reviews. The master records table of contents was used as a checklist for the reviews of the master records. A review of the documentation for the 10 audits submitted by the URC showed that a lot of detail was obtained regarding the record. Overall, these appeared to be thorough reviews by the URC. She had made many entries regarding missing or out of date	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	documents, absence of signatures, and so forth. Some of the items had an indication of (in bold font) of what action was to be taken, or what action had been taken by the URC or the PST member. It was unclear, however, as to how the actions were determined and how they were followed up, though it seemed likely that some, if not all, occurred during the post-audit PST meeting (see below). QA department staff were just beginning to do reliability checks of URC reviews using the self-monitoring tool. QA staff were not yet obtaining reliability using the full table of contents guidelines. At this time, five full audits were not being done consistently every month. As reported by the URC and as indicated in documentation, five were completed in both January 2011 and February 2011, but she was unable to complete full audits of five unified records in March 2011 or April 2011. The audits that were completed included all components of the unified record and were quite detailed and required a lot of time to complete, approximately four hours for each audit, according to the URC. A meeting with the PST and home secretary followed each audit review. This was an excellent idea and was also welcomed by the home secretaries. During this meeting, the URC reviewed the record audit, talked about any needed corrections and answered any questions. A training roster was signed and the home manager was then responsible to follow up and to do training as needed with home direct care staff. Even given the above actions, and as reported by the URC, the facility had not yet implemented any systematic procedure to notify PST members of required corrections, list the corrections in any organized manner, determine if the correction had been made, and verify its occurrence. This was not unexpected and was the next step in the development of the facility's overall unified record auditing review system. In addition, the URC should do some sort of summarizing of the data from the reviews in both a graphic/tabular format and in a short narrative that describes the highlights of the data. Moreover, the information should be tracked and trended over time and included in the facility's QA program. The information should include, for example, number of reviews conducted, number of items that needed correction, and number of outstanding corrections (see V1 above). The monitoring recommends that state office share best practices across facilities regarding unified record review and auditing practices.	

#	Provision	Assessment of Status	Compliance
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	DADS and SGSSLC had taken some first steps towards addressing this provision item. Much more work will need to be done, however, to determine what activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams presented, to DADS and DOJ, a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. One activity that the URC was planning to implement was the state's brief questionnaire of PST members regarding their use of the unified records. Another possible activity to consider might be to ask QI Council members to describe how each of their departments uses the records as per the requirements of this provision item. The answers might provide some direction to the recordkeeping department. These activities, however, are just one or two of a number of actions that each facility will need to take towards meeting this provision. 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. • Several homes, the monitoring team found the individual notebooks locked in the medication room (see K4). Several individuals were out at the gym, and their individual notebooks were left in the home. Several staff interviewed indicated the individual notebooks were not used as intended and not useful. • Primary care providers did not document in the integrated records on many occasions when documentation was required. There were many examples where there was a nursing entry stating that rounds were completed with the physician, but no documentation from the physician was found in the records. • Nurses' notes were not consistently documented in SOAP (Subjective and Objective (data), Analysis, and Plan) format, names and/or credentials were often illegible, and across all interviews with nursing staff members it was reported that records were not available on the homes when needed by the clinical professionals. • In clinic setting during the psychiatric clinic encounter, the individual's record was available and the psychiatric practitioner referenced the document as clinically indicated. • The lead psychiatrist has initiated a procedure to enhance documentation from multiple disciplines for the psychiatric quarterly follow-up to review the individual's diagnosis and medication regimen.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In some cases there was likely appropriate follow-up by the habilitation therapy clinicians, but the documentation was not consistent to track an issue or problem through to resolution or to clearly document that specific actions were taken, the outcomes and required monitoring.	

Recommendations:

1. Obtain approval from central office before deleting any items from table of contents of any component of the unified record.
2. Develop metrics (i.e., data, outcomes) for the recordkeeping department activities and regularly record these data.
3. Finish the task of moving the active records into new binders, as necessary.
4. Ensure the unified records contain legible signatures, and include credentials, as necessary.
5. Put in place a procedure so that a home secretary knows what to do if she come across a document that is unclear where or how to file because, for example, the header/title is incorrect, new, or different.
6. Complete task of determining what medical consultation documentation should be in each active record. To do so, it would be helpful if the URC could obtain a listing of each individual's medical consultations
7. When doing a record audit, the reviewer should look at the PSP to determine what SPOs should be in the active record.
8. Demonstrate how data are collected and recorded reliably and accurately if the individual notebooks are stored in the records rooms.
9. Complete the development of policies as described in provision item V2.
10. Clarify why four policies on the SGSSLC V2 spreadsheet are designated "do not operationalize."
11. Conduct the required number of quality assurance reviews (audits) per month (minimum of five).
12. Provide feedback to PST members regarding corrections that are needed as a result of each audit.
13. Develop a system to manage and track all of these needed corrections to completion.
14. Summarize/graph data on audit activities and findings, for review by senior management and inclusion in QA program (this is a subset of recommendation #2 above).
15. Ensure records are used in making care, medical treatment, and training decisions. With guidance from DADS central office, determine what activities and actions the facility must engage in. Determine a way to assess whether or not these are occurring (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced BY
AED	Anti Epileptic Drugs
AFO	Ankle Foot Orthosis
AIMS	Abnormal Involuntary Movement Scale
AMA	Annual Medical Assessment
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APRN	Advance Practice Registered Nurse
APS	Adult Protective Services
ARD	Admissions, Review, and Dismissal
ASAP	As Soon As Possible
AT	Assistive Technology
ATP	Active Treatment Provider
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Criminal Background Check
CBC	Complete Blood Count
CC	Cubic Centimeter

CCC	Clinical Certificate of Competency
CD	Computer Disk
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DCP	Direct Care Professional
DC	Discontinue
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
e.g.	exempli gratia (for example)
EEG	Electroencephalogram
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
ENT	Ear, Nose, Throat
EPS	Extra Pyramidal Syndrome
ER	Emergency Room
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation

FNP	Family Nurse Practitioner
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FU	Follow Up
FY	Fiscal Year
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
HCG	Health Care Guidelines
HCL	Hydrochloric
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HRT	Hormone Replacement Therapy
HRC	Human Rights Committee
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LOD	Living Options Discussion
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LVN	Licensed Vocational Nurse
MA	Masters of Arts

MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCV	Mean Corpuscular Volume
MD	Medical Doctor
Meq	Milli-equivalent
MG	Milligrams
ML	Milliliter
MH	Mental Health
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MRI	Magnetic Resonance Imaging
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
NGA	New Generation Antipsychotic
NOO	Nurse Operations Officer
NL	Nutritional
N/V	No Vomiting
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PET	Performance Evaluation Team
PFA	Personal Focus Assessment

Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PLTS	Platelets
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)
POI	Plan of Improvement
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QDRR	Quarterly Drug Regimen Review
QMRP	Qualified Mental Retardation Professional
QTR	Quarter
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RTA	Rehabilitation Therapy Assessment
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SGSSLC	San Angelo State Supported Living Center
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan

SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
STAT	Immediately (statim)
STD	Sexually Transmitted disease
STEPP	Specialized Teaching and Education for People with Paraphilias
TD	Tardive Dyskinesia
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
TT	Treatment Therapist
UA	Urinalysis
UII	Unusual In
UIR	Unusual Incident Report
US	United States
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VIT	Vitamin
VNS	Vagus nerve stimulation
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
YO	Year Old