United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

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Background

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

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

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

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

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

Methodology

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

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

(b) **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. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Interdisciplinary Team (IDT) meetings, discipline meetings, incident management meetings, and shift change.

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

Organization of Report

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

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

Substantial Compliance Ratings and Progress

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

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

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

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

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

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

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.

A number of senior staff had received promotions since the time of the last onsite review. As a result, there was a new facility director, new ADOP, new director of residential services, and one new unit director. All of these staff were promoted from within the facility and had many years of experience at SGSSLC. Partly as a result of these promotions, there was a vibrancy and optimism at the facility. The monitoring team shares this optimism and wishes the newly appointed administrators success in their new positions.

Specifically, the new facility director, Charles Njemanze, was extremely supportive of the monitoring team's activities throughout the week of the onsite review. The Settlement Agreement Coordinator, Misty Mendez, once again did an outstanding job in helping the monitoring team with its activities all week long, as well as the weeks prior to and after the onsite week. She was extremely knowledgeable about the facility and that experience was helpful to the monitoring team. Moreover, she played an important role in the facility's QA program and QI Council.

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. 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, below, are comments on a few general topics regarding service operations at the facility.

- Areas of lack of progress: Although there were many areas of progress, as detailed in the following report and as evidenced by some provision items being rated in substantial compliance for the first time, there were two areas in which there was a notable and serious lack of progress. These two areas will require considerable attention from the senior administration at SGSSLC if substantial compliance is to be obtained.
    - Medical: especially provisions L and G. There was a lack of progress and lack of preparation for this monitoring review, including absence of documentation, examples, and evidence of actions. Further, as a result of problems in medical, pharmacy and psychiatry services had to be supervised by other administrators.
    - Nursing: especially provision M. There continued to be problems in the organization and delivery of nursing services.

- Integration: There continued to be work towards integration of clinical services and it remained a salient topic for clinical directors. This was the case even though section G activities were not properly managed by the medical department.

- Outcomes: SGSSLC will need to ensure its QA program obtains and reports on important outcomes, measures, and indicators (sections E1 and E2). This will require working closely with all departments, especially medical services. For example,
    - The monitoring team noted an increase in the number of individuals diagnosed with diabetes.
    - TB test status of staff was not part of the QA program. This was discovered during the onsite review when it became clear that not all staff had TB testing done as required by state policy.

- Self-advocacy: The self-advocacy program remained an important part of the program of services at SGSSLC. The monitoring team continued to be impressed by the rights protection officer, Roy Smith, and his collaborative work with the assistant independent ombudsman, Melissa Deere, the residential staff, clinical staff, and administrators. As a result, individuals were learning to make group decisions, problem solve, and learn about transition to the community. The monthly self-advocacy meeting had become a learning experience rather than primarily an opportunity for individuals to complain about services without taking any responsibility or action to improve or fix those problems.

- Self-assessment: This was SGSSLC's first try at the new self-assessment process. Overall, there was good progress. Most discipline and Settlement Agreement provision leaders spent a good deal of time talking with the monitoring team about how to make the self-assessment process valid, meaningful, and in line with the

Settlement Agreement requirements. Most challenging will be developing a set of self-assessment activities for each provision that separates the fine distinction between activities to engage in to meet the requirements of the Settlement Agreement versus activities to engage in to assess whether substantial compliance is being met. More detail is provided below in each section of this report for each of the provisions of the Settlement Agreement.

Fourth, 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

- DADS updated the statewide restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The director of psychology had reviewed the new policies and had begun planning for implementation.
- Between 12/1/11 and 4/18/12, there were 438 restraints used for crisis intervention. This was a decrease in the number of restraints since the last monitoring visit, however, still showed that a large number of restraints were occurring. Seventy-three individuals were subject to restraints. There were 88 restraints for medical and/or dental treatment.
- Some mechanical protective restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. This needs to be corrected and, although not implemented yet at SGSSLC, there was a new statewide plan to do so, as part of the newly revised policies.
- Since the last monitoring visit, the facility director held meetings with all departments to emphasis the use of restraint as a last resort. He also attended new employee orientation monthly to emphasize the use of restraint as a last resort to new employees.
- In addition, staff responsible for restraint documentation and review had been retrained on documentation and reporting requirements, restraint documentation was being reviewed and returned for correction when errors were found, and the use of PRN psychotropic medications was discontinued.

Abuse, Neglect, and Incident Management

- DFPS confirmed 9 cases of physical abuse, and 31 confirmed cases of neglect from December 2011 through April 2012. There were investigations of 470 allegations conducted by DFPS at the facility during this time.
- An additional 79 other serious incidents were investigated by the facility, including three deaths.
- There were a total of 2051 injuries reported between 11/1/11 and 4/30/12. These included 33 serious injuries resulting in fractures or sutures. Documentation indicated that a large number of injuries were resulting from

behavioral issues, including peer-to-peer aggression. The facility needs to aggressively address trends in injuries and implement protections to reduce the number of incidents and injuries.

- Some positive steps taken included:
  - Developed and implemented a log to track protective actions recommended for each case of abuse, neglect, and exploitation.
  - Implemented a semi-annual audit process of homes for unreported injuries.
  - Added two additional investigator positions to the Incident Management Department.
  - Began providing an analysis report of the section D monitoring tool during the monthly Benchmark meeting.

Quality Assurance

- The QA department had made good progress towards creating a fairly comprehensive listing/inventory of data collected at the facility. It was managed as an electronic spreadsheet with 19 separate tabs. During the week of the onsite review, the monitoring team learned of two important sets of data that were missing from the data listing/inventory (a) data on staff TB test status and (b) number of individuals with diabetes.
- The SGSSLC QA narrative was an excellent first version. The QAD should now revise it to edit in all of the topics that are bulleted in E1. The QA matrix was also much improved from the previous report. Monthly benchmark meetings were initiated after the previous onsite review and continued regularly since then.
- QA staff program auditors were busy conducting and documenting observations and monitoring. SGSSLC was now using its own tools for sections N, F, and H.
- The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) and they need to be summarized. This was not yet occurring for all of the items in the QA matrix.
- There continued to be improvements in the QA report. The QA report had apparently become a regular and typical part of the QA program and QI Council.
- During the QI Council meeting observed by the monitoring team, provision leaders presented data and some commentary, but there was little to no discussion or participation from attendees. During the presentations by each Performance Improvement Team, there was more discussion.
- SGSSLC had a very good system of PITs. Corrective action plans (CAP) were readily and often created. As a result, there were many active (and many completed) CAPs at the facility. Not all CAPs, however, were implemented fully and in a timely manner or modified when needed.

Integrated Protections, Services, Treatment, and Support

- Progress had been made with regard to the facilitation of ISPs by one person from the team. The facility had begun to track data on attendance. Attendance by team members at annual ISP meeting was between 86% and 94 % for the four months audited; the lowest participation in team meetings was for vocational staff and OT/PT staff.
- The quality and timeliness of some assessments continued to be an area of needed improvement. A database to track submission of assessments prior to the annual ISP meeting was being used, and audits were conducted of clinical assessments for the inclusion of required elements. Even so, little progress had been made in ensuring that assessment results were used to develop, implement, and revise the ISP.
- Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences or that all supports were addressed in ISPs. While most plans included opportunities to take trips to the community, plans did not include action steps to ensure participation in a manner that would support continuous community connections, such as friendships and work opportunities.
- ISPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs.
- The IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues, however, it was not evident that team members were using data collected to drive revisions in teaching strategies or supports. Further, it was not evident that supports were revised when IDTs noted regression.

Integrated Clinical Services

- During each monitoring visit, the monitoring team conducts a meeting with the facility staff to discuss integration of clinical services and the minimum common elements of clinical care.
- The medical director served as lead for section G. There was little preparation for the interview, very few examples of integration were provided, statements were made without any examples or documentation, and almost no evidence was included in the presentation book.
- During the December 2011 review, the staff at SGSSLC exhibited a high level of enthusiasm regarding the concept of integration of clinical services. That enthusiasm was muted during this visit and the rate of progress appeared to slow down.
- The facility had not developed any guidelines or procedures to assist with this most important provision.
- Nonetheless, some progress was noted. The monitoring team encountered a few good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

Minimum Common Elements of Clinical Care

- A significant amount of progress was made in provision H1 because a great deal of thought and effort had gone into it and that was good to see.
- The appointment of the QA nurse as facility lead for this provision was a good decision because Provision H in many ways addressed issues related to quality. It did not require that disciplines complete new tasks, but rather required that the facility pull together information about many of the tasks that were already being completed.
- During discussions during the onsite review, it was clear that much work needed to be done in most areas, but the monitoring team believes that the facility lead was beginning to develop a good sense of what actions needed to occur. This was reflected in the QA nurse's action plans, which provided a detailed series of steps for each provision item. With direction from state office, the leadership of a very enthusiastic and competent QA nurse, and support from the facility director, SGSSLC should be able to make considerable progress over the next six months.

At-Risk Individuals

- Progress had been made to ensure all individuals were accurately assessed and action plans were in place to address risks. Even so, the facility was not yet in compliance with the three provisions in section I. Teams were still not accurately identifying risk factors and risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review.
- As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.
- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Plans should be implemented immediately when individuals are at risk for harm.
- The facility was still waiting on consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process

Psychiatric Care and Services

- SGSSLC provided psychiatric services by qualified physicians, however, continued to experience difficulty with the retention of psychiatrists. Fortunately, the facility secured the services of a contract psychiatrist who had additional subspecialty training in child and adolescent psychiatry.
- The psychiatric clinic included representatives from all disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings. Given the lack of clinical resources, the facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration since most provision items in this section rely on collaboration with other disciplines.
- In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation.
- The evaluation, diagnosis, and justification for treatment with medication were improving due to the development of the quarterly psychiatric review process, however, there were an inadequate number of psychiatric assessments completed.
- Psychiatry did not routinely attend meetings regarding behavioral support planning for individuals assigned to their own caseload, and was not consistently involved in the development of the plans. There were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, and collaboration regarding case formulation).
- There was the initiation of exchange of documentation between the psychiatrist and the community neurologist. The IDT inclusive of the psychiatrist, however, must routinely dialogue with the neurologist, as clinically indicated, to coordinate the use of medications when they were to treat both seizures and a mental health disorder.
- The facility made minimal gains in the area of informed consent. Psychology department was responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. The psychiatrists were receptive to being responsible for this medical duty.

Psychological Care and Services

- There were several improvements since the last onsite review. These included the regular occurrence of internal peer review weekly, and external peer review monthly, improved data collection, initiation of the collection and graphing of replacement behaviors, and the initiation of the collection of data reliability, and inter-observer agreement (IOA) data. In addition, there were improvements in the comprehensiveness of annual psychological assessments, the quality of PBSPs, and in the initiation of the collection of treatment integrity data.
- SGSSLC should next also work to ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts. The psychology department will also need to track data reliability, establish data reliability goals, and ensure that those levels are achieved; track IOA scores, establish IOA goals, and ensure that those levels are achieved; and track treatment integrity scores, establish treatment integrity goals, and ensure that those levels are achieved. In addition, they will need to increase the number of individuals with functional assessments and annual psychological assessments. All training of PBSP implementation should include a competency-based component.

Medical Care

- The medical department had taken no reasonable actions to demonstrate movement towards compliance with the Settlement Agreement in several medical service areas. The medical director was not prepared for meetings with the monitoring team and did not provide all of the information expected or requested.
- In previous reviews, the medical director had simply reported that the facility elected not to follow some recommendations. The monitoring team acknowledged that this was acceptable, however, compliance needed to be achieved through other mechanisms. The monitoring team found that little was done to address concerns related to DNRs, mortality reviews, and medical quality at the facility level.
- Even so, individuals received basic medical services. They also received immunizations, and vision and hearing screenings, but for the most part, they did not receive cancer screenings in accordance with facility and state medical policy.
- When problems were brought to the attention of the medical staff, they addressed them. All of the physicians were noted to respond promptly to concerns during the week of the review, and records indicated that they responded to the needs of individuals.
- Verbal orders were excessively utilized and many were never signed. There were many problems with medication orders due to incomplete orders and other issues. Treatments were provided to individuals through standard operating procedures, but in many instances, physicians never signed the orders. It was also not clear, in some cases, if they were aware of the individual's medical problem.

- Annual Medical Summaries were completed in a timely manner, but Quarterly Medical Summaries did not appear to be done as required. IPN entries were generally written in SOAP format, but were brief. Some providers included all positive and negative findings, while others did not. Most notes were legible.
- External and internal medical audits were conducted. Medical management audits were also conducted. Corrective action plans were implemented for both. The medical audits remained focused on processes with no assessment of the clinical outcomes for individuals.
- The medical department had not selected any indicators to be used as measures of medical quality, was not tracking key quality data and had not trained the medical staff on the clinical guidelines issued by state office. Based on comments made in interviews and documentation in the self-assessment, the medical director was certainly aware of the need to perform these important tasks.

Nursing Care

- All provision items of section M were in need of significant improvement in order to meet the requirements of the Settlement Agreement and Health Care Guidelines. There was a lack of progress in most areas. Nursing care was not being documented or delivered in accordance with generally accepted professional standards of care or in accordance with the protocols developed by the state and adopted by the facility.
- There continued to be problems ensuring the presence of adequate numbers of trained, competent, stable nursing staff members across the campus. There were numerous violations of basic standards of infection control occurring on a regular basis, as well as gross violations of basic health and safety practices.
- There continued to be lapses in tracking and recording individuals' basic health status information, such as their food/fluid intake, output, bowel movements, weight, and presence of triggers of aspiration. Although the absence of these data had, and continued to, negatively impact the delivery of individuals' health, medical, and rehabilitation services, to date, corrections had not been consistently developed and/or implemented. Thus, these problems persisted and they continued to jeopardize the health and safety of individuals served by the facility.

Pharmacy Services and Safe Medication Practices

- Significant progress was not seen in this area. The pharmacy staff did not adequately document the communications between pharmacists and prescribers and had not started the process of lab reviews prior to dispensing medications.
- A review of the most recent QDRR schedule indicated that the reviews may not have been completed in a timely manner. This was very unfortunate, because to the credit of the clinical pharmacist, the quality of the actual QDRR evaluations was the best seen since the compliance reviews began.

- The MOSES and DISCUS evaluations were not completed in accordance with state policy as the psychiatrists continued to complete both. The facility met some requirements with regards to ADRs and DUEs, but overall it failed to meet the requirements set forth in the Health Care Guidelines.
- Improvement was seen in some aspects of the medication variance system. The facility attempted to capture variances in all steps of the medication use system, but fell short by failing to report all medication errors particularly those that related to physician prescribing errors.

Physical and Nutritional Management

- There was a fully constituted PNMT, including a full time nurse. While the team met weekly, attendance was less than adequate by all team members (dietitian and physician). A meeting observed during this review showed improvement since the last review. Members of the IDT attended for the individuals they served. The setup of the room and the meeting format, however, led to a tone more of an inquisition by the PNMT rather than a collaborative review of the individual's status. Continued experience with the PNMT process will likely result in further refinement.
- The timeliness of the PNMT assessment and the implementation of necessary supports is a key element to the effective provision of services by the PNMT and should be tracked and analyzed. These data were not documented in the weekly meeting summaries or the assessments reviewed.
- The PNMT should examine PNM issues from a system perspective in conjunction with other groups or teams in the facility to ensure there is effective trend analysis of identified issues. Key clinical indicators and health risk status should drive identification of the need for PNMT supports and services. The documentation of routine reviews conducted by the PNMT did not consistently close the loop on identified concerns or the effectiveness of strategies implemented.
- Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to the environments and implementation of the dining plans, though there were issues noted, many of which should have been identified through monitoring by PNMPCs and professional staff. Staff continued to require coaching and supports for consistency with techniques and there were some food texture issues noted. Positioning was also improved. Overall, staff did not understand the relationship of individual risks and triggers to their duties and responsibilities, however, small number were exceptional in their knowledge of the individuals they supported.
- The majority (100%) of the PNMP monitoring sheets submitted reported compliance (80% or greater) with implementation of the PNMP. The excessively high scores did not correlate well with general observations. This issue should be addressed via training and inter-rater reliability checks for monitors.

Physical and Occupational Therapy

- Progress continued to be made and substantial compliance was achieved in provision P1. 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 (e.g., wheelchairs), and to review other supports and services.
- Assessments were reviewed and consistency for content was improved since the last review. Audits were completed by the department director for assessments completed by clinicians to establish competency for each. The reviewed assessment was to be corrected by the therapist prior to submitting to the IDT. Initially every assessment was audited until the therapist achieved 80% compliance, then one assessment was audited monthly. The clinician was expected to maintain the 80% compliance level. Scores averaged 84% and reflected a significant and consistent improvement in the quality of the assessments completed by the clinicians.
- There continued to be a very small number of individuals participating in direct PT and OT. Documentation was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process.

Dental Services

- The part time hygienist continued to work at the facility. This was a positive step for the facility because the full time hygienist at SGSSLC was largely responsible for administering programmatic services at the facility. A great deal of regression was noted at the December 2011 visit, so the hygienist returned to a program that lost significant ground since her departure in terms of suction toothbrushing, desensitization, and data collection.
- It appeared that individuals appeared to get the basic dental treatment they needed. Oral hygiene ratings improved, but the monitoring team had concerns about the data used to derive the overall scores. The suction toothbrushing program improved and this was certainly good to see, particularly because it demonstrated good integration of clinical services.
- Annual assessments, for the most part, were completed in a timely manner, but the monitoring team found some discrepancies in data.
- The facility must address issues related to data management. The clinic attempted to present a great deal of data, but there were problems with this. First, not of all the data were continuous. For several data sets, there were no data reported for three or four months. Second, the dental clinic presented data in multiple formats. That is, the same type of data was presented in different formats each month, which made month to month comparisons very difficult. Third, the various documents were inconsistent and contained many inaccuracies.

Communication

- The existing clinicians appeared to be strong in their knowledge, skills, and enthusiasm for developing effective, functional, and meaningful communication supports for individuals.
- SGSSLC was conducting audits of the assessments previously completed for individuals who were considered to be Priority 1 and, if compliance with those assessments was less than 80%, the assessment would be redone. Audit scores were reported to be below the 80% compliance benchmark established.
- The clinicians reported difficulties with implementation of AAC related to inconsistent use throughout the day. Communication Plans were provided for staff reference. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff.
- On the other hand, there were success stories, such as Individual #183. He had been unable to go to work for the last year due to challenging behaviors. The SLP in conjunction with other team members developed an AAC system that consisted of a schedule to guide the length of time he stayed on task at work, as well as a token system to provide reinforcement at intervals until his payday. This had been effective and resulted in his transition from on-home work initially to a full return to the worksite.
    - This collaboration was an excellent example of the potential for creative solutions to issues or barriers identified for individuals.

Habilitation, Training, Education, and Skill Acquisition Programs

- Improvements since the last review included the beginning of the integration of Skill Acquisition Plans (SAPs) into day programming, and improved data reflecting the training of SAPs in the community (S3).
- The facility needs to focus on actions to ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference and ensure that each SAP has an individualized plan for maintenance and generalization. The staff responsible for SAPS will need to simplify the collection of engagement data, ensure that it is collected in all homes and day programs, and summarized and shared with managers responsible for improving engagement.
- Decisions concerning the continuation, discontinuation, or modification of SAPs need to be based on outcome data. The facility should collect and track SAP integrity measures, expand the number of SAPs in day programming, and establish acceptable percentages of individuals participating in community activities, and training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- SGSSLC continued to make progress towards substantial compliance. The specific numbers of individuals who were placed remained extremely stable, at an annual rate of approximately 10%, and approximately 11% of the individuals were on the active referral list. 12 individuals were placed in the community since the last review. 26 were on the active referral list.
- Opinions and determinations of professionals regarding community placement were not being adequately presented in the ISP. No special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. A new class, however, was created, called Community Re-entry.
- SGSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs.
- IDT members continued to be very involved in the placement activities of the individuals. They took action when necessary. For example, the IDT abandoned one possible provider when the proposed home turned out to be in a very bad neighborhood. Another individual visited numerous providers, two times each, before a decision was made.
- The CLDP meeting held during the week of the onsite review was a great improvement in content, style, and participant involvement compared to the one observed during the last onsite review.
- The lists of ENE supports still needed more work because a number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included. The amount of items missing, however, was improved since the last onsite review.
- 34 post move monitorings for 15 individuals were completed. This was 100% of what was required. All 34 (100%) occurred within the required timelines. This was no easy feat given the locations of day and residential sites all over the state (e.g., Houston, Amarillo). All 34 (100%) were documented in the proper format.
- Of the 15 individuals who received post move monitoring, 10 (67%) appeared to be doing very well and having a great life. Many of the post move monitoring reports noted that families were very happy to have their loved one nearby. Three individuals (20%) had experienced some problems, but these seemed to be resolving. One individual was doing very badly, including being moved from her group home for placement with her mother, and one individual died at around the time of the 90-day review.

Consent

- Positive steps were taken in regards to consent and guardianship issues. The Rights and Protection Officer continued to work with families applying for guardianship and maintained contact with community resources for guardians and advocates. A letter was sent out to 55 past employees of SGSSLC regarding opportunities to become advocates for individuals at the facility.

- In addition, a check sheet had been developed with a series of questions to prompt IDTs to evaluate each individual's ability to give informed consent during the annual ISP meeting, and a prioritized list for individuals who need guardians had been updated. The Rights and Protection Officer continued to provide training and support to IDTs regarding guardianship and rights.
- Even so, the facility had not yet completed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs were not adequately addressing the need for a LAR or advocate.
- The Human Rights Committee continued to meet and review all restrictions of rights.
- The facility had a self-advocacy group comprised of individuals residing at the facility.

Recordkeeping Practices

- SGSSLC demonstrated continued progress with this provision item. Overall, the active records were organized and well maintained. IPNs and observations notes had improved. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. Frequently, there were items in the IPNs or in the observation notes that did not belong there.
- SGSSLC continued to use individual notebooks successfully. SGSSLC maintained the same satisfactory system of managing the master records. The staff had not, however, resolved what to do about items that should be in the master record, but were not.
- The URC continued to do a thorough job conducting quality assurance audits of the unified record. She completed five each month, as required. In addition, the home secretaries, the unit directors' secretaries, and the QA staff conducted reviews.
- Overall, the monitoring team was satisfied with the audit procedures, however, to achieve substantial compliance, the URC should consider developing a new audit tool that incorporates the components of the statewide tool and the table of contents tools. A list of medical consultations also needs to be created so that the URC knows what to look for in the medical consultation section of the active record.
- The URC recently received the list of actions and topics that were now to comprise V4.

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 looks forward to continuing to work with DADS, DOJ, and SGSSLC. Thank you for the opportunity to present this report.

II. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy: Use of Restraints 001.1 dated 4/10/12 o SGSSLC Self-Assessment o SGSSLC Provision Action Information Log o SGSSLC Section C Presentation Book o SGSSLC Policy: Management of Inappropriate Behavior dated 3/30/95 o SGSSLC Policy: PMAB Investigations dated 7/9/99 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines dated 9/9/05 o SGSSLC Policy: Response to Behavioral Emergencies dated 9/3/10 o SGSSLC Policy: Restraint Notification Process and Responsibilities of Restraint Monitors and Health Care Professionals dated 3/31/11 o SGSSLC Policy: Consumer Emergency Relocation dated 12/3/04 o SGSSLC Policy: Physician's Notification and Orders for Use of Restraint 12/18/09 o FY12 Restraint Trend Analysis Report o Sample of IMRT Minutes o SGSSLC QA/QI Council Quality Assurance Report o List of all restraint by Individual 12/1/11 through 4/18/12 o List of all chemical restraint used for the past six months o List of all medical restraints used for the past six months o List of all restraints used for crisis intervention for the past six months o List of all mechanical restraints for the past six months o SGSSLC "Do Not Restrain" list o List of individuals with desensitization plans o Desensitization plans for Individual #7, Individual #18, Individual #217, and Individual #130 o Restraint Reduction Committee meeting minutes for past six months o Training transcripts for 24 SGSSLC employees o Documentation for medical restraints for: • Individual #126 (x4), Individual #367, Individual #38 (x2), Individual #294, Individual #384, and Individual #389 o ISPs, PBSPs, and ISPAs for: • Individual #9, Individual #116, Individual #346, Individual #189, Individual #24, and Individual #59, Individual #215, Individual #34, Individual #241, and Individual #292

- A sample of restraint documentation for crisis intervention including:

Individual	Date	Type
#9	4/18/12	Chemical
#9	4/18/12	Physical
#9	4/18/12	Chemical
#9	4/17/12	Physical
#9	4/17/12	Chemical
#9	4/17/12	Physical
#9	4/16/12	Physical
#9	4/15/12	Chemical
#116	4/6/12	Physical
#116	4/3/12	Physical
#116	4/3/12	Physical
#116	2/27/12	Physical
#116	2/8/12	Physical
#116	2/5/12	Physical
#346	4/16/12	Chemical
#346	4/16/12	Physical
#346	4/9/12	Chemical
#346	4/4/12	Physical
#277	2/22/12	Physical
#277	1/7/12	Physical
#208	3/17/12	Physical
#208	3/3/12	Physical
#280	4/3/12	Physical
#280	4/3/12	Physical
#52	3/8/12	Chemical
#189	4/18/12	Chemical
#59	4/18/12	Chemical
#24	4/18/12	Chemical

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Dana Robertson, Provision Coordinator
- John Church, Psychologist
- Jalown McCleery, Incident Management Coordinator
- Michael Davila, QDDP Coordinator
- Michael Fletcher, QDDP Educator

	Observations Conducted: o Observations at residences and day programs o 505B IDT Meeting 6/5/12 o 511B Home Meeting 6/5/12 o Unit I Morning Meeting 6/6/12 o Incident Management Review Team Meeting 6/6/12 o Annual ISP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting o Restraint Reduction Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment. It was updated on 5/1/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. Findings from the facility's audit process were similar to those found by the monitoring team. The facility self-assessment commented on the overall compliance rating for each provision item, based on the sample of restraint documentation audited, as well as, commenting on processes in place to address compliance with each item. The monitoring team agreed with the facility's self-ratings. The facility had met substantial compliance with C2, C3, and C6. The other five provisions in section C were rated as noncompliant. Although this was still a fairly new process for the facility, it appeared that the facility had an effective self-assessment process in place for determining compliance with section C requirements.
	Summary of Monitor's Assessment: DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The facility had reviewed the new policies and had begun planning for implementation. Based on information provided by the facility, there were 438 restraints used for crisis intervention

	between 12/1/11 and 4/18/12. There was a significant decrease in the number of restraints reported compared to the previous five month reporting period when 528 restraints were reported. Seventy-three individuals were subject to restraints. This was still a large number of restraints. The facility did not show a commitment to using restraint as a last resort measure for crisis intervention. From 12/1/11 through 6/1/12, the facility reported 88 incidents of restraint used for medical and/or dental treatment. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility reported that no individuals received pretreatment sedation prior to dental procedures from 12/1/11 through 6/1/12. During observation at the facility, it was found that some protective mechanical restraints were not routinely reviewed by IDTs or reported in terms of restraints at the facility. This needs to be corrected and, although not implemented yet at SGSSLC, there was a new statewide plan to do so, as part of the newly revised policies. Action taken by the facility to address compliance with section C since the last monitoring visit included: • The director of the facility held meetings with all departments to emphasize the use of restraint as a last resort. He also attended new employee orientation monthly to emphasize the use of restraint as a last resort to new employees. • Staff responsible for restraint documentation and review had been retrained on documentation and reporting requirements. • Restraint documentation was being reviewed and returned for correction when errors were found. • The use of PRN psychotropic medications had been discontinued. • IDT meetings held for more than three restraints in a rolling 30-day period were being reviewed to ensure documentation included all required information. • An action plan was developed to address deficiencies noted in the last monitoring team report. • The new statewide restraint policy was adopted and implementation had begun. The facility had made progress in meeting compliance with requirements for documenting and reviewing restraint usage. Substantial compliance was found with three of the eight provision items.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The facility provided a list of all restraints between 12/1/11 and 4/18/12: • 449 restraints occurred. • 438 were for crisis intervention. • 73 individuals were subject to restraints. • 31 (42%) of 73 individuals only had a single restraint during the reporting period. • 4 individuals accounted for 205 restraints (46%). • 14 restraint incidents resulted in injuries to individuals. • 320 were personal hold restraints; • 113 were chemical restraints; • 3 were mechanical restraints; • 11 were chemical pretreatment sedation administered prior to medical treatment; and • 2 were listed as "other." The new statewide restraint policy required that: • Restraints were not to be used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used. • Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of 28 restraints for 10 individuals. There were 18 physical restraints and 10 chemical restraints. Three of the individuals in the sample were the three with the greatest number of restraints. Seven others were randomly selected. The individuals in this sample were Individual #9, Individual #116, Individual #346, Individual #277, Individual #208, Individual #280, Individual #52, Individual #189, Individual #59, and Individual #24. • Individual #9 had the greatest number of restraints, accounting for 82 (18%) of the 438 restraints for crisis intervention between 10/1/11 and 3/31/12. • Individual #346 had the second greatest number with 46 (11%) of the restraints. • Individual #116 had the third greatest number with 40 (9%) of the restraints.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Prone Restraint 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 a review of 18 physical restraint records for individuals in Sample #C.1 involving six individuals, 0 (0%) showed use of prone restraint. Other Restraint Requirements 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 documentation for 28 restraints. The following are the results of this review: • In 28 of the 28 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 24 of 28 (86%) restraints, staff documented events leading to the behavior that resulted in restraints. Exceptions included restraint checklists for: o Individual #99 dated 3/23/12, Individual #74 dated 1/9/12, Individual #116 dated 2/27/12, Individual #346 dated 4/9/12, and Individual #277 dated 1/7/12. The behavior leading to the restraint was documented, but not what occurred prior to the behavior. • Some examples where staff adequately described events leading to the behavior were: o The restraint checklist for Individual #280 dated 4/3/12 noted she became upset because she missed her grandmother. o The restraint checklist for Individual #52 dated 5/8/12 indicated that she became upset when she had to wait too long at a medical appointment. o Staff documented that Individual #346 on 4/16/12 after staff removed some of his personal possessions. • Some examples where events leading to restraint were not adequately documented included: o The restraint checklist for Individual #346 dated 4/9/12 documented that he received a chemical restraint at his request. o Restraint checklists for Individual #277 dated 1/7/12 described her	

#	Provision	Assessment of Status	Compliance
		behavior prior to the restraint, but did not document what events led to the behavior. • In 20 of 28 the records (72%), 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. Some examples where staff did not document that a graduated range of less restrictive measures had been attempted included: o The restraint checklist for Individual #9 dated 4/17/12 indicated that a chemical restraint was administered after verbal prompts were unsuccessful. o On restraint checklist for Individual #208 dated 3/17/12, staff documented "verbally prompted her to stop being physically aggressive toward staff. She did not comply so she was restrained." There was no indication that staff attempted redirection or other PMAB recommended interventions prior to restraining her. A horizontal restraint was implemented without staff attempting a less restrictive restraint first. • On none (0%) of 28 restraint checklists, staff documented that individuals were engaged in adequate programming or engaged in any activity prior to the behavior, thus, it was not possible to determine if restraint was used in the absence of, or as an alternative to, treatment or programming. A number of individuals at the facility were wearing protective equipment (i.e., helmets). The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. There was no indication that plans to reduce the amount of time spent in restraint were addressed by the IDT. This issue, however, was going to be addressed via the new statewide policy and procedures. State policies identified a list of approved restraints techniques. Based on the review of documentation for 28 restraints, 28 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of pretreatment sedation and medical restraints to promote healing between 12/1/11 and 6/1/12: this included • 31 instances of pretreatment sedation, and • 57 instances of the use of mechanical restraint used to promote healing involving two individuals. The facility reported that no individuals received pretreatment sedation prior to dental	

#	Provision	Assessment of Status	Compliance
		procedures from 12/1/11 through 6/1/12. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were four desensitization plans in place. Progress had not been made on developing desensitization plans and/or strategies to minimize the use of medical and dental restraints. The facility was not yet in compliance with provision C1. To do so: • Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, including whether or not the individual was engaged in activities, and all interventions attempted prior to restraint. • Staff need to ensure restraints are only implemented after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner. • The long-term use of protective mechanical restraints should be reviewed periodically by the IDT and strategies should be developed to reduce the amount of time in restraint. • A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs. • Desensitization strategies should be considered by the IDT for all individuals requiring the use of pretreatment sedation for routine medical appointments. • IDTs for should focus on developing ISPs that support meaningful engagement throughout each individual's day.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Safety Plans for Crisis Intervention (SPCIs) had been discontinued for all individuals at the facility. The psychologists were in the process of developing Crisis Intervention Plans for individuals who had been restrained more than three times within a 30-day period to comply with the new statewide policy. The Sample #C.1 restraint documentation for 18 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. • 17 of 18 (94%) restraints reviewed indicated that the individual was released immediately when no longer a danger.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• One restraint checklist indicated that the individual was released because staff could not maintain the restraint correctly (Individual #277 dated 2/22/12). • The longest physical restraint in the sample was 28 minutes for Individual #116 on 2/5/12. Six (33%) of the restraints in the sample lasted three minutes or less. Two (7%) lasted over 10 minutes. The facility was in substantial compliance with C2	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 23 of 24 (96%) had current training in RES0105 Restraint Prevention and Rules. • 21 of the 21 (100%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. Two of the employees had been hired in the past year. • 23 of 24 (96%) had completed PMAB training within the past 12 months. • 19 of the 21 (90%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. The facility had begun training all staff on the new statewide restraint policy. SGSSLC was in substantial compliance with this provision item.	Substantial Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical	Based on a review of 28 restraint records (Sample #C.1), documentation in 28 (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 reported 88 incidents of restraint used for medical and/or dental treatment in the past six months. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	reported that no individuals received pretreatment sedation prior to dental procedures from 12/1/11 through 6/1/12. According to a list provided to the monitoring team, a desensitization program had been developed for four individuals who needed pretreatment sedation or restraint to have routine medical or dental care completed. The facility had not developed treatment strategies for all individuals who required the use of restraint for routine medical or dental treatment. Five desensitization plans were reviewed for four individuals (one individual had both a medical and dental desensitization plan). All plans in the sample included individualized strategies (also see S1 below). The facility had created a "Do Not Restrain" list. The list was updated on 5/11/12. There were 24 individuals at the facility who were on this list for which restraints would be contraindicated due to medical or physical conditions. The list specified what types of restraints should not be used. Two individual on the list had been restrained in contradiction to restraint types on the list in the past six months. Individual #68 was the subject of a horizontal restraint on 1/4/12. He was placed on the "Do Not Restrain" list due to cardiac concerns. Individual #165 was placed in a baskethold on 12/10/11. As noted in C1, the facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of mechanical restraints and document attempts at reducing the use of these restraints. Progress had not been made towards developing desensitization plans for individuals who needed restraints for routine medical and dental treatment. The facility needs to ensure that individuals on the "Do Not Restrain" list are not restrained in a manner that places them at risk. The facility was not yet in compliance with this item.	
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	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 28 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 28 out of 28 incidents of restraint (100%), there was assessment by a restraint monitor.	Noncompliance

#	Provision	Assessment of Status	Compliance
	restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• In the 28 instances of restraint in the sample, there was a face-to-face assessment form completed. • The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 18 (64%) out of 28 instances. Exceptions were: o Individual #9 dated 4/17/12 o Individual #9 dated 4/16/12 o Individual #116 dated 2/8/12 o Individual #346 dated 4/26/12 o Individual #346 dated 4/4/12 o Individual #277 dated 2/22/12 o Individual #277 dated 1/7/12 o Individual #208 dated 3/3/12 o Individual #280 dated 4/3/12 (x2) o Individual #52 dated 5/8/12 Based on a review of 28 physical and chemical restraints used for crisis intervention 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 15 (54%) of the instances of restraint. The exceptions were: o Individual #9 dated 4/16/12; o Individual #116 dated 4/6/12, 4/3/12 (x2), and 2/27/12; o Individual #346 dated 4/16/12 and 4/4/12; o Individual #277 dated 2/22/12 and 1/17/12; o Individual #208 dated 3/17/12 and 3/3/12; o Individual #280 dated 4/3/12 (x2) o Individual #52 dated 3/8/12 A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Seven of 10 (70%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the restraint. The exceptions were: • Pretreatment sedation for Individual #126 dated 4/4/12. • Pretreatment sedation for Individual #38 dated 3/29/12. • Pretreatment sedation for Individual #294 dated 3/29/12 The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	

#	Provision	Assessment of Status	Compliance
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample of 28 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 28 (100%), continuous one-to-one supervision was indicated as having been provided. • In 28 (100%), the date and time restraint was begun were indicated. • In 28 (100%), the location of the restraint was indicated. • In 27 (96%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. The exception was the restraint for Individual #346 dated 4/9/12. • 24 (86%) indicated what events were occurring that might have led to the behavior (see C1). • In 27 (96%), the specific reasons for the use of the restraint were indicated. The Restraint Checklist for Individual #346 on 4/9/12 did not give a clear reason for the restraint. • In 28 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 28 (100%), the names of staff who applied/administered the restraint was recorded. • In 18 (100%) of 18 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 18 (100%) of 18 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 27 (96%) of 28 restraints, 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. The exception was for Individual #346 dated 4/4/12. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 28 minutes in duration. In a sample of 28 records (Sample #C.1), restraint debriefing forms had been completed for 28 (100%). A sample of 10 restraint checklists for individuals receiving medical restraint was reviewed to ensure enhanced supervision was provided. Enhanced supervision was documented in all 10 (100%). The facility had made significant progress in adequately documenting restraint incidents.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility was in substantial compliance with this provision. Documentation of events occurring prior to the change in behavior leading to restraint should be documented. This information could be useful in modification of supports and programming to avoid further restraint incidents.	
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 20 individuals were placed in restraint more than three times in a rolling 30-day period. This represents a decrease from the 25 Individuals placed in restraint more than three times in a rolling 30-day period reported during the last review, and the 30 reported in the May 2011 review. Five of these individuals (i.e., Individual #9, Individual #292, Individual #34, Individual #241, and Individual #215) were reviewed (25%) to determine if the requirements of provision C7 of the Settlement Agreement were met. PBSPs, safety plans, and ISP addendums (ISPAs) following more than three restraints in 30 days were requested for all five individuals. A safety plan was not provided for Individual #292, Individual #34, or Individual #241. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because none of the ISPA minutes were organized so as to ensure that each of the issues below were discussed. Additionally, in order to achieve compliance with this item, SASSLC needs to document that each individual's PBSP had been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent). Only one (i.e., Individual #292) of the five (20%) ISPAs reviewed reflected a discussion of how an individual's adaptive skills, and biological and/or psychological factors may have contributed to the behaviors that provoked restraint. Individual #292's ISPA listed potential adaptive skills, biological, medical, and psychosocial factors. Simply listing biological and psychosocial factors, however, is not likely to be useful in better understanding the behaviors provoking restraint. Identifying the adaptive skills, and biological, medical, and/or psychosocial factors (if any) hypothesized to be affecting these dangerous behaviors will be useful if they are accompanied by an action plan to decrease the likelihood of these behaviors in the future.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The minutes from all ISPA meetings following more than three restraints in a rolling 30-day period 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 ISPA meeting minutes 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 ISPA minutes of meetings in response to more than three restraints in a 30-day period 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 environmental antecedents to the behaviors that provoke restraint. None of the ISPA minutes reviewed reflected a discussion of potential environmental antecedents. Examples of possible environmental antecedents include things, such as the cancelling of an outing or being told to wait. In order to achieve compliance with this provision item, ISPA minutes need to reflect a discussion of the effects of these types of variables on the individual's restraint, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint.	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 ISPAs reviewed included a discussion of a variable or variables maintaining the dangerous behavior that provoked restraint. An example of what could be included here is an individual whose ISPA reflected a conversation that physical aggression that often leads to restraint may be maintained by escape or avoidance of undesirable activities. The intervention, or action based on that hypothesis, could be to establish and reinforce a functional replacement behavior (see K9), such as communicating that the individual wants a break. All ISPAs should document a discussion of variables that may be maintaining the dangerous behavior that provokes restraint. This discussion should also include how these functions will be addressed (e.g., establishing and reinforcing replacement behaviors) to prevent restraints in the future.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(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 of the individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Five (100%) were based on the individual's strengths, • Five (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint, • Four (80%) of the PBSPs reviewed specified the alternative, positive and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (Individual #34 was the exception), and • All five of the PBSPs (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. All five of PBSPs reviewed had procedures to weaken or reduce the behaviors that provoked restraint (see K9). The two Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In both of the Safety Plans reviewed (100%), the type of restraint authorized was delineated, • In neither (0%) of the two safety plans reviewed, the maximum duration of restraint authorized was specified, • In all (100%), the designated approved restraint situation was specified, and • In all of the safety plans reviewed (100%), 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%) were 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.	In the last review, all of the ISPA minutes reviewed included a discussion of the effectiveness of the current PBSP (including possible modification when necessary) to decrease the future probability of requiring restraint, therefore, this item was rated as being in substantial compliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
		During this review, two (i.e., Individual #215, and Individual #241) of the five ISPAs reviewed (40%) did not address the issue of review of the effectiveness of the PBSP. Additionally, there was no evidence that the PBSPs for any of the individuals reviewed were modified (when necessary) to decrease the future probability of requiring restraint. Therefore, the facility did not maintain substantial compliance and this item was now rated as being in noncompliance.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	A sample of Face-to-Face Debriefing and Review Forms related to incidents of non-medical restraint was reviewed by the monitoring team. The review form had an area for signature indicating review by the unit director and the IMC. Fourteen restraints in the sample (50%) were signed by both the unit director and IMC/Designee within three days. The facility did not have a system in place to track recommendations or follow-up to the restraint incident. Restraints for crisis intervention were to be reviewed in the daily unit meeting, and Incident Review Team meeting. Observation by the monitoring team of both of these meetings during the onsite review confirmed that restraint incidents were reviewed and recommendations were made regarding follow-up (i.e., IDT should meet to discuss the restraint incident). The facility, however, did not have a system in place to comment on errors or to track follow-up recommendations made during the review. Comments regarding findings were not found on any of the restraint checklists signed off on by administrative staff. For example, it was noted that some of the restraint checklists in the sample did not document adequate monitoring by nursing staff. In some cases, restraint monitors, unit directors, and the psychology staff had signed the Restraint Review form without noting errors in monitoring by the nurse and there was no indication that errors would be addressed with nursing staff. Restraints were also referred to the IDT for review and follow-up. The Restraint Reduction Committee reviewed restraint trends for the facility and for individuals with the most restraints. The facility will need to develop a restraint review system that documents follow-up to any issues identified during the review process.	Noncompliance

Recommendations:

1. Ensure restraints are only implemented after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner (C1).

2. The long-term use of protective mechanical restraints should be reviewed periodically by the IDT and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs (C1, C2, C4).

3. 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 (C1, C2, C6).

4. IDTs should discuss the need for restraints during medical and dental procedures and strategies should be developed to try to reduce or eliminate the need for restraint (C2, C4).

5. The facility needs to ensure that individuals on the "Do Not Restrain" list are not restrained in a manner that places them at risk. (C4)

6. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

7. The facility will need to develop a restraint review system that documents follow-up to any issues identified during the review process (C8).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Section D Presentation Book o SGSSLC Section D Self-Assessment o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o SGSSLC Policy: Spurious Allegations of Abuse, Neglect, and Exploitation o SGSSLC Policy: Management of Conduct Between Staff and Persons Served o SGSSLC UII Action Plan Tracking o Comprehensive Investigator Training Curriculum o Unusual Incidents Training Curriculum o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Committee meeting minutes for each Monday of the past six months o Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months o List of staff who failed to report abuse, neglect, or exploitation (10) o Training and background checks for the last three employees hired o Training transcripts for facility investigators (12) o Training transcripts for DFPS investigators assigned to complete investigations at SGSSLC (12) o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 o QA Report o Flow Chart for Unknown Client Injuries o List of incidence for which the reporter was known to be the individual or their LAR 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 ISPs for: • Individual #12, Individual #369, Individual #24, Individual #66, Individual #94, Individual #44, Individual #59, Individual #273, Individual #269, and Individual #389 o Injury reports for three most recent incidents of peer-to-peer aggression incidents

- ISP, BSP, and ISPA related to the last three incidents of peer-to-peer aggression
- List of all serious injuries for the past six months
- List of all injuries for the past six months
- List of all A/N/E allegations since 12/1/11 including case disposition
- List of all investigations completed by the facility since 12/1/11
- List of employees reassigned due to ANE allegations
- Injury reports for the past three months for:
  - Individual #318, Individual #288, Individual #241, Individual #201, Individual #61, and Individual #400
- Documentation from the following completed investigations, including follow-up:

Sample D.1	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
#41732956	Emotional/Verbal Abuse	Unconfirmed	4/7/12 1:34 pm	4/7/12 2:39 pm	4/17/12
#41709332	Neglect	Unfounded	4/4/12 6:55 pm	4/5/12 4:20 pm	4/14/12
#41709292	Physical Abuse Sexual Abuse	Unfounded Unfounded	4/4/12 6:55 pm	4/5/12 5:01 pm	4/10/12
#41696652	Physical Abuse	Unconfirmed	4/3/12 6:23 pm	4/4/12 2:34 pm	4/13/12
#41671336	Physical Abuse	Unconfirmed	3/31/12 4:41 pm	4/1/12 3:26 pm	4/10/12
#41669277	Neglect (2) Physical Abuse (1)	Unconfirmed (2) Unconfirmed (1)	3/30/12 6:59 pm	3/31/12 3:16 pm	4/12/12
#41571592	Neglect (2) Physical Abuse (1)	Unconfirmed (2) Unconfirmed (1)	3/20/12 8:30 pm	3/21/12 4:29 pm	4/4/12
#41646992	Neglect (1) Physical Abuse (4)	Unconfirmed (1) Unconfirmed (4)	3/29/12 7:14 am	3/29/12 12:56 pm	4/4/12
#41582875	Physical Abuse (2)	Unconfirmed (2)	3/21/12 6:26 pm	3/22/12 10:30 am	3/30/12
#41452792	Neglect (2)	Confirmed (2)	3/5/12 3:00 pm	3/7/12 2:14 pm	3/9/12
#41444294	Neglect (4)	Confirmed (4)	3/4/12 3:00 pm	3/5/12 11:50 am	3/8/12
#41440634	Physical Abuse	Confirmed	3/3/12 2:57 pm	3/4/12 11:44 am	3/14/12
#41295884	Neglect (3)	Confirmed (3)	2/11/12 5:20 pm	2/12/12 11:50 am	2/23/12
#41295917	Physical Abuse (2)	Confirmed (2)	2/11/12 5:20 pm	2/12/12 11:50 am	2/24/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#41770972	Neglect	Admin. Referral	4/12/12	4/16/12	4/17/12
#41659139	Neglect	Clinical Referral	3/30/12	4/5/12	4/5/12
#41440598	Neglect	Clinical Referral	3/3/12	3/5/12	3/5/12
#41339773	Neglect	Clinical Referral	2/22/12	2/24/12	2/24/12
#41253379	Neglect	Clinical Referral	2/6/12	2/14/12	2/14/12
#41199638	Neglect	Clinical Referral	1/29/12	2/2/12	2/2/12

Sample D.3	Type of Incident	Date/Time of Incident Reported	Director Notification		
#4962	Sexual Incident	4/17/12 9:40 am	4/17/12 9:40 am		
#4958	Serious Injury	4/16/12 11:00 am	4/16/12 11:00 am		
#4942	Serious Injury	4/10/12 10:25 am	4/10/12 11:00 am		
#4924	Serious Injury	4/1/12 11:49 am	4/1/12 11:53 am		
#4912	Sexual Incident	3/28/12 7:30 pm	3/28/12 8:19 pm		
#4926	Pregnancy	4/2/12 12:50 pm	4/2/12 11:00 am		
#4913	Sexual Incident	3/28/12 8:05 pm	3/28/12 8:19 pm		
#4850	Serious Injury	2/28/12 7:33 pm	2/28/12 6:50 pm		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Jalown McCleery, Incident Management Coordinator
- Dana Robertson, POI Coordinator
- John Church, Psychologist
- Michael Davila, QDDP Coordinator
- Michael Fletcher, QDDP Educator
- Roy Smith, Rights and Protection Officer
- Brendi Gentry, Investigator

	Observations Conducted: o Observations at residences and day programs o 505B IDT Meeting 6/5/12 o 511B Home Meeting 6/5/12 o Unit I Morning Meeting 6/6/12 o Incident Management Review Team Meeting 6/6/12 o Annual ISP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting o Restraint Reduction Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment. It was updated on 5/1/12. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the section D audit tool developed by the state office to measure compliance with the Settlement Agreement. Findings from this tool were supplemented by a staff interview tool used to determine if staff was aware of the reporting requirements associated with incidents and injuries. The self-assessment indicated that the findings from the facility's monthly audit process were used to self-assess compliance. Findings from the facility's audit process were similar to those found by the monitoring team. The facility self-assessment commented on the overall compliance rating for each provision item, based on the sample of documentation audited, as well as, commenting on processes in place to address compliance with each item. In some cases, the audit tool alone was not sufficient for determining compliance. For example, the self -assessment indicated that the facility was in substantial compliance with the requirements of D2a based on 100% compliance rate with the requirement for completing training, signing an acknowledgment to report form, and answering interview questions. The monitoring team did not find substantial compliance given that, although staff had been trained, the large number of cases found not be reported in a timely manner suggested that training is not effective. The facility self-assessment indicated substantial compliance with 19 out of 22 items in section D. The monitoring team found the facility to be in substantial compliance with 18 of the 22 provision items. The facility rated D1, D2e, and D2i as noncompliance. The monitoring team did not find compliance for D2a, D2i, D3g, and D3i. The facility had made significant improvements in the self-assessment process. The IMC should carefully

	review each section of the monitoring team's report and note activities engaged in by the monitoring team to assess each area. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. Trend reports should be used to analyze whether or not compliance with section D requirements has an impact on the number of incidents and injuries at the facility. Ultimately, a reduction in these numbers should be a result of improvements in the incident management system .
	Summary of Monitor's Assessment: According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 470 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 12/1/11 and 4/18/12. Of the 470 allegations, there were nine confirmed cases of physical abuse, and 31 confirmed cases of neglect. An additional 79 other serious incidents were investigated by the facility, including three deaths. There were a total of 2051 injuries reported between 11/1/11 and 4/30/12. These 2051 injuries included 33 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries documented at the facility with preventative actions. Documentation indicated that a large number of injuries were resulting from behavioral issues, including peer-to-peer aggression. The facility needs to aggressively address trends in injuries and implement protections to reduce the number of incidents and injuries. The facility had taken steps to address concerns related to incident management at the facility. Some positive steps taken to address the provision items of section D included: • Developed and implemented a log to track protective actions recommended for each case of abuse, neglect, and exploitation. • Implemented a semi-annual audit process of homes for unreported injuries. • Added two additional investigator positions to the Incident Management Department. • Began providing an analysis report of the section D monitoring tool during the monthly Benchmark meeting. A considerable focus had been placed on documentation and investigation of unusual incidents at the facility, but there had still been little focus on the prevention and reduction of unusual incidents. The thorough investigation and documentation of incidents should ultimately result in identification of those factors that continue to contribute to incidents at the facility. Recommendations resulting from investigations should include a focus on systemic issues that are identified and action steps should be developed to address those issues. Some systemic issues that appear to contribute to the alarming number of incidents and injuries at SGSSLC included: • Poorly trained staff,

	• Inadequate programming options, • Inadequate supervision, • Inadequate planning in regards to transition (from one home to another) • Overcrowded homes, • Lack of attention to risk factors, and • Failure to provide interdisciplinary supports. The facility needs to focus next on: • Ensuring IDTs are adequately addressing all incidents and putting necessary protections in place. • Ensuring that the facility audit system accurately identifies areas of needed improvement. • Taking an integrated, aggressive approach to restructuring environments, supports, and programming to adequately meet the needs of individuals at SGSSLC and protect them from harm.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. In practice, the facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this section D of the report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies,		

#	Provision	Assessment of Status	Compliance
	procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such 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.	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This 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 470 allegations of abuse or neglect were conducted by DFPS at the facility between 12/1/11 and 4/18/12. There were no allegations of exploitation. From these 470 allegations, there were: • 323 allegations of physical abuse: o 9 were confirmed, o 256 were unconfirmed, o 13 were inconclusive, o 24 were unfounded, o 13 were referred back to the facility for further review, o 6 were pending outcomes, and o 2 were other. • 137 allegations of neglect: o 31 were confirmed, o 44 were unconfirmed, o 4 were inconclusive, o 3 were unfounded,	Noncompliance

#	Provision	Assessment of Status	Compliance
		o 54 were referred back to the facility for further investigation, and o 1 was a pending outcome. The facility reported that there were 79 other investigations of serious incidents not involving abuse, neglect, or exploitation between 11/1/11 and 4/30/12. This included: o 3 deaths, o 31 serious injuries, o 3 choking incidents, o 19 sexual incidents, o 1 pregnancy, o 9 unauthorized departures, o 6 encounters with law enforcement, and o 7 other/unknown category incidents. From all investigations since 12/1/11 reported by the facility, 27 investigations were selected for review. The 27 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample (14 cases). • Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation (6 cases). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (7 cases). Based on a review of the 14 investigative reports included in Sample #D.1: • Eight of 14 reports in the sample (57%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. Two of the other six incidents in the sample were particularly concerning because the incidents were witnessed by a number of staff who did not report the incidents immediately. This raised questions regarding whether or not staff recognized what constitutes abuse or neglect and whether or not staff felt an obligation to report. o In DFPS #41295917, allegations of physical abuse were confirmed on two DSPs for throwing ice at an individual. The two staff members continued to throw ice at the individual even after he began to cry and tried to get away from them, falling in the process. A DSP witnessing the event tried to stop the attack, but they ignored her. The incident was not reported to DFPS until more than five hours later. The investigator expressed concern that "many of the employees interviewed were not forthcoming with the course of events involving this allegation." o In DFPS #41295884, neglect allegations were confirmed against five	

#	Provision	Assessment of Status	Compliance
		staff after it was reported that some staff did not intervene when watching two individuals wrestling on the floor. One staff person tried to intervene, but did not get support from the other staff present. This incident was also not reported immediately by those witnessing the incident. • 14 of 14 (100%) indicated the facility director or designee was notified within one hour by DFPS. • 12 of 12 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • 12 of 14 (86%) indicated that the state office was notified as required. Cases that did not include documentation of state office notification in the UIR were DFPS #41709332 and DFPS #41709292. However, notification was documented on the UIR tracking sheet. In reviewing Sample D.3 (serious incidents), documentation indicated: • Five of seven (71%) were reported immediately (within one hour) to the facility director/designee. In the two incidents not immediately reported, staff who failed to report incidents as required by the facility policy were retrained on the policy. o UIR #530 was the investigation of a sexual incident between two individuals. Two staff were aware of the incident, but it was not reported until the following day. o UIR #526 was the investigation of a serious injury. It was not reported by the nurse to the facility director until two days after the incident occurred • Documentation of state office notification, as required by state policy, was found in seven of seven (100%) UIRs. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: • 20 out of 20 (100%) investigation files in Sample #D.1. • 8 of 8 (100%) investigation files in Sample #D.2 and Sample #D.3. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was reviewed for 89 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form.	

#	Provision	Assessment of Status	Compliance
		The sample reviewed by the monitoring team did not confirm substantial compliance with the reporting requirements of this provision. The facility needs to further explore why there continued to be incidents that were not reported immediately for investigation.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility did have a policy in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 14 investigation reports included in Sample D.1, in 14 out of 14 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 1/1/12. The log included the applicable investigation case number and the date the employee was returned to work or, in some cases, was discharged. All allegations were discussed in the daily IMRT meeting and protections were monitored through meeting minutes for each open investigation. The facility did allow for staff to continue working with individuals under additional monitoring by a supervisor when the individual reporting was considered a spurious reporter. For two cases in the sample involving allegations by Individual #346, the APs were allowed to continue working with increased supervision. This individual had a long history of making spurious allegations. There was no evidence that the allegations made by Individual #346 in the sample had any basis. In 14 out of 14 cases (100%), there was no evidence that the employee was returned to his or her previous position prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 14 investigation files in Sample D.1, 14 (100%) UIRs documented at least some additional protections implemented following the incident. This typically consisted of three actions, including placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and an emotional assessment. Examples of other immediate action taken included, • In DFPS #41452792 and DFPS #41444294, the level of supervision was increased for the alleged victim.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• In DFPS #41295917, there was a recommendation for the immediate retraining of staff. The facility needs to more thoroughly document all immediate corrective action taken, including but not limited to, removing APs, providing immediate medical care, discussion by the IDT, and environmental modifications. Careful consideration should be given to the immediate protections needed for each incident. The facility was in substantial compliance with this provision. All immediate corrective action should be documented in the investigation file.	
	(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. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 22 (100%) of 22 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 22 (100%) of the 22 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with six direct support staff in various homes and day programs: • Six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement	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 reviewed for 89 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. A review of training curriculum provided to all employees at orientation and annually	Substantial Compliance

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	that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that 10 employees failed to report abuse, neglect, or exploitation or did not cooperate with investigators during an investigation in the past six months (in six different investigations). Sample #D1 included two additional substantiated cases where employees failed to report abuse or neglect. The facility was now tracking action taken in cases where an employee failed to report abuse, neglect or exploitation. The facility was in substantial compliance with this item.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	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. A sample of 10 ISPs developed after 1/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #12, Individual #369, Individual #24, Individual #66, Individual #94, Individual #44, Individual #59, Individual #273, Individual #269, and Individual #389. • Nine (90%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception was the ISP for Individual #369. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility provided a list of 33 investigations since 12/1/11 where the individual self-reported abuse or neglect indicating that at least some individuals at the facility knew how to report abuse or neglect to DFPS. The facility was in substantial compliance with this item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to	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.	Substantial Compliance

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	report violations of such rights.	Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the rights officer with his name, picture, and contact information. The Alternate Duty Safety Officer was assigned responsibility for checking for posters throughout the facility. The facility remained in substantial compliance with this provision item.	
	(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. Based on a review of 14 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in 12 (100%), as appropriate. The facility remained in substantial compliance with this provision 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 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.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • SGSSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of SGSSLC. • 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 occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported zero cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation for reporting. The facility self-assessment also reported no complaints of retaliation in the cases audited during the past six months. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	Substantial Compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probably cause cannot be determined and to DADS Regulatory if the injury was deemed serious. According to the facility action plan, the following measures had been implemented to address this provision. • The Risk Manager had developed a Flow Chart for Unknown Client Injuries. It was designed to be a quick reference for staff on steps to take when an injury was discovered. • Supervisory staff were trained on the flow chart. • All significant and serious injuries were being audited monthly for compliance with reporting and investigation procedures. • IDTs were asked to review trends of injuries identified in monthly trend reports. The facility's self- audit found a number of injuries not documented and reported for review. The facility assigned a noncompliance rating to this item based on the self-audit. The monitoring team observed daily IMRT meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries, and trends of injuries were reviewed and recommendations were made by the team for follow-up. An additional sample of serious client injuries was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. The facility was in the initial stages of developing an audit process that was adequate for ensuring that injuries or trends of injuries were reported for investigation. This audit system will be reviewed further at the next monitoring team visit. Continued low compliance ratings should be analyzed in terms of whether or not the current audit system was adequately identifying problems that need to be addressed by the facility in reporting injuries for investigation.	Noncompliance
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,		

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	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.	DFPS reported its investigators were 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 conducting investigations and working with people with developmental disabilities. Twelve DFPS investigators were assigned to complete investigations at SGSSLC. The training records for DFPS investigators were reviewed with the following results: • Twelve investigators (100%) had completed the requirements for investigations training. • Twelve DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SGSSLC had 12 employees designated to complete investigations. This included the IMC, Facility Investigator, Rights and Protections Officer, and Campus Administrators. The training records for those designated to complete investigations were reviewed with the following results: • Twelve (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • Twelve (100%) had completed UNU0100 Unusual Incidents within the past 12 months. • Twelve (100%) had completed Root Cause Analysis according to training transcripts reviewed. The Campus Coordinators had not completed this course. There was no evidence that they had completed any of the investigations in the sample. • Twelve (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were completing all investigations at the facility. Additionally, facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. Facility staff (direct care) had failed to cooperate with investigators in one of the cases. Staff involved were terminated. The facility IMC continued to meet quarterly with DFPS and OIG to discuss coordination	Substantial Compliance

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		of investigations between agencies.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency 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 14 investigations completed by DFPS (Sample #D.1), 12 had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial 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.3): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout SGSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	Substantial Compliance

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	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. o Contact occurred within 24 hours in 13 of 14 (93%) investigations. DFPS case #41452792 was the exception. • Fourteen (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. For the two investigations in which initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. • 10 of 14 (71%) were completed within 10 calendar days of the incident. o Extensions were filed in four cases that were not completed within 10 calendar days. Extension requests seemed to be reasonable in these cases. o Investigation #41295917 was the lengthiest investigation in the sample. It was completed on the 13th day. OIG was also investigating the incident, which may have resulted in a delay in the DFPS investigation. Two allegations of physical abuse were ultimately confirmed. • All 10 (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 10 of the 20 DFPS investigations reviewed (50%) in sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Seven of those cases resulted in referrals back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation. The other three did not have concerns that resulted in referrals. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Seven (100%) of the UIRs reviewed indicated that the investigation began within 24 hours. • Seven of seven (100%) indicated that the investigator completed a report within 10 days of notification of the incident. All UIRs in the sample noted completion within 24 hours. • Seven of seven (100%) investigations included recommendations for corrective action.	Substantial Compliance

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		The facility was in substantial compliance with this item.	

	(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.	DADS Incident Management Policy required a UIR to 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.3) 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 the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following:
		o In 14 (100%), each serious incident or allegations of wrongdoing;
		o In 14 (100%), the name(s) of all witnesses;
		o In 14 (100%), the name(s) of all alleged victims and perpetrators (when known);
		o In 14 (100%), the names of all persons interviewed during the investigation;
		o In 14 (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 14 (100%), all documents reviewed during the investigation;
		o In 14 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case.
		o In 14 (100%), the investigator's findings; and
		o In 14 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of seven facility investigations included in sample #D.3
		• The report utilized a standardized format that set forth explicitly and separately, the following:
		o In seven (100%), each serious incident or allegations of wrongdoing;
		o In seven (100%), the name(s) of all witnesses;
		o In seven (100%), the name(s) of all alleged victims and perpetrators
			Substantial Compliance

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		when known; o In seven (100%), the names of all persons interviewed during the investigation; o In four (57%), 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. Exceptions included UIR #73, UIR #41, and #141 o In seven (100%), all documents reviewed during the investigation; o In seven (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. o In seven (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(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.3) 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 20 DFPS investigations included in Sample #D.1 and #D.2: • In 20 (100%) investigative files reviewed from Sample #D.1 and #D.2, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Samples #D.1, • 14 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. o Nine of 14 (64%) were reviewed by the facility director and Incident Management Coordinator within five working days of receipt of the completed investigation. Exceptions included: ▪ DFPS #41671336 – reviewed 9 days after completion, ▪ DFPS #41669277 – reviewed 15 days after completion, ▪ DFPS #41571592 – reviewed 12 days after completion, ▪ DFPS #41646992 – reviewed 8 days after completion, ▪ DFPS #41452792 – review was undated	Noncompliance

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		DFPS noted concerns or made recommendations in six (43%) of the cases in sample #D.1. The facility maintained a log of follow-up action taken to address concerns and recommendations. • The facility tracking log included follow-up to all six cases. • Four of six investigation files included documentation of follow-up to concerns and recommendations. Follow-up documentation was not provided to the monitoring team for DFPS #41295884 and DFPS #41295917. • Documentation of follow-up to all DFPS concerns was found in five (83%) of the six investigation files in the sample. o In DFPS #41452792, a concern was referred back to the facility for follow-up regarding a concern by the victim that she would be further harassed by the perpetrator in the case. The facility UIR included a recommendation for the unit director to address the concern. There was no evidence that the unit director addressed her concern. Sample #D.2 included six investigations that were referred back to the facility for further review. • Five were clinical issues referred back for further review by the facility. One case included a referral for an administrative issue and a rights issue. Reviews were completed by the facility in all cases. It appeared reasonable for all of these investigations to have been referred back to the facility for clinical reasons. • Five included recommendations for follow-up by the facility. • Of the five investigations that included recommendations, four (80%) included documentation of follow-up. DFPS #41253379 was referred back to the facility as a clinical issue. There was no documented evidence that the facility followed up with recommended retraining of nursing staff. Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In seven of seven (100%) UIRs from sample #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon within two days of completion. • All seven of the UIRs included recommendation for follow-up. Documentation was only included in one of the investigative records provided to the monitoring	

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		team. The facility tracking log included recommendations for follow-up action in four of six (67%) cases. The two cases that did not include recommendations on the tracking log recommended that the IST meet with the individuals involved. The facility needs to ensure that all investigations are reviewed in a timely manner to ensure swift completion of follow-up action when indicated. Documentation of follow-up to recommendations should be included in the investigation file. This item was not in substantial compliance.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 27 out of 27 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	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.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in the sample. Five investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in all five cases. The facility had developed a log to track follow-up action taken in regards to recommendations included in investigations. In six of 14 DFPS cases reviewed from Sample #D.1, DFPS documented additional concerns or recommendations. In five of those six cases (86%), the facility investigation file included documentation that concerns or recommendations were addressed. Examples found where documentation of programmatic action was not adequate included: • In DFPS #41452792, a concern was referred back to the facility for follow-up regarding a concern by the victim that she would be further harassed by the perpetrator in the case. The facility UIR included a recommendation for the unit director to address the concern. There was no evidence that the unit director addressed her concern. Recommendations for programmatic actions were made in five of seven cases reviewed for facility investigations in Sample #D.3. Adequate follow-up documentation was not provided to the monitoring team to confirm follow-up action. According to the facility tracking log, follow-up had been completed in three of the seven investigations. Two cases were still open and two cases indicated no follow-up on the tracking log. The cases did include recommendations for the IDT to meet in those two cases.	Noncompliance

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		The facility did not have a system in place to assess whether outcomes of disciplinary or programmatic actions corrected a situation and/or prevented recurrence. For example, training or retraining of staff was the recommended action taken to address identified problems with staff performance related to incidents. This training or retraining typically consisted of a brief reminder memo or description of a procedure that staff were to sign when they had read the memo. There was no indication that any type of review or monitoring occurred to determine if the training resolved the issue. Examples of this included: • In DFPS #41659139, it was recommended that the nurse receive training regarding procedures to follow when an individual refused medication. The nurse signed a statement that read, "Please ensure if a patient refuses their medications originally, and then asks for them later that you call the physician and see if the doctor wants them to have them later or not. Additionally, please document all refusals in the IPN." There was no indication that follow-up was completed to ensure this was occurring throughout the facility. • An IDT meeting was held for Individual #318 following a serious injury that resulted from a fall. It was noted that he had several injuries due to falls over the past year. It was discovered that protections previously put into place (eyeglasses and night light) to prevent falls were no longer in place. His eyeglasses had been broken and never replaced and his night light was missing. • Failure to report incidents and injuries to the appropriate parties had resulted in retraining for employees in several cases. As noted in D2a, retraining had not been adequate to ensure that employees were consistently reporting incidents and injuries as required. The facility needs to ensure that appropriate follow-up action is completed and documented. Follow-up needs to occur to ensure problems identified are corrected and remain corrected. The facility did not achieve substantial compliance with this item.	
	(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.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self-assessment rating of substantial compliance with this item.	Substantial Compliance

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D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of the investigation. 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 gather accurate data and frequently evaluate how data can best be used to evaluate that progress and take action to reduce the number of incidents and injuries. To that end, the monitoring team found a lack of focus on addressing factors that contribute to the high number of incidents and injuries at the facility. This is an important component of protecting individuals from harm. There had been little consideration given to addressing factors that contributed to incidents and injuries at the facility, such as lack of supervision, competently trained staff, crowded living environments, ensuring preventative supports are in place, and availability of meaningful programming. The facility was in substantial compliance with this provision item. The monitoring team, however, expects to see the incident management department start to take a role in the facility's overall approach to addressing the frequency of occurrence of incidents and injuries at SGSSLC.	Substantial Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall	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.	Substantial Compliance

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	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.	In concert with the DADS state office, the facility 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. Background checks were conducted on new employees prior to orientation and 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. According to information provided to the monitoring team, for FY12, criminal background checks were submitted for 366 applicants. There were a total of 52 applicants who failed the background check in the hiring process and therefore were not hired. 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. • Signed acknowledgement forms were submitted for 15 of 24 employees (63%). The facility reported that an acknowledgement form was not available for nine of the employees in the sample. The facility remained in substantial compliance with this provision. The facility, however, needs to ensure that all employees review and sign an acknowledgement to self report criminal activity.	

Recommendations:

1. Ensure that staff know appropriate reporting procedures for each type of incident (D2a).

2. Document all immediate corrective actions taken in the investigation file (D2b).

3. Audit findings should be analyzed in terms of whether or not the current audit system is adequately identifying problems that need to be addressed by the facility in reporting injuries for investigation (D2i).

4. Investigation documentation should indicate that all investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).

5. The facility needs to ensure that appropriate follow-up action is completed and documented in investigation files (D3g, D3h, D3i).

6. Address factors that contributed to incidents and injuries at the facility such as lack of supervision, competently trained staff, crowded living environments, ensuring preventative supports are in place, and availability of meaningful programming (D4).

7. Data 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 if data are accurate and how data can best be used to evaluate that progress (D4).

8. The facility, however, needs to ensure that all employees review and sign an acknowledgement to self report criminal activity (D5).

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 #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o SGSSLC facility-specific policies, "Quality Assurance Process," dated 4/14/11, with an update 4/19/12 that added the QA plan narrative o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, revised draft June 2012 (though still dated April 2012) o Draft agenda for statewide Quality Assurance Directors meeting, scheduled for 6/21/12 o SGSSLC organizational chart, undated, but probably May 2012 o SGSSLC policy lists, 4/19/12 o List of typical meetings that occurred at SGSSLC, 5/22/12 o SGSSLC Self-Assessment, 5/1/12 o SGSSLC Action Plans, 5/1/12 o SGSSLC Provision Actions Information, most recent entries 5/15/12 o SGSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/4/12 o SGSSLC DADS regulatory review reports, through 4/14/12 o SGSSLC QA department meeting notes, (none) o SGSSLC QA plan narrative, 4/19/12 o SGSSLC data listing/inventory electronic spreadsheet, 2/14/12 o SGSSLC Quality Assurance matrix, included in electronic spreadsheet, 2/14/12 o Set of blank tools used by QA department staff (6) o Sets of completed tools used by QA department staff for 4 of the 6 tools (hundreds of pages) o Sets of completed statewide/facility self-assessment tools showing department scores and QA staff scores (for interobserver agreement determination) o A 3/12/12 review by the QA department nurse, of actions taken regarding enteral feeding issues from monitoring team review May 2011 o Trend analysis reports, all four data sets, two quarters, September 2011 through February 2012 o SGSSLC QA Reports, monthly, January 2012 through May 2012 (five) o QAD/SAC monthly report on benchmark meetings for each provision, January 2012 to April 2012 o Departmental QA efforts compliance scores, Sections QA efforts compliance scores, Sections departmental monitoring compliance scores, 10 individual questions, and Section analysis compliance scores, monthly data and graphs, February 2012 through April 2012 o Spreadsheet comparing rating of self-assessment tools to ratings from monitoring reports o QI Council agenda and meeting minutes from 1/30/12 through 4/12/12 (4 meetings) o PIT meeting notes for mealtimes, restraint reduction, active treatment, health community, and enteral feeding

	o QI Council handouts, and slides, from 6/5/12 meeting o SGSSLC Corrective Action Plan, tracking, 43 pages, 5/15/12 o SGSSLC CAP tracking/updates compliance scores, 2 pages, undated, probably 5/15/12 o SGSSLC QIC action plans, 3 pages, undated, probably 5/15/12 o DADS SGSSLC family satisfaction survey online summary, monthly, December 2011 through March 2012, total of 16 respondents (average of 4 per month) o Self-advocacy monthly meeting minutes, monthly December 2011 through May 2012 o Notes about other self-advocacy group activities o Home meeting agenda and notes, last two meetings, each of the homes o SGSSLC Enlightener staff newsletter, January/February 2012, March/April 2012 o SGSSLC Settlement Agreement brochure, undated o SGSSLC About Us Newspaper, individual's newsletter, undated <u>Interviews and Meetings Held</u>: o Angela Kissko, Director of Quality Assurance o Misty Mendez, Settlement Agreement Coordinator o Leticia Williams, QA staff member o Unit Directors: Cedric Woodruff, Tricia Trout, Mandy Rodriguez o Roy Smith, Human Rights Officer, Zula White, Human Rights Office Assistant, Melissa Deere, Assistant Independent Ombudsman o Priscilla Munoz, Settlement Agreement Coordinator, El Paso SSLC; Larry Algueseva, Director of Quality Assurance, Andy Rodriguez, Settlement Agreement Coordinator, San Antonio SSLC <u>Observations Conducted</u>: o QI Council meeting, 6/5/12 o Self-advocacy group, 6/5/12
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with the QA director and Settlement Agreement Coordinator about the new self-assessment. They were very eager to implement this new process correctly and in a way that would be beneficial to them. The most difficult

	aspect of this appeared to be understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. That is, the self-assessment should assess the activities of the QA department and whether those activities were implemented thoroughly, correctly, and adequately. Thus, the self-assessment should look at (i.e., assess) all of the activities that are discussed in the report below, such as the working relationship between the QAD and SAC, the data listing/inventory, QA plan narrative and matrix, QA department review of all data in the QA matrix, the QA report, QI Council, corrective actions, and so forth. The SGSSLC self-assessment for E1, for example, only looked at a small number of activities (e.g., trend analysis, self-monitoring by departments, occurrence of benchmark meetings). Coincidentally, during the week after the onsite review, the monitoring team was sent a revised draft statewide self-monitoring tool for section E. This statewide tool was a vast improvement from the previous version and accomplished some of what is described in the paragraph immediately above. Although a good revision, the tool did not include all of the areas looked at by the monitoring team (see report below). Nevertheless, with further revision and additions, this tool may be useful to the QA department. The facility self-rated itself as being in compliance with E3 and in noncompliance with the other four provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress continued to be evident since the time of the last onsite review.
	Summary of Monitor's Assessment: SGSSLC continued to make good progress towards substantial compliance with all of the items of provision E. This was due to the extensive efforts of the QA director and the Settlement Agreement Coordinator. Now that facility-specific and state policies had been developed, training and orientation of both the state and facility policies and their requirements needs to occur. The QA department had made good progress towards creating a fairly comprehensive listing/inventory of data collected at the facility. It was managed as an electronic spreadsheet with 19 separate tabs. The next step is to ensure that the list is comprehensive and as complete as possible. The QAD and SAC should always be adding and editing this spreadsheet as they learn about data being collected at the facility. This is important because, for example, during the week of the onsite review, the monitoring team learned of two important sets of data that were missing from the data listing/inventory: • Data on staff TB test status (see section M) • Number of individuals with diabetes (a trend of more than a 50% increase in the number of individuals with the diagnosis of diabetes, see section L) The SGSSLC QA narrative was an excellent first version. The QAD should now revise it to edit in all of the topics that are bulleted in E1. The QA matrix was also much improved from the previous report. Monthly benchmark meetings were initiated after the previous onsite review and continued regularly since

	then. It was a meeting of the QAD, SAC, and the staff person responsible for being the facility lead for each provision of the Settlement Agreement. The monitoring team believes these benchmark meetings, although time consuming for the QAD and SAC, were an excellent part of the QA program at SGSSLC because it kept departments focused on QA, the Settlement Agreement, processes, data, outcomes, and corrective actions. Overall, documentation showed that the QA staff program auditors were busy conducting and documenting observations and monitoring. SGSSLC was now using its own tools for sections N, F, and H. Further, the possible development of additional facility-specific self-monitoring tools was reported by the QAD and SAC to be discussed during the monthly benchmark meetings. There are some important considerations as the facility revises/creates self-monitoring tools. Family and LAR satisfaction information were being collected, and staff satisfaction was being assessed annually. There were, however, no measures of individual satisfaction or of others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) and they need to be summarized. This was not yet occurring for all of the items in the QA matrix. There continued to be improvements in the QA report. The QA report had apparently become a regular and typical part of the QA program and QI Council. This was all good to see. The QI Council meetings had two major parts, one was a review of the scheduled Settlement Agreement provisions. During the meeting observed by the monitoring team, the provision leader presented data and some commentary, but there was little to no discussion or participation from attendees. The second part of the meeting was for the presentations by each Performance Improvement Team. There was more discussion than during the first part of the meeting, but even so, not much more. This was in stark contrast to what was observed during the last onsite review during which there was much engaged conversation, commentary, and discussion throughout the meeting. SGSSLC had a very good system of PITs. Corrective action plans (CAP) were readily and often created. As a result, there were many active (and many completed) CAPs at the facility. These were tracked by the QA director. The 26-page list at the time of the previous review had grown to 43 pages. There were CAPs for 17 of the 20 Settlement Agreement provisions. Staff who were deemed responsible for CAPs were aware of their CAPs and of their responsibilities. Not all CAPs, however, were implemented fully and in a timely manner or modified when needed.

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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 continued to make good progress towards substantial compliance with all of the items of provision E. This was due to the extensive efforts of the QA director and the Settlement Agreement Coordinator (SAC). Furthermore, they had the support of the facility director and the senior management of the facility. The QA director and SAC worked collaboratively and their combined efforts resulted in continued progress and improvement of the SGSSLC Quality Assurance program. During this onsite review, the QA director and SAC from the San Antonio SSLC, and the new SAC from the El Paso SSLC, were present. This was a great opportunity for collaboration across the three facilities and for the visitors to see a good example of how a QA director and a SAC can work together. <u>Policies</u> The state's QA policy was finalized and disseminated. The new policy was titled #003.1: Quality Assurance, dated 1/26/12. The new policy provided detail and direction to QA directors and facility staff, much more so than did the previous policy. SGSSLC had one facility-specific QA-related policy. It was called Quality Assurance Process. It was the same policy that had been in place for the past year, but was updated, 4/19/12, with the addition of the facility's QA plan narrative. A second facility-specific policy regarding the QI Council was discontinued because the content was in the Quality Assurance Process policy. Now that facility-specific and state policies had been developed, training and orientation of both the state and facility policies and their requirements needs to occur and should: • Be provided to QA staff. • Be required for senior management, including but not limited to QAQI Council. o This might easily be accomplished during the monthly benchmark meetings. • Involve more than just the reading of the new policy. The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. The statewide QAQI Council requirement was being met by the recent (3/5/12) formation of the statewide leadership council. Statewide discipline QAQI committees were not yet in place. Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this. In the week following the onsite review, the monitoring team was sent a draft of a new	Noncompliance

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		proposed statewide self-monitoring tool to be used for section E. This was an improvement from the previous draft tool. The monitoring team's comments on this draft are above, in the section "Facility Self-Assessment." <u>QA Department</u> Angela Kissko remained as the QA director. To reiterate from the previous monitoring report: She was well organized and she was responsive to the comments made in the previous monitoring report. She was moving the facility forward in its quality assurance program and activities. The Settlement Agreement Coordinator (SAC), Misty Mendez, was new at the time of the previous review. Since then, she had settled into her role very well and worked closely with the QA director. Their collaborative efforts were working to the benefit of the QA program at the facility. The QA director continued to work closely with the director of incident management because she managed the statewide trend analysis (i.e., data regarding restraints, abuse neglect allegations, injuries, and unusual incidents). The director of incident management submitted these data, as relevant, for inclusion in the QA report. • It was not clear, however, if the QA director was also doing her own review of the trend analysis data. This should occur because the trend analysis was part of the QA matrix, and all data in the QA matrix should receive review by the QA department (see below). The QA department did not have a periodic staff meeting. The monitoring team suggests that the QA director consider doing so. If so, the meetings could also be used as a staff training-type of opportunity, so that staff can learn about the profession of quality assurance, participate in creating processes for the department and facility, and so forth. <u>Quality Assurance Data List/Inventory</u> The creation of a list of all of the data collected at the facility is an important first step in the development of a comprehensive quality assurance program. The QA department had made good progress towards this by creating a fairly comprehensive list. It was managed by the QAD and SAC as an electronic spreadsheet with 19 separate tabs. The tabs were for all aspects of service, support, and operation at the facility, including clinical services, administrative services, and all provisions of the Settlement Agreement. This was an excellent way to manage the data listing because it allowed for easy review and updating. To fully understand all of the data collected at SGSSLC, one would have to read all of the tabs. This, however, seemed reasonable to the monitoring team. In addition, two useful columns were recently added. These indicated if the data were to be reviewed at QI Council, be included in the QA report, be reviewed during monthly	

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		benchmark meetings, or not be reviewed at all. Given that the listing/inventory was new, the next steps for the QA department are to: • Ensure that the list is comprehensive and as complete as possible. The QAD and SAC should always be adding and editing this spreadsheet as they learn about data being collected at the facility. The list will evolve over the first six months of its development and then will likely only need updating once per year or so. The current spreadsheet had not had any additions or edits since 2/14/12. The importance of this cannot be overstated. For example: o During the week of the onsite review, the monitoring team learned of an important set of data that were missing from the data listing/inventory: data related to staff training and HR-related activities of the CTD department. In this specific case, it appeared that many staff were not up to date on their annual TB test. Data on TB test status were not part of the data listing/inventory, but should have been. o The number of individuals given a diagnosis of diabetes had increased dramatically since the last onsite review (a trend of more than a 50% increase (see section L). • "Clean up" the contents. Some of the items were in yellow shading, some had information for all of the columns filled in, some had just some of the columns filled in, and some had none of the columns filled in. It may be that yellow highlighting meant that the item was also included in the QA matrix, but this was not clear or consistent. The QAD and SAC reported that they discussed the data listing/inventory during the monthly benchmark meetings. If so, this would be a good opportunity to address the two bulleted items immediately above. <u>Quality Assurance Plan and Matrix</u> The QA Plan should consist of a QA narrative and a QA matrix. SGSSLC made very good progress on both of these. The narrative should be a description that might include a two or three page overall description of how QA is conducted at SGSSLC: • a description of the comprehensive list/inventory of all data that are collected across the facility • a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department • the role of the monthly benchmark meetings • the role of any QA databases • a description of the QA report • the way that the QIC meetings work	

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		• the overall expectation and processes for data analysis, corrective action planning, and corrective action management o including the role of PITs and PETs. The SGSSLC QA narrative was an excellent first version. The QAD should now revise it to edit in all of the topics that are bulleted in the above paragraph. In the current version, the data listing/inventory and the QA matrix descriptions were combined into a single somewhat confusing paragraph. The descriptions should be separated. The QA matrix was also much improved from the previous report. The purpose of the QA matrix is to show all of the data that the QA department will track, trend, and comment upon. Some, but not all, will go into the QA report; and some, but not all, will be reviewed by QI Council. The SGSSLC QA matrix was included in the electronic spreadsheet along with the data listing/inventory. In fact, the QA matrix was the very first tab. The QAD and SAC reported that every item in the QA matrix also appeared in one of the tabs of the data listing/inventory. This made sense and was a good way to organize the matrix. The monitoring team provides the following guidance to the QAD and SAC as they further develop the QA matrix. Some of the activities below were already being done at SGSSLC. • All items in the QA matrix are data that are to be submitted to the QA department. • All items in the QA matrix receive review and analysis by the QA department. o Some of the summarizing and graphing of the data, however, can be done by the discipline/department prior to submission to the QA department (see E2 below). • The selection of what items are in the QA matrix should come from: o QI Council, o Clinical, service, and operational department heads, and o The QAD and SAC. • Typically, this will result in a number of "types" of items, such as: o A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, these are the statewide self-monitoring tools, plus any other self-monitoring tools used by the department. o A list of data that the QI Council wants to see. In some facilities, these are called key indicators. o A list of data that the QA staff collect themselves. o Any other data that the QA department wishes to receive from the facility's many departments. o Any data that the discipline department heads determine are important to submit to the QA department.	

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		• All items on the QA matrix should also appear in the data list/inventory. <u>QA Activities</u> Monthly QA Benchmark meetings: The QA department engaged in many activities. One was initiated after the previous onsite review and continued regularly since then. It was called the monthly benchmark meeting and was a meeting of the QAD, SAC, and the staff person responsible for being the facility lead for each provision of the Settlement Agreement. During these one-hour meetings (there were about a dozen or so every month), they reviewed QA-related actions (10 were listed), reviewed the data listing/inventory, discussed data and outcomes, reviewed conduct of the self-monitoring tools, created corrective action plans, and reviewed previous corrective action plans. The monitoring team reviewed minutes from the last few months of these meetings (these were called Status Reports) and hopes to observe one or more of these meetings during the next onsite review. In addition, the QAD and SAC generated a set of graphs that portrayed the departmental performance on those metrics that were part of the benchmark meeting agenda and reports. The monitoring team believes these benchmark meetings, although time consuming for the QAD and SAC, were an excellent part of the QA program at SGSSLC because it kept departments focused on QA, the Settlement Agreement, processes, data, outcomes, and corrective actions. The monitoring team recommends that the state office QA coordinator consider this as a best practice. QA staff activities: QA staff spent their time collecting data implementing their department's own QA tools (there were six), completing statewide self-assessment tools, primarily to assess interobserver agreement, and participating on various committees and in meetings. They had revised some of these tools to make them more efficient and less redundant. Of the six tools, three were included in the QA report and reviewed by QI Council. Two of the other three were summarized by the QA department and reviewed by the QAD. It was unclear if the third was reviewed at all. If the data were never reviewed or used, the QA department should consider whether it was important to continue to collect those data. Completed data sheets were given to the monitoring team for four of the six tools for the past few months, and for QA staff's completion of IOA observations. In some of the IOA forms, there was documentation showing discussion between the observers. This was good to see. Overall, the documents showed that the QA staff were busy conducting and documenting observations and monitoring.	

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		Self-monitoring activities: The DADS state office had recently given new direction to the facilities regarding these tools. The monitoring team's understanding was now that each facility could choose to use the current statewide tools, modify the current tools, or develop new tools. Thus, Settlement Agreement self-monitoring tools could become facility-specific. State office approval was not required, however, the facility department head was supposed to collaborate with his or her state office discipline coordinator. Further, state office did not require the facility to have any specific type of facility-level review and approval process, other than the involvement of QI Council. On the other hand, it seemed that the state office discipline coordinator could require the facilities to all use the same tool. The QAD reported that SGSSLC was now using its own tools for sections N, F, and H. Further, the possible development of additional facility-specific self-monitoring tools was reported by the QAD and SAC to be discussed during the monthly benchmark meetings. Self-monitoring tools can be very helpful if done correctly and if they direct managers to important areas and activities. That is, the content needs to be valid and needs to line up with what the monitoring team is assessing. Thus, the self-monitoring tools should become an important part of the self-assessment process for each provision. It may be that a well-designed and comprehensive self-monitoring tool <u>is</u> the self-assessment, or it may turn out that self-monitoring tool is but one of a number of sources of data and information that the department uses in self-assessing its substantial compliance with each provision item. The monitoring team has commented on the facility's self-assessment of each Settlement Agreement provision at the beginning of each section of this report. There are some important considerations as the facility revises/creates self-monitoring tools (some of the following is repeated from the previous monitoring report): • Again, the content of the tools should be relevant and valid. • Some items in each tool may be more important than others. These should be indicated. • Consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. o It is possible to do too much monitoring, especially if it competes with the completion of other duties and responsibilities and/or if the additional monitoring does not provide any additional information. • Attend to duplication of efforts, such as two observers sitting in the same ISP meeting when it might have been done by one observer.	

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		As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information were now being collected regularly and shared with QI Council. Staff satisfaction was also being assessed annually and was presented during the last monitoring review. In addition, the unit directors were routinely collecting some data regarding satisfaction of direct care staff. These data might be of interest to the QA department, too. There were no measures of individual satisfaction. One way to obtain some of this information might be via self-advocacy committee and/or the weekly individual home meetings. The human rights officer and his staff may be able to assist with this. Satisfaction measures should also extend to others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Overall, to meet the requirements of this provision item, SGSSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. The activities that are relevant to this provision item are the facility's management and analysis of data, the QA report, the QI Council, the use of performance improvement activities, and the management of corrective actions and corrective action plans. Continued progress was again demonstrated by SGSSLC. <u>QA Data Management and Analysis</u> The data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) <u>and</u> they need to be summarized. This was not yet occurring for all of the items in the QA matrix. The importance of QA department review of data plays a very important role in the QA process. Summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be 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. A proper graph takes time to initially create, but after that, only requires an additional data point to be added each month, quarter, etc. Note that not all of these graphs need to be created by the QA department. It is possible for the facility to set an expectation for the service departments to submit data and	Noncompliance

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		graphic summaries each month. Of particular note, the data in the quarterly trend analysis data should be graphed. There were data for more than three years, but most of it was presented in only tabular form (monthly restraints were the exception). Many of these graphs can be inserted into the QA report and be presented to QI Council. But to reiterate, the QA department should be managing all of the data on the QA matrix of which some, but not necessarily all, will end up in the QA report. <u>Benchmark Meetings</u> The new monthly benchmark meetings played an important role in the analysis of data. The meetings were discussed above in E1. <u>QA Report</u> There continued to be improvements in the QA report. It continued to be a monthly report, but now only included data on the Settlement Agreement provisions that were to be reviewed at QI Council that month. Each provision was now reviewed quarterly, thus, the provisions were grouped into three sets. This made sense to do and made the report more focused and streamlined. Other improvements included the inclusion of a narrative analysis/description of the data. In addition, resolution of disagreements found during inter-observer agreement checks were described. The QA report had apparently become a regular and typical part of the QA program and QI Council. This was all good to see. The monitoring team has the following suggestions and comments: • Consider if there are any key indicators that should be in the QA report every month. These might be high profile important outcomes. o The inclusion of the benchmark data each month was an example of this. • Consider how to best include and present correction action plan information. Overall, it seemed to take up a lot of space in the QA report and the monitoring team was not sure how much value it provided, in its current form, to the reader. For example, there were six pages of correction action plan information in the psychology section and five pages in the nursing section. • Consider including graphs of the long-term data from the four sections of the trend analysis report. Currently, the reader was referred to the trend analysis report and a lengthy narrative was in the QA report. • The section O report was one of the best. It included the self-monitoring tool data, and then followed with graphs of other relevant data.	

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		QI Council This meeting plays an important role in the QA program and is to be led by the facility director. Since the last onsite review, the QI Council met once per month. Previously, the QI Council met twice per month. The QA department changed this to once per month because they now only addressed each Settlement Agreement provision quarterly, and they had added the monthly benchmark meetings. This seemed like a good way to operate. The meetings had two major parts, one was a review of the scheduled Settlement Agreement provisions. During the meeting observed by the monitoring team, the provision leader presented data and some commentary, but there was little to no discussion or participation from attendees. The second part of the meeting was for the presentations by each Performance Improvement Team. There was more discussion than during the first part of the meeting, but even so, not much more. This was in stark contrast to what was observed during the last onsite review during which there was much engaged conversation, commentary, and discussion throughout the meeting. If QI Council content is merely a presentation of data, with no discussion and no decisions to be made, it will become a meeting of decreasing value to attendees. In a way, the facility director, QAD, and SAC could think about attendee participation as one indicator of the quality of the QI Council meeting, especially for the part of the meeting when the Settlement Agreement provisions are presented. To perhaps improve these presentations, the monitoring team suggests that the presenter plan his or her presentation such that: • The most interesting and important data are presented verbally, even if additional data are in the QA report. The presenters do not have to talk about, or read, every part of their section of the QA report. • Important indicators that line up with the facility's most important outcomes are presented. Performance Improvement Teams SGSSLC had a very good system of PITs. When a topic or support was in need of additional attention and action, the QI Council created a PIT. The PIT leader then coordinated activities and made a monthly presentation to the QI Council. Once a PIT had finished its work, the QI Council sometimes made it into a Performance Evaluation Team (PET). A PET meant that the PIT's major work was completed, but that data relevant to the topic or support would continue to be presented to QI Council. At SGSSLC, there were PITs for enteral feeding, healthy choices on campus, active treatment, and pain management. Previous PITs on mealtimes, medication variances, suction toothbrushing, and spurious allegations had become PETs. One previous PIT, the	

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		staff recognition group, became a regular committee and, therefore, was neither a PIT or a PET any longer. Overall, this seemed like a good system. Of concern to the monitoring team, however, was the pneumonia PIT. It was in operation at the time of the last review, but had been discontinued. That is, it was no longer a PIT and did not become a PET. The medical director was not able to provide a good reason for its discontinuation at the QI Council meeting when she was asked about it. This needs to be re-visited and resolved. During the onsite review, based on these questions, the facility director re-instated the pneumonia PIT. <u>Corrective Actions</u> At SGGLC, corrective action plans (CAP) were readily and often created. - during benchmark meetings - during PIT meetings - sometimes at QI Council meetings As a result, there were many active (and many completed) CAPs at the facility. These were tracked by the QA director. The 26-page list at the time of the previous review had grown to 43 pages. There were CAPs for 17 of the 20 Settlement Agreement provisions. The status of each CAP was reviewed at each benchmark meeting. The QAD and SAC had recently begun collecting data on whether the provision leader had updated his or her list of CAPs each month. Collecting data on CAPs was good to see. In addition, the monitoring team recommends other monthly data that will likely be useful to the QA staff and QI Council: • Total number of active CAPs • Number of CAPs completed and closed out • Number of CAPs that are active (i.e., not completed) past their due date Given that the lengthy CAP tracking list will continue to grow, the monitoring team recommends that the QA director write a one-page cover page that describes the document so that the reader can easily understand the contents and how the CAPs are organized. For example, some boxes were shaded, some wording had strike-through font, and some were in italics. This description could also describe the relationship between CAPs and what is included in the facility's action plan document. The QA director also needs to determine what to do long-term with this document. At the current rate, it will likely be more than 100 pages long in the near future.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based upon the organized system of CAPs management at SGSSLC, the CAPs tracking form, observation during the onsite review, and discussions with various staff, the monitoring team found that staff who were deemed responsible for CAPs were aware of their CAPs and of their responsibilities.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	SGSSLC was not in compliance with this provision item. CAPs were discussed and reviewed during the monthly benchmark meetings. Not all CAPs were implemented fully and in a timely manner.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SGSSLC was not in compliance with this provision item. Although CAPs were discussed and reviewed during the monthly benchmark meetings, many were not modified when needed. Further, the QA director did not have a systematic method for determining which CAPs needed modification.	Noncompliance

Recommendations:

1. Provide training to QA staff, and senior management and clinical staff on the new state policy and any QA-related facility-specific policies. Training should involve more than the reading of the policies (E1).
2. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
3. Consider whether the state policy might need any updates or revisions (E1).
4. Consider holding a monthly QA department meeting (E1).
5. Ensure the comprehensive listing/inventory of all data collected at SGSSLC is complete. "Clean up" the current electronic spreadsheet presentation (E1).
6. Revise QA plan narrative as suggested in E1 (E1).
7. Follow the suggestions regarding the QA matrix presented in E1 (E1).
8. If the data from one of the QA staff tools is not used, consider whether the data need to be collected (E1).
9. Determine how to best use the statewide self-monitoring tools. Consider the suggestions made in E1 regarding development of facility-specific self-monitoring tools (E1).

10. Include a staff and community satisfaction measures in the QA program (E1).
11. Review and summarize all data in the QA matrix, including data from the trend analysis (E2).
12. Consider the suggestions provided in E2 regarding the QA report (E2).
13. Consider/review attendee participation at QI Council meetings (E2).
14. Resolve the status and operation of the pneumonia PIT (E2).
15. Describe the CAP system in a one-page cover page (E2).
16. Add CAP data as described in E2 (E2).
17. Address the implementation and modification of CAPs (E4, E5).

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 Supporting Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o SGSSLC Self-Assessment o List of all serious injuries for the past six months o List of all injuries for the past six months o SGSSLC Section F Presentation Book o A sample of completed Section F audits done by SGSSLC o Attendance records for the Suzy Crawford center (April and May 2012) o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews (for some individuals in the sample) for the following Individuals: • Individual #44, Individual #12, Individual #367, Individual #389, Individual #258, Individual #66, Individual #73, Individual #53, Individual #151, Individual #367, Individual #126, Individual #388, Individual #24, Individual #331, Individual #273, Individual #269, Individual #59, Individual #400, and Individual #94. o Injury reports for the past three months for: • Individual #258, Individual #288, Individual #241, Individual #201, Individual #61, and Individual #400 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Michael Davila, QDDP Coordinator o Michael Fletcher, QDDP Educator o Jalown McCleery, Incident Management Coordinator o Dana Robertson, POI Coordinator o John Church, Psychologist o Roy Smith, Rights and Protection Officer <u>Observations Conducted</u>: o Observations at residences and day programs o 505B IDT Meeting 6/5/12 o 511B Home Meeting 6/5/12 o Unit I Morning Meeting 6/6/12 o Incident Management Review Team Meeting 6/6/12

	o Annual ISP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from another document that listed all of the action plans for each provision of the Settlement Agreement. 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. Most of the items required by this provision were not yet fully implemented and the facility was waiting for further guidance from the state office. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was a positive development in the facility self-assessment process. The "activities engaged in" section of the self-assessment noted use of the section F monitoring tool for most provisions in section F. The results of the self-assessment section gave a brief summary of compliance percentages by month for each item. The list of activities engaged in by the facility for many provisions was not as comprehensive as activities reviewed by the monitoring team to assess compliance. It was not evident that the quality of documentation was taken into consideration when assessing compliance. For example, the facility reported data on the submission of assessments prior to annual IDT meetings. Quality of assessments submitted was not discussed To take this process forward, the monitoring team recommends that the QDDP Coordinator continue to review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the QDDP Coordinator to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." The facility self-assessment did not find any provision of section F to be in compliance at this time. The monitoring team agrees with this assessment, although progress towards meeting substantial compliance with each of these provision items was noted.
	Summary of Monitor's Assessment As noted in the last report, DADS had revised the ISP process and hired a set of consultants to help SSLCs move forward in developing person centered ISPs developed by an integrated support team. SGSSLC was still awaiting training and technical assistance from the consultant team. Observation of three ISP meetings and review of 19 ISPs confirmed that teams were still at varying stages in developing integrated plans that

	included all needed supports and services based on preferences and needs of each individual. It was apparent that teams were attempting to follow the format of the new ISP process and include all required information in the plan. It was not apparent, however, that teams really understood the philosophy behind the person centered planning process and were any closer to developing meaningful support plans and services. Intensive technical assistance will be needed by the state office to help IDTs understand what the outcome of the process should look like and how to achieve that outcome. As was noted in section D of this report, there were many incidents and injuries at the facility and it was not evident that supports and services were being provided in a way that protected individuals from harm. Adequate assessments were not developed or revised when needed for most individuals. All team members were not participating in the planning process. Without an adequate assessment process and participation by all team members in planning, IDTs could not develop plans to address individual's preferences and needs. For needs that had been identified, a service delivery system was not in place to address those needs.

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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.	Progress had been made with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive steps taken by the facility included: • The QDDP Coordinator and QDDP Educator continued to attend a sample of IDT meetings to evaluate the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. • Scribes were assigned for all ISP meetings to allow the QDDP to concentrate on facilitating discussion at the meeting. • The agenda for facilitating the ISP meeting had been updated in an effort to ensure that all important areas were discussed and provide structure to the meetings. • An ISP tracking log had been created to track important timelines in the ISP process including training, implementation, and quarterly reviews. Assessing facilitation was still a new process for the QDDP Coordinator, but should be an effective tool for evaluating the facilitation skills of each QDDP and focusing training	Noncompliance

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		efforts where most needed. The facilitation tool used to assess compliance rated: • The QDDP's knowledge, preparedness, and whether he/she could demonstrate inclusiveness and assertiveness, • The QDDP's ability to solicit information using the ISP prompts, and • The QDDP's ability to guide team members through the ISP process. The facility self-assessment indicated that three QDDPs still needed to be assessed for competency in meeting facilitation. For those QDDPs that had been assessed, 21% showed full competency in all areas. During the week of the review, the monitoring team observed a number of team meetings. Progress definitely continued to occur with regard to the facilitation of meetings, but was not consistent among the meetings observed. At one meeting observed, the QDDP failed to keep the meeting moving along resulting in a very lengthy meeting where key information was not shared and very little long range planning occurred. At another meeting, the QDDP did an excellent job of facilitating an integrated discussion among team members while keeping the meeting moving at a good pace. Based on these observations and a review of ISPs, some of the areas in which progress had begun included: • Efforts were made to include the individual and focus the discussion on him/her. • More effort was being made to elicit information from all team members. . • Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. • Based on the meetings observed, QDDPs appeared to have come prepared with an agenda. Documents, such as a draft Integrated Risk Rating Form and a draft ISP format, appeared to provide team members with some relevant information and assist teams to remain focused. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. QDDPs were in attendance at all annual meetings in the sample reviewed. Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but it was not yet resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to	

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		address all risk that teams identify. The facility remained out of compliance with 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.	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Personal Focus Assessment (PFA) was the document that should have identified the team composition based on the individual's preferences, strengths, and needs. The facility had begun to track data on attendance at IDT meetings. The facility audit indicated that attendance by the individual and LAR at annual ISP meetings was between 63% and 82% between December 2011 and March 2012. The facility self-assessment indicated that data regarding attendance by other team members at annual ISP meeting was between 86% and 94 % for the four months audited. The audit found that the lowest participation in team meetings was for vocational staff and OT/PT staff. A sample of ISP signature sheets was reviewed with the following results in terms of appropriate team representation at annual IDT meetings. The sample was Individual #367, Individual #126, Individual #389, Individual #388, Individual #53, Individual #12, Individual #151, Individual #400, and Individual #73. Nine (90%) of 10 indicated that the individual attended the meeting; • The exception was Individual #367. Only one of the individuals in the sample had a guardian. The guardian was in attendance at the meeting. The primary correspondent participated in one other ISP meeting via teleconference. A review of signature sheets for participation of relevant team members at the annual IDT meeting indicated that none (0%) of the meetings were held with <u>all</u> relevant staff in attendance. There had been progress made in ensuring participation of key team members in the planning process for some disciplines. There was still a notable lack of participation by day habilitation staff, dieticians, SLPs, and OTs. Without the presence of key team members in attendance at meetings, there cannot be adequate discussion regarding risk areas and planning for comprehensive, integrated treatment and supports.	Noncompliance

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		Some examples where team participation was not found to be adequate were: • A review of the attendance sheet for Individual #367 indicated that the following relevant team members were not in attendance at his annual ISP meeting: day habilitation staff, occupational therapist, his contract LA, and his dietician. He was not receiving any day habilitation supports and none were developed at the meeting. The team agreed that he needed the support of a dietician due to his risk for weight issues. He had a mealtime plan in place due to his risk for choking. • Individual #12 was at risk for choking and had a mealtime plan to address his risk. His OT and SLP were not at his annual ISP meeting. He required the use of sedation for dental work. Dental staff were not at his meeting. He had a psychiatric diagnosis and took psychotropic medications. The psychiatrist was not present at his annual meeting. As noted in previous reports, The absence of key members was a significant barrier to integration in the development of ISPs. The facility had just begun to use a database to track attendance at meetings by discipline. The database should allow QDDPs to identify trends in low participation by discipline and thus, be able to address lack of participation with specific department heads. The self-assessment indicated that the facility was not yet in compliance with requirements for integrated team participation. The monitoring team agreed.	
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.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. Steps the facility had taken to improve the assessment process used for planning included: • The facility was using a database to track submission of assessments prior to the annual ISP meeting. • Audits were conducted of clinical assessments for the inclusion of required elements. • Change of status for individuals was being identified in the daily unit meetings. According to the facility self-assessment, the QDDP Coordinator had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data collected for December 2011 through March 2012 showed low compliance rates for all disciplines with the requirement that assessments be submitted at least 10 days prior to the annual IDT meeting. Scores ranged from a low of 12% to a high of 54%.	Noncompliance

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		Details were not given regarding whether or not the other assessments were submitted late or not at all. The quality and timeliness of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's ISP, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed (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 facility was using Personal Focus Assessment as a screening tool to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. Teams were still not consistently completing and using this tool to drive planning of supports and services. The state had recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. The facility will need to be trained on how to complete the PSI and how to use it in planning services and supports. The PFA process was reviewed for individuals in the sample. Teams were not consistently completing the assessment in a way that would make it a useful guide for determining preferences and priorities or the need for further assessment. For example, • The PFA for Individual #73 indicated that it was completed by the QDDP 11 days prior to the annual ISP meeting. The Section III- Summary was the only part of the PFA completed and it appeared to be a summary of the ISP discussion. It was not evident that information was gathered prior to the ISP meeting and used to drive planning. The summary stated some preferences and long term visions, but did not describe what supports may be needed to ensure those preferences were included in her day or what supports were needed to achieve her vision. The summary section noted barriers to achieving her vision for living and working in the community, but did not discuss what supports the team could put into place to support her in achieving her vision or what additional assessments may be necessary to develop that list of supports. • The PFA for Individual #389 was completed prior to his annual ISP meeting. The Section II Summary Section and the Section III Assessments Needed section were not completed.	

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		The PFA for Individual #126, however, was a good example of a PFA that was completed with thought and resulted in an assessment that was useful for planning. Ten ISPs developed after 1/1/12 were reviewed to determine if the list of preferences was adequate for planning. The following are comments regarding those ISPs. • Progress had been made towards developing a list of individualized preferences for each individual in the sample. None were as comprehensive as they needed to be to provide the team with enough information for individualized planning, but all offered a good starting point for discussion. • Few described preferences for daily schedules. Given the high number of self-injurious behaviors and aggressions towards others at the facility, this type of information would be critical for support staff to know. Structuring an individual's day and environment to encourage participation often relies on information such as: o Does the individual like to wake up early or sleep in? o Does he/she like quiet time in the morning? Or need quiet time after work to wind down? o Does he/she need coffee in the morning before getting dressed? o Does the individual prefer to shower/bathe in the morning or evening? o Is he/she more productive at work in the morning or afternoon? o Does the individual prefer to spend time alone in the evenings or socialize with friends? o Does the individual prefer assistance from particular staff members? Information gathered from the PFA was discussed in the IDT meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in limited discussion on how these might be supported. Measureable outcomes were not always developed with preferences in mind. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Consideration of outcomes was limited based on activities available at the facility. Outcomes should be considered that might lead to greater exposure to the community. The facility was using the Functional Skills Assessment (FSA) to assess each individual's functional skills. Staff completing the assessment will need to put thought into information gathered from the assessment and make recommendations that will assist the team in planning. Staff were completing the checklist in some cases, but not using it to develop individualized recommendations from the results.	

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		Other examples found where assessments were either not submitted prior to the annual ISP meeting to be used for planning or were not adequate for planning purposes included: • Individual #73 had multiple health risks. Her annual physical exam was completed after her annual ISP meeting. Lab work was completed on the day of her annual meeting. Her FSA was incomplete. Her behavior assessment appeared to be updated one day prior to her ISP meeting. She was at high risk for weight issues. There was no evidence that a nutritional assessment had been completed prior to her annual meeting. • Individual #388's annual psychological evaluation noted that he needed a comprehensive psychological evaluation and an updated functional assessment prior to his PBSP being updated. There was no evidence that assessments were obtained or even discussed by the team. His PFA was dated almost a year prior to his annual ISP meeting and did not identify the need for any assessments. • The annual nursing assessment and ophthalmology assessment for Individual #126 were completed after her annual ISP meeting. There was no evidence that a communication assessment or a functional skills assessment had been completed. All four of these assessments would have been important in planning appropriate supports and services. The facility rated F1c as not in compliance based on the timely submission of assessments. The self-assessment did not, but should, look at the adequacy of assessments submitted. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not in compliance with this item.	
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.	Little progress had been made in ensuring that assessment results were used to develop, implement, and revise the ISP. QDDPs continued to "cut and paste" information from assessments into the ISP without describing how supports should be implemented throughout the individual's day. There was little evidence that assessment results were discussed by the team and integrated into a comprehensive plan with clear instructions for staff providing daily supports. For example, • Individual #126's ISP consisted primarily of a sequence of summary sections copied from each discipline's latest assessment. There was little discussion regarding training opportunities or how she spent most of her day other than to note that she watched TV, walked around the home, and attended the Suzy	Noncompliance

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		Crawford Center for activities. The ISP should have described her daily schedule along with what supports were needed throughout her day. There was little discussion regarding how her list of preferences would be supported. For example, it was noted that she enjoys "going into town." She had outcomes to attend community events and participate in shopping trips and dining out. There was nothing regarding her preferred community activities, what supports were needed for her participation, what training opportunities could occur on the trips, or how often she would be supported to go into the community. • The ISP for Individual #367 noted that he was a medium risk for weight gain. The IDT discussed the dietician's recommendation for him to keep a food diary to track his food intake. The team disagreed with this recommendation citing the fact that he would be unable to keep a diary on his own. The team did not develop other strategies to monitor his weight other than an action step to "monitor his weight." The team did not set parameters for weight gain or describe how his weight would be monitored. The team also disagreed with the SLP's recommendation for assistive technology for communication. The team did not discuss other communication supports that might increase his ability to communicate effectively. • The ISP indicated that Individual #367 exhibited behaviors that would be problematic to him living in the community. He did not participate in any type of day habilitation program, also attributed to his behaviors. The team reported that he was not interested in work or in classes available at the facility. The team did not explore options for day habilitation based on his preferences. It was reported that he spent his day wandering around not engaged in any meaningful activity. The team did not develop a plan to attempt to engage him in any other activities. • Individual #73's PFA identified a fairly comprehensive list of preferences and interests. None of them, however, were used to develop training objectives. As noted in section I of this report, it was not clear that identification of risk factors led to adequate action plans to monitor or reduce the risks. None of the ISPs in the sample adequately addressed day programming at the facility. A summary of participation in day programming was provided prior to annual ISP meetings. There was little indication that individuals were attending day programming and teams were not addressing the lack of participation or programming options at annual meetings. Some examples found in ISP documentation of this included: • The participation summary for Individual #388 noted that he was enrolled in Zumba classes two days per week and bowling two days per week. The note under attendance indicated that he did not attend any of his classes. The	

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		reporter suggested "delete due to lack of attendance." The team did not discuss day programming at his ISP meeting. There were no objectives developed to address day habilitation. A vocational assessment had not been completed and employment was not addressed. • The participation summary for Individual #151 also indicated that he was enrolled in two sensory classes, but had not attended either class. The suggestion was to remove him from enrollment to open the position for another individual who would attend. His ISP noted that he would attend classes, but he was unsure where his classes were located. An action step was created to help him locate his class, but the team did not discuss which classes he preferred. Observation of day programs at the facility confirmed that very few individuals were attending formal day programming. On one day of observation, there were only 35 individuals in attendance at day programs during afternoon programming. There was no indication that teams were developing plans to ensure that adequate programming occurred during the day. The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Plans should be clear and easy to follow for all non-clinical staff responsible for providing daily supports.	
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).	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 ISP meeting, at minimum. A sample of 10 ISPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement, as required. The 10 ISPs were for Individual #126, Individual #53, Individual #367, Individual #73, Individual #388, Individual #389, Individual #367, Individual #151, Individual #400, and Individual #12. • In 10 (100%), this discussion took place at the annual IDT meeting. Although there had been some notable improvements in the living options discussion, as evidenced by the example below, this discussion was still not always adequate (also see section T of this report). • The ISP for Individual #126 summarized her preference for a specific living option by stating that the when asked her preference, she did not respond. As a result, the LA was unable to determine what her living preference was. When asked if there were any daily living skills she felt she needed to learn that would	Noncompliance

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		be helpful for her in the community, she did not respond. Her communication assessment noted that she "did not typically speak in order to communicate." She had limited expressive communication skills. The team agreed that she should continue to visit homes in the community setting. It was further noted that she does not "express her want to move to the community when asked," but the team would continue to offer her the choice and allow her to make decisions. There was no plan developed to offer further exposure to community options. Many of the same common themes still existed among the discussion and determination of most integrated setting placement and programming in the ISPs reviewed: • Community integration and employment were still not adequately being addressed. • Measurable action plans with reasonable timelines for completion were not developed when IDTs agreed that placement in a least restrictive environment would be an appropriate consideration. • Measurable outcomes to address community awareness were not developed when teams identified a lack of awareness regarding placement options. • Behavior incidents triggered by environmental factors and lack of adequate supports and programming were considered barriers to placement in alternate living environments rather than a consideration for determining that another placement may be more appropriate for an individual. IDTs need to give consideration to the following: • The primary focus of all IDTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting. • When individuals have visited community living options, the individual's response to the setting should be recorded and used in the team's discussion regarding preferences for living options. • As noted in the last review, the high number of injuries and incidents for some individuals may be an indicator that placement at SGSSLC is not the safest or most optimal living environment. Teams were still not reviewing each individual's history of incidents and injuries, decline in health status, or regression in skills to determine whether or not the facility is able to provide a safe living environment. None of the outcomes for individuals in the sample addressed measurable training objectives to be implemented in the community. Community based outcomes were a	

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		general statement than a functional outcome to achieve a desired objective. For example, Individual #12 had an outcome that stated "will participate in activities of interest in a community setting at least 2x monthly." This type of general statement outcomes was included in most of the ISPs in the sample (also see section S3b). None of the plans in the sample included opportunities to develop relationships and gain membership in the community. Although it was evident that teams were attempting to include outcomes to ensure more frequent exposure to the community, outcomes were not written to ensure consistent implementation. Plans will need to include community based teaching strategies to ensure that training is functional, consistent, and measurable (see section S3b). The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agrees with this self-rating. Not only will teams need to look at living options, they will need to determine the least restrictive setting to provide day habilitation and other services. 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.	
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	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." The ISPs in the sample continued to include a list of the individual's preferences and interests. The facility had made progress in developing more comprehensive lists of preferences for each individual. While this list was a good starting point, limited exposure to new activities meant that this list was often limited. As noted in F1c, lists of	Noncompliance

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	community participation;	preferences did not include detailed information about what things are most important in regards to routine, environment, communication, relationships and other key areas. In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Plans developed after 1/1/12 included a more comprehensive list of preferences, but plans did not consistently describe how those preferences would be supported. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences or that all supports were addressed in ISPs. There was some notable improvement in some of the homes in offering active treatment opportunities based on preferences. Very few individuals, however, were involved in meaningful day programs. Options for day habilitation were limited and individuals were vocal about not being interested in programming options available. At the annual ISP meeting for Individual #322, the team spent a great deal of time discussing his refusal to go to his assigned classes or to the sheltered workshop. He had been reassigned to take a class because he was not consistently showing up to class the first time that he was assigned to take it. The team never asked him why he refused to attend class. He also had been refusing to go to the workshop to work. His work preferences were never discussed by the team. He was not offered any other options for day programming. The team should have used his known preferences to develop other possibilities for work or training. There was minimal focus on training in the community and community employment. Vocational assessments were rarely completed 10 days prior to the ISP meeting and as noted in F1b there was a lack of participation in IDT meetings by vocational staff. None of the ISPs in the sample included adequate discussion of vocational training and skills. While most plans included opportunities to take trips to the community, plans did not include action steps to ensure 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. Some examples are noted above in F1e. The facility was not in compliance with this item.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	ISPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were	Noncompliance

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	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;	not written in a way that progress or lack of progress could be consistently measured. Participation in programming rarely included the frequency that should occur and specific objectives were not developed to ensure that participation was meaningful. Specific behavioral indicators should be identified to determine successful implementation for all outcomes. For example: • Individual #388's ISP did not include any measurable goals for participation in a day program or in the community. The team discussed ideas for work, but did not develop any goals related to work. There was no indication that his days were structured to provide meaningful day habilitation. • Individual #73's ISP did not include any measurable goals for participation in day programming or in the community. She had no outcomes based on the list of preferences identified in her PFA. Action steps to address risks identified by the team did not identify supports needed to address her risks. For example, she was identified as being at risk for respiratory compromise. Her action plan stated no respiratory incidents in a year. Supports to reduce her risk were not identified. • Individual #66's ISP did not specify a schedule for day programming or ensure that he would have adequate interaction with staff throughout his day. He had outcomes to be given the opportunity to attend community events, participate in activities on and off campus, and attend the Suzy Crawford center. Action steps were not developed to determine how often he would be involved in activities or what type of training would occur. There was no way to measure progress or move forward towards next step objectives. • Individual #24's PFA indicated that she liked to work. She was attending the workshop daily according to her ISP. She had one outcome related to work that stated, "Continue daily attendance to the workshop." The team should have developed meaningful work outcomes that included support strategies needed to move her towards working in a less restrictive environment. The lack of meaningful, measurable goals contributed to low engagement levels throughout the facility. There was no system in place to ensure that individuals were receiving active treatment or engaged in meaningful activities for a majority of the day. According to the schedule at the Suzy Crawford Center, Individual #66 was scheduled to attend the center for an hour every day. Attendance records showed that during the month of May 2012, he only attended four times. When questioned about attendance at day programming, residential staff reported that there was not always enough staff available to take individuals to day programming. During the review week, this individual was found in bed in the middle of the afternoon.	

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		Three other individuals in the same home were observed to be sitting in their wheelchairs in front of the TV with little staff interaction for most of the afternoon. One individual was crying because she could not get her purse open. Staff continued to walk by, ignoring her cries. When the reviewer approached her, she clearly indicated that she just needed help opening her purse. Once her purse was opened for her, she entertained herself placing objects in and out of her purse. Staff were never seen interacting with her during the observation. Other individuals were observed wandering around outside throughout most of the day during the monitoring visit with no attempts by staff to ensure that they were engaged in any type of activity. This continued to be an area in which substantial effort was needed in order to comply with the requirements of the Settlement Agreement. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. In reviewing the action plans that had been developed to address individuals' risk areas, adequate measurable clinical indicators generally were not included. This is discussed in detail in section I of this report. The lack of these clinical indicators resulted in teams not having a mechanism to measure whether the individual was progressing, declining, or remaining stable. Teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs in the document request. These plans should be attached to the ISP and considered an integral part of the plan. The newer plans in the sample were showing progress in attempts to integrate all supports into one plan. Plans were still more of a multidisciplinary review of services than an interdisciplinary approach to developing supports. For example, the ISP for Individual #44 included a good summary of her risks and supports needed. Her preferences were identified in the plan, though the plan stopped short of describing supports needed to ensure she had a meaningful day based on her preferences. For instance, it was noted that she enjoyed participating in activities at the Suzy Crawford Center. It was noted on attendance logs that she was only scheduled to participate at the	Noncompliance

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		Suzy Crawford center for 45 minutes each day, but she only attended programming on three days during the month of April 2012, presumably due to staff's failure to get her to the center. Supports were not put into place to ensure adequate participation in programming. The ISP for Individual #59 was another example of a plan showing improvement in integrating all supports into the ISP. His plan also included a good summary of his risks and supports needed. The plan included a better description of how he preferred to spend his day and what supports were needed to ensure his preferences were met. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members. Recommendations included in assessments were not integrated into SAPs for training in all areas. For example: • Recommendations from Individual #151's PBSP were not integrated into teaching strategies in any of his SAPs. • Recommendations from Individual #389's communication assessment were not integrated into his SAPs. His money management outcome included an action step to state the amount of money that he had. His communication assessment indicated that he was nonverbal and used gestures or an AAC device to communicate. When developing the ISP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, ISPs described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in section S below. Methodology was not clear enough to ensure consistent implementation for many actions steps. For example: • Individual #367 was at risk for fluid imbalance. He had an action step to reduce his risk that stated "direct care staff are encouraged to offer fluids and encourage adequate intake of fluids." There were no further instructions for how often fluids should be offered, what type of fluids, or what quantity of fluids was sufficient. His action steps to reduce his risk of choking stated "individualized	Noncompliance

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		dining instructions." • Individual #12 had an outcome stating that he would "participate in activities of interest." No methods for implementation were developed and it was not clear what his level of participation would be or what supports would be needed. Similarly, he had outcomes to "attend and participate" in vocational opportunities, cultural services opportunities, and session psychology. Training methods were not specified and the level of participation required was not clear. • Individual #24 was at risk for falls and injury. Her ISP included an objective stating "will be free from serious injury related to scoliosis, osteopenia during the next 12 months." Supports needed from DSPs to ensure that she was protected from injury were not included in her ISP/risk action steps. Similarly, she had action steps that stated "will have zero UTI occurrences" and "will be free of exacerbations of allergies." Again, supports needed to reduce her risks were not clearly indicated. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had not made progress towards compliance with this item. As noted throughout the report, plans did not adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the ISPs in the sample. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Most training was offered in a classroom setting. Few training opportunities were offered in the community. The only ISP in the sample that included an action step for functional training in the community based on assessment information was the ISP for Individual #269. The team had determined that he needed training on money management and social skills. An outcome was developed using his preference for eating out in the community that integrated money management and social skills training. The team stopped short of developing an SAP to ensure training was implemented consistently and measurable. Individuals did not participate in meal preparation and service. They did not bank in the community or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities, such as church, art, and gym classes. Interventions, strategies and supports did not adequately address individual's needs and	Noncompliance

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		many were not practical and functional at the facility and/or in community settings.	
	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.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. Generally, ISPs identified the person responsible for implementing service and training objectives and the frequency of implementation. ISPs also included a column to note where information should be recorded. Skill acquisition plans were developed for some action steps in the ISP with further detail for implementation, data collection, and review. As discussed above in section F2a2, many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., health management plans, PNMPs, psychiatric treatment plans). Even when plans included objectives, such as those related to PBSPs, individuals' ISPs did not consistently identify the specific data to be collected, the frequency, and/or the persons responsible for reviewing data collected. Little progress had been made in developing measurable outcomes. Most ISPs still lacked guidance that would instruct staff in collecting consistent data to evaluate the effectiveness of training in the day program and community, and/or to monitor health and therapy related supports. Overall, the plans defined very little objective data that would be collected, reviewed, and used to make decisions regarding the efficacy of plans. Some examples: • Individual #24 had an outcome to participate in community activities at least monthly. Data were to be collected in the activity record as activities occur. As noted previously, this type of outcome did not permit analysis of progress towards meeting any particular goal. • Individual #331's ISP did not include instructions on where to record data, how often to record data, or when data should be reviewed. The where to record column for the action steps was left blank. The how often column stated quarterly for each action step. It was not clear if data should only be collected quarterly or reviewed quarterly. She was at high risk for weight gain. What data should be collected was not included. Quarterly data collection or review of data would not have been frequent enough to address her risk. Similarly, her risk for skin integrity and GI problems included action steps that did not state data to be collected, and indicated quarterly. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and	Noncompliance

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		nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
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 item will also require that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical services. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. As noted in F2a3, PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs. These plans should be attached to the ISP and considered an integral part of the plan. The facility did not have a process to ensure coordination of all components of the ISP.	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 individual records was reviewed in various homes at the facility. Current ISPs were in place in all but two individual notebooks of the 14 reviewed. This was a significant improvement from the last monitoring visit. AODs had been assigned responsibility for checking to see if updated ISPs were in records during rounds. When ISPs were not available, the AOD was directed to notify the QDDP Coordinator. As noted in F1d, ISPs did not always include staff instructions for support that were clear enough for DSPs to follow. Staff interviewed by the monitoring team were not consistently familiar with PBSPs, PNMPs, healthcare plans, and risk action plans. Some staff interviewed could not describe risks and interventions needed by individuals whom they were assigned to support. The facility had developed an ISP tracking log to document competency training on individual ISPs. Data from January 2012 through March 2012 indicated an 18% compliance rate. As noted in F1c, it was not clear in most ISPs as to what supports should be provided for an individual during the course of a 24-hour day. Lack of integration of plans contributed to this confusion. Many separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in ISP development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation.	Noncompliance

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F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues, however, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors by implementing appropriate protections and supports, and revising plans as necessary. There was no indication that all supports were reviewed at least monthly. It was not evident that team members were using data collected to drive revisions in teaching strategies or supports. Monthly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the month should be consistently documented. As was previously noted, individuals were consistently refusing programming or unable to attend due to staffing issues. In many cases, lack of implementation was not discussed until the annual ISP meeting when it was noted that the individual had not attended programming. Services should be reviewed monthly. When support and services are not in place or not implemented, the team should take immediate action to either ensure supports and services are implemented or revise the ISP. It was not evident that supports were revised when IDTs noted regression. For example, Individual #258's team met in March 2012 when she experienced an increase in falls. There was not a representative from the PNMT at the meeting. The recommendation was to remind her to watch where she was walking. She had another fall in April 2012 and one in May 2012. There were no serious injuries and the team did not convene to discuss her falls or revise her supports. In June 2012, she fell again, this time resulting in an injury to her head. She was then referred to the PNMT for assessment. When supports are failing to protect individuals from harm, IDTs need to meet immediately to revise supports. The facility self-assessment indicated that the facility was not in substantial compliance with this provision item. The audit found that plans were not being reviewed appropriately, IDTs were not consistently meeting, and action plans were not consistently being coordinated. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs 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. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues.	Noncompliance

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F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	In order to meet the Settlement Agreement requirements with regard to competency based training, QDDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on ISP process entitled Supporting Visions. The facility was still waiting for additional training to be provided by the state office on further implementation of the new ISP format. QDDPs were utilizing the new format, but had not yet been trained on the ISP development and risk identification processes. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written. The facility was aware of problems in the implementation of the ISP and was providing additional monitoring and training to direct support staff. This had improved implementation in some homes, but had little impact on training that was occurring in day programs. The facility's self-assessment indicated that training on specific plan implementation had was not consistently occurring. The facility self-rated the provision as being out of compliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
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 the ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. The facility self-assessment indicated a 100% compliance rate with the development of ISPs within required timelines, but only a 58% compliance rate with filing completed ISPs within timelines. As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in all individual notebooks in the sample except for two. This was a significant improvement since the last onsite visit. As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable. Staff were not trained on the requirements of individual ISPs. The facility was rated as being out of compliance with this provision item.	Noncompliance

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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 was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had made some progress in this area. They had just begun to analyze findings and develop corrective action plans.	Noncompliance

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. It will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (F1b).

4. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

6. Provide additional training to IDT members on developing and implementing plans that focus on community integration. (F1e, F2a).

7. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

8. IDTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

9. IDTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

10. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The IDTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

11. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes. (F2a2)

12. IDTs should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual (F2a3).

13. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs (F2a4, F2c).

14. IDTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

15. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

16. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation (F2c).

17. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues (F2d).

18. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

19. Develop an effective quality assurance system for monitoring ISPs (F2g).

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 Policy/Procedure: Consultation Process, 12/8/09, rev. 8/25/11 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC facility-specific policy, Minimum Common Elements of Clinical Care, 10/6/11, revised 11/3/11 o SGSSLC Section G Self-Assessment o SGSSLC Section G Action Plan o SGSSLC Provision Action Information o SGSSLC Sections G Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes o Clinical IDT meeting minutes o Quality Improvement Council Notes o QI Council Meeting: Quality Assurance Report o Review of records listed in other sections of this report Interviews and Meetings Held: o Rebecca McKown, Medical Director, o Charles Njemanze, Facility Director o Lisa Owen, QA Nurse o Albert Fiero, RN Medical Compliance Nurse 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 Dental Clinic o Psychiatry clinics o Daily medical meeting/Medical rounds

	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. During the week of the onsite review, the monitoring team met with the facility staff to discuss the self-assessment and this provision. In moving forward, the monitoring team recommends that facility director and medical director both review this report. Most items will likely be executed by the medical director with the support of the facility director. For each provision item in this report, the medical director should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: During the December 2011 review, the staff at SGSSLC exhibited a high level of enthusiasm regarding the concept of integration of clinical services. To some extent, that enthusiasm was muted during this visit and the rate of progress appeared to slow down. Staff continued to state the merits of integration clinical services, but the innards of many departments would signal that true integration would be difficult at best. This report details problems in how services were delivered when multiple departments came together such as medical and pharmacy, psychology and dental, medical and nursing, and dental and psychology. Integration of services requires that these disciplines effectively come together. While department heads touted great integration during major meetings, during interviews many told a different story. There were reports of lack of cooperation, lack of clinical accountably, failure to share vital information and other problems that indicated there were problems delivering services in an integrated manner. During each monitoring visit, the monitoring team conducts a meeting with the facility staff to discuss integration of clinical services and the minimum common elements of clinical care. The medical director served as lead for section G. There was little preparation for the interview, very few examples of integration were provided, statements were made without any examples or documentation, and almost no evidence was included in the presentation book. The monitoring team did not believe that this was representative of the facility and it's status on integration of clinical services. Yet, the facility appeared to struggle. It had not developed any guidelines or

	procedures to assist with this most important provision. Nonetheless, some progress was noted. Throughout the week of the review, the monitoring team encountered a few good examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The facility had taken some steps in this area, but had not developed any formal policies or procedures nor put together a cogent statement or presentation to demonstrate or outline the activities undertaken to promote and/or deliver services in an integrated manner. As lead for this provision, the medical director described examples, such as the daily medical meeting, tracking of assessments, pretreatment sedation discussions, better food choices, and desensitization. Unfortunately, no data were provided to substantiate any of these efforts. The medical director also stated that the medical staff felt as though they were "ancillary team members," a comment which the monitoring team believed unusual and questioned. To determine compliance with this provision, the monitoring team reviewed state procedures, conducted interviews, completed observations of activities, and reviewed records and data. During the conduct of this review, examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • SGSSLC continued to conduct daily medical provider meetings. These meetings were facilitated by the full time PCP and discussed information regarding the past 24-hours' hospitalizations, emergency room visits, campus calls, infirmary reports, etc. These meeting were largely presided over by the medical staff and the monitoring team noted a lack of a collegial tone that diminished the ability to improve integration of clinical services. This meeting recorded minutes, which failed to document appropriate follow-up. This is discussed in section L1. • Dental, Nursing, and Habilitation – This was a good example of integration of clinical services. Multiple clinical areas came together to identify individuals who needed services, ensure that staff were appropriately trained, and that individuals received the treatment. • There was some effort for clinical integration via the various meetings (i.e., medical provider meeting, P & T Committee, Polypharmacy Committee). As noted in the report of section J, one concern was that while information about various topics (i.e., polypharmacy; individuals with epilepsy) were discussed with the necessary disciplines, it was not possible to determine the integration	Noncompliance

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		of that information via the treatment plan provided for the individual. A meeting to briefly review and collate that information into an applicable plan of action for the individual was necessary. o There was, however, some integration among nursing, psychiatry, psychology, and pharmacy with regard to the IDT process evident in psychiatry clinic. • Integration of psychology and psychiatry was improved. • There was improved integration of psychology and communication around communication SAPs (however, see section R). • During the onsite review, the monitoring team attended one of the facility's Clinical IDT/Case Study meetings, which was led and facilitated by the facility's director. As noted during the facility's daily clinical services meetings, the facility's clinical IDT/case study appeared to provide the forum, topic, and opportunity for the integration of clinical services, however, it was unclear whether or not the meeting would/could help ensure that individuals received the clinical services they needed by simply bringing together various heads of departments and clinical specialty areas to discuss an individual with complex and challenging needs. o When the various department heads and directors were called upon by the facility director to present an update to the group, most were well prepared to present an update, from their perspective, of the individual's status and needs. However, it remained unclear what outcomes would occur for the individual as a direct result of the meeting of a roomful of clinicians, directors, and department heads, especially since most of the attendees were not the direct deliverers of the clinical services that were discussed, planned, etc. Several areas offered great opportunities for improvement: • There was a lack of integration between medical and pharmacy. QDRR review times were documented as excessive and it was reported and documented that this was addressed with some but little improvement. This service impacts clinical care. • Integrated services were hampered by the failure to conduct appropriate meetings, such as the Pharmacy and Therapeutics Committee meeting. This is discussed in section N. • There was a definite lack of integration of services between dental and psychology. In fact, it appeared that very little effort occurred without repeat requests from the dental clinic staff. In May 2012, the PAI noted that there was a lack of communication between psychology and dental clinic regarding desensitization.	

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		• IDTs did not appropriately make referrals for assessment by the PNMT. The PNMT included IDT members throughout the process of review at this time, though the format of the weekly meetings were not conducive to active. • PNMT members did, however, attend ISPAs post-hospitalization and other changes in status of individuals they were reviewing. The PNMT nurse also conducted post-hospitalization assessments for individuals.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The medical department utilized a stamp to track consultation reports once they returned from the providers. The stamp documented a number of important items such as date received, PCP review date, and the need for PCP rounds, psychiatry review date, and filing date. The size of the stamp required that it be placed on the back of each consult. In order to review compliance with requirements of the Health Care Guidelines, the monitoring team requested that both the front and back copies of all consultations were provided. This was not consistently done which significantly decreased the sample size of consultations available for review. The consults and IPNs for 10 individuals were requested. A total of 40 consults completed after November 2011 (including those from the record sample) were reviewed: • 22 of 40 (55%) consultations were summarized by the medical providers in the IPN o 16 of 22 (73%) consultations were documented in the IPN within five working days The compliance rate for Question #27 in the external medical audits was 50%. This question addressed documentation by the medical provider These findings were further exemplified across the 20 sample individuals reviewed for section M. There were delays in clinical professionals reviews of non-facility clinicians' reports and recommendations, and there was no consistent documentation of the clinical professionals' rationales/justifications for implementing/not implementing the non-facility clinicians' recommendations. There was also no evidence that the clinical professionals consistently referred the non-facility clinicians' recommendations to the individuals' IDT for either purposes of information and/or integration with the individuals' existing supports and services. The case of Individual #26, described in more detail in section M, provides a specific example. She was sent to the emergency room after a weeklong period of decline in her	Noncompliance

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		health status. Unfortunately for Individual #26, her complete record of what took place during her emergency room evaluation and treatment was not provided to her physician, psychiatrist, and other relevant clinical professionals. Generally, when the providers summarized the recommendations of the consultants, they stated agreement or disagreement with the recommendations. The monitoring team recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Dermatology Consult, 1/1/11).	

Recommendations:

1. The facility should draft a local policy or guidelines to provide some direction of this provision. (G1).

2. The daily clinical services meeting should record minutes, which should be reviewed for accuracy and signed by the medical director. When follow-up is required, the minutes should document action steps, responsible persons, and timelines for follow-up. (G1).

3. The facility should ensure that committees are functioning as stated in policy with the required participants (G1).

4. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

5. The facility need to reconsider the use of "the stamp" as the mechanism for tracking consultation or consider use of a smaller stamp that can be place on front of consults (G2).

6. The facility needs a mechanism to track all consultations and appointments for diagnostics. Consideration should be given to using a format that will allow sorting by multiple fields including specialty, individual, appointment date, and PCP (G2).

7. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

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:** Interviews and Meetings Held: o Rebecca McKown, Medical Director, o Charles Njemanze, Facility Director o Lisa Owen, QA Nurse o Albert Fiero, RN Medical Compliance Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. o Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily medical meeting/Medical rounds
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions (provision action information). For the self-assessment, the facility described for each of the seven provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. During the week of the onsite review, the monitoring team met with facility staff to discuss the self-assessment and the provision. Each provision item, the various assessment tools and evidence were reviewed and this was certainly helpful for the monitoring team. In moving forward, the monitoring team recommends that the facility lead follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the facility lead should review, for each provision item in this report, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with all seven provision items. The monitoring team agrees with the facility's self rating.

	Summary of Monitor's Assessment: The facility's QA nurse was assigned as the lead for Provision H. Much of the work had been targeted at the first two provision items. A significant amount of progress was made in provision H1 because a great deal of thought and effort had gone into it and that was good to see. Provision H1 was very important because it is a metric of the facility's management of its assessments. The appointment of the QA nurse as facility lead was, therefore, a good one because Provision H in many ways addressed issues related to quality. It did not require that disciplines complete new tasks, but rather required that the facility pull together information about many of the tasks that it were already being completed. During the week of the onsite visit, the monitoring team had the opportunity to meet with the facility director, medical director, QA nurse, and the medical compliance nurse. During discussion, it was clear that much work needed to be done in most areas, but the monitoring team sensed throughout the week that the facility lead was beginning to develop a good sense of what actions needed to occur. This was reflected in her action plans, which provided a detailed series of steps for each provision item. The monitoring team believes that with direction from state office, the leadership of a very enthusiastic and competent facility lead, and support from the facility director, SGSSLC should be able to make considerable progress over the next six months.

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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.	The state office policy, which remained in draft, required each department have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. In response to this, the facility developed Section H audit tools for nursing, medical psychiatry, psychology, dental, and habilitation services. There was no tool developed for pharmacy and that was needed. It was described that the tools were developed to measure elements and capture items that were not found within the standard tools. The facility began using the tools on 3/13/12. A detailed report and data analysis was done. It provided good information. It was a baseline review of data. The facility concluded that at the time of data review, there was not compliance for any provision with the minimum Common Elements of Clinical Care. The QA nurse and staff who worked on this report should be commended for the effort and work that were involved in this project. The work was through, detailed, and made every effort to address the spirit of the provision. This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring	Noncompliance

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		team participated in interviews, completed record audits, reviewed assessments and facility data. The results of those activities is summarized here: • Annual Medical Assessments were found in all of the records in the record sample. The overall compliance with timely completion (365 days since previous assessment for the sample reported in section L) was 84%. The quality of the assessments was problematic and is discussed further in section L1. • Quarterly Drug Regimen Reviews were not completed in a timely manner. This is discussed in detail in section N2. • Annual Dental Assessments: Compliance with timely completion for the six month review period was 90%. • Regularly scheduled quarterly and annual nursing assessments were present in only 14 of the 20 sample individuals' records. At least two more individuals' nursing assessments were signed/dated before the assessments' dates of completion, which raised question regarding the authenticity of the assessments. In addition, of the three sample individuals recently admitted to SGSSLC, not one had an admission assessment that was completed in a timely manner. • A review of the individuals with currently dated nursing assessments revealed that all, but one (Individual #218), assessments failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. • Due to changes in the psychiatry department, such as the retirement of the lead psychiatrist since the last review, the data were presented by the psychiatric assistant (designated as the back-up lead for the department). The data included all of the information pertaining to provision J (e.g., if Appendix B evaluations and 90-day evaluations were conducted on a regular basis). • The facility completed 18% of comprehensive evaluations as described in the Appendix B format. The majority of individuals (151) enrolled in psychiatric clinic at SGSSLC still required a comprehensive psychiatric assessment. • Not everyone had an initial psychological assessment. • Functional assessments were not completed for all individuals with PBSPs, annual psychological assessments were not completed for all individuals. • Annual assessments and updates were generally completed for those who received some level of support or service from OT or PT, but this was less consistent for speech. It was not possible to review documentation for individuals post-hospitalization or for other changes in status, as Integrated Progress Notes were not submitted though they had been requested for the individuals included in the sample selected for Sections O, P, and R.	

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		Many of the deficiencies noted throughout the review were related to required annual assessments. It was clear that the facility was not meeting several basic requirements and will need to take immediate action to correct these deficiencies. The monitoring team emphasizes that the facility must monitor all three elements that this provision item addresses: (1) the timelines for completion of scheduled assessments, (2) the appropriateness of interval assessments in response to changes in status, and (3) the quality of all assessments (compliance with accepted standards of practice). It was not clear that the various tools developed would actually capture compliance with accepted standards of practice and it some cases such as dental, it was not clear how the tool would be used. In other words, would the dentist rate himself or would another dentist, review the records?	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The facility had taken some action to move towards substantial compliance in this area. The medical and psychiatry audit tools had been revised to capture the requirements to utilize appropriate terminology and nursing audit tools had undergone revision as well. Additionally nursing received training related to nursing diagnosis. The facility had outlined a series of steps in its action plan that were currently in progress or scheduled to begin that should assist in achieving substantial compliance in this area. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. Nonetheless, minutes from the various meetings, etc. where official discussions occurred regarding the health status of individuals occurred tended to use "slang" and other inappropriate terminology. • Over the course of the visit, the monitoring team observed that the psychiatry team addressed the presenting psychiatric symptoms identified in order to establish the diagnosis. The IDT needs to address combined case formulations in order to provide a cohesive diagnosis consistent with DSM-IV-TR and an applicable treatment plan. • Across 20 of the 22 sample individuals' reviewed, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks.	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 appropriate based upon	The QA nurse acknowledged little progress in this area, but the monitoring team believes that the basic understanding of this provision item was present. That is, the key staff understood that state office, through the development of clinical protocols, had in fact provided the foundation for assessing compliance for some elements of care. The multidisciplinary protocols described a series of actions or interventions that the medical and nursing staff needed to take in managing certain conditions. As discussed in section	Noncompliance

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	assessments and diagnoses.	L, the need to add clinical outcomes to the medical audits cannot be overemphasized. The facility had data that could be used to determine if interventions were appropriate for some clinical conditions. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed. • The absence of complete nursing diagnoses was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Thus, the overwhelming majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. • There was lack of completion of comprehensive psychiatric assessments. There was a delay in the administration of the Reiss screens. This led to individuals not receiving either upon admission to the facility. Additionally, there was noted delay in consents being signed that further posed postponement in the delivery of care once the agent was prescribed. There remained a need to enhance both the identification and implementation of non-pharmacological interventions. • Medical care is discussed in detail in section L.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Medical quality audits were completed, but the criteria used will need to be reviewed. Clinical indicators assess particular health processes and outcomes. Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization of health care delivery. The facility will need to give considerable thought to this process to ensure that a solid combination of clinical indicators is selected. This must be established for individuals and for facility aggregate data. Specific examples related to clinical indicators include: • Collaboration between psychiatry and psychology was beginning to identify the selection of clinical indicators to address evidence-based reasons for the particular medication regimen. Polypharmacy will not be reduced with the practice of medication targeting maladaptive behaviors instead of psychiatric symptoms of a psychiatric disorder (i.e., hallucinations for a psychotic disorder as opposed to or in addition to aggression to self/others, depending on clinical relevance) • Across all records reviewed the clinical justification for the goals/indicators of the efficacy of treatments were unclear. For example, most individuals had goals	Noncompliance

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		that indicated that they would suffer no untoward outcome(s), and all individuals' HMP goals were associated with outcomes that would/would not occur over the next 12 months. During the onsite review, the monitoring team attended three individuals' IDT meetings where their risk assessments/risk action plans were reviewed. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas. The current local draft policy addressed only medical indicators. Indicators are needed for psychiatry, psychology, nursing, and habilitation services.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility did not have an overarching plan to address this provision item and there was no systematic monitoring of health status of all individuals: • Databases were established to track some elements of preventive care, diabetes, and seizure management, but there was no evidence that this data were used in any meaningful way. • Although the nursing assessment process vis a vis acute, quarterly, and annual assessments, would/could serve as such a system, there was no evidence that it was implemented, partially or otherwise. Thus, health plans (acute and chronic), which were in place for days, weeks, months, and even years, were not adequately reviewed/revised and modified to meet the individuals' needs and the changes in their health status and risks. • Nursing staff presented medical information for the psychiatry clinic with information noted on a form. The psychiatrist had access to the physician's medical assessment in the record. Unfortunately, the lab matrix does not capture necessary components to monitor psychotropic medication and needs to be revised. The various disciplines do not routinely take into consideration the entire medical clinical picture of the individual when discussing case reviews as outlined in the report. • Furthermore, with regard to health status, the psychiatrist was not identifying the risks versus benefit of the psychotropic medication that impacted other health conditions, in concert with the IDT. This was reflected in the inadequate consent process and the polypharmacy regimen pervasively utilized at SGSSLC. There was sufficient representation of the IDT in psychiatry clinic to review these factors, therefore the facility was encouraged to use this forum to respond to changes in an individual's status to ensure the timely detection of the needs of the individual. Achieving such a system will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The first step in the process is to define what is important to the individuals and what is important	Noncompliance

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		that the facility monitor. The facility needs to proceed with developing a comprehensive list of indicators based on these findings.	
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.	As mentioned in H5, the facility needs to establish a comprehensive set of clinical indicators. Many of those will be based on clinical guidelines developed. There are many other indictors that could and should be included. Examples would include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, the days of healing for pressure ulcers, the number of acute interventions required for bowel management, the prevalence of dehydration, and the prevalence of undesired weight loss. Once the indicators are established and treatment expectations outlined, audits of records and other documents will indicate if treatments and interventions were appropriate. During this review, there, was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address obesity were not modified in response to their failure to lose weight; individuals with plans to address fluid/electrolyte imbalance were not modified in response to episodes of dehydration, hyponatremia, etc.; and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s).	Noncompliance
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.	State office had developed a draft policy for Provisions G and H. The facility had developed a local policy for H, but none for G.	Noncompliance

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. All assessments must occur within the required timelines. This will require tracking of scheduled assessments in all clinical disciplines.
    b. Interval assessments must occur in a timely manner and in response to a change in status.
    c. All assessments must meet an acceptable standard of practice
    d. Tools must capture the quality of the assessments (H1).

2. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition. (H2).

3. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

4. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

5. Provide all staff with the copies of the applicable clinical guidelines, protocols, policies, and procedures, ensure that training has been completed, and hold staff accountable for use (H4, H6).

6. In addition to tracking assessments, the QA nurse will need to generate a report on a regular basis, perhaps quarterly, that shows compliance with timelines, appropriateness of assessments, the quality of assessments and other chosen indicators. If deficiencies are noted, a corrective action plan should be developed to address the problems. This should apply to all clinical disciplines (H1).

7. The facility must have a system that regularly reviews clinical guidelines, protocols and selected indicators to ensure that current practices are implemented and the most relevant indicators are being measured (H3, H4).

8. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

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 At Risk Training Rosters o Preventing Aspiration Training Curriculum o List of serious injuries for the past six months o List of individuals seen in the ER since 4/1/11 o List of individuals hospitalized since 4/13/11 o List of individuals seen in the infirmary since 4/13/11 o List of all choking incidents o List of individual at risk for aspiration o List of individual receiving enteral feedings. o List of individuals with pneumonia incidents in the past 12 months o List of individuals with chronic pain. o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o List of individuals at risk for skin breakdown o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for harm to self or others o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals at risk for dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individuals with a pica diagnosis o List of individuals considered missing or absent without leave

	o List of individuals required to have one-to-one staffing levels 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 Injuries since the last review o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #44, Individual #12, Individual #367, Individual #389, Individual #258, Individual #66, Individual #73, Individual #53, Individual #151, Individual #367, Individual #126, Individual #388, Individual #24, Individual #331, Individual #273, Individual #269, Individual #59, Individual #400, and Individual #94. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Michael Davila, QDDP Coordinator o Michael Fletcher, QDDP Educator o Jalown McCleery, Incident Management Coordinator o Dana Robertson, POI Coordinator o John Church, Psychologist o Roy Smith, Rights and Protection Officer <u>Observations Conducted</u>: o Observations at residences and day programs o 505B IDT Meeting 6/5/12 o 511B Home Meeting 6/5/12 o Unit I Morning Meeting 6/6/12 o Incident Management Review Team Meeting 6/6/12 o Annual ISP meetings for Individual #274 and Individual #322
	Facility Self-Assessment: SGSSLC submitted its self-assessment The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using the section I audit tool. The self-assessment indicated that the findings from the facility's audit process were used to self-assess compliance.

	For I1, the QDDP Educator indicated that a sample of four records was reviewed each month between January 2012 and April 2012. Compliance ratings ranged from 38% to 52% compliance. The self-assessment also considered data related to assessment submission for section F. For I2, the QDDP Educator reviewed the same sample of ISPs and risk assessments along with a spreadsheet indicating when assessments were submitted for individuals with a change in status. He found that teams were not completing risk forms in a timely manner or responding to changes in status with any sense of urgency. The monitoring team found similar results. I2 was assigned a noncompliance self-rating. For I3, compliance was determined by the facility section I audit using the same four samples per month. Additionally, a spreadsheet had been developed to track implementation of plans once a risk was identified. It was not clear how this was determined. This review found that Risk Action Plans were not being monitored by the discipline assigned responsibility. I3 was also assigned a noncompliance self-rating. The facility did not currently have an effective audit system in place. It will be important to look at the self-assessment activities in more detail and determine if the audit process is an effective way to assess compliance.
	Summary of Monitor's Assessment: While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Teams were still not accurately identifying risk factors. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review. As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. 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. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Plans should be implemented immediately when individuals are at risk for harm. The facility was still waiting on consultation and training on the new ISP and risk identification process from the state office. This training should move teams further towards integrating the risk process into the ISP development process.

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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 state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT 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 when appropriate. A list of indicators for each of 21 risk areas had been identified by the state policy. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. The state office had hired a team of consultants to work with facilities on developing person centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The risk identification process had undergone several revisions in the past year. As noted in section F, the consultants had not yet provided training and technical assistance to SGSSLC. The facility was moving forward slowly with the risk process in anticipation of further changes in the state policy and procedures. The facility had taken some positive steps to address the development of an adequate at risk process including: • The QDDP Educator had been assigned responsibility for compliance with section I requirements. He was working closely with the QDDP Coordinator to train QDDPs on facilitating an adequate risk discussion among team members. • A database was being used to track the submission of assessments by each discipline prior to the annual ISP meeting. Audit results regarding the submission of assessments by discipline were submitted to each department for corrective action when warranted. • A check sheet had been revised to assist the QDDP in preparation for the annual ISP meeting. The check sheet included timelines for the risk management process. • Universal prompts had been incorporated into the Integrated Risk Rating form to ensure data were used to drive the discussion for addressing and managing risks. • Universal prompts were also being incorporated into annual assessments to ensure that each discipline was addressing risk factors. Clinicians were being trained on the new format. • Attendance of key team members at ISP meetings was being tracked in a database. • A spreadsheet was developed to track timelines for completion of risk	Noncompliance

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		documentation. This included information on hospital stays, ER, and infirmary visits to ensure that teams were meeting immediately to discuss support needs when health status changed for an individual. • A competency quiz was developed to be used with DSPs to assess their understanding of the risk process. Results of this quiz were included in the facility audit for section I. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The lack of input by team members either through the completion of adequate assessments or attendance at meetings contributed to IDTs not having the necessary information to accurately identify risk factors. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. Audits completed by the facility for February 2012, March 2012, and April 2012 indicated that the facility was not in compliance with this requirement as evidenced by the following chart. Assessment and participation in the risk process by speech clinicians, psychiatry, and dieticians was particularly low. Without updated accurate assessment information, IDTs were not able to accurately identify risks for individuals.	

Discipline	% submitted prior to annual ISP		
	Feb 2012	March 2012	April 2012
Audiology	10%	12%	29%
Behavioral/Psychology	80%	35%	78%
Dental	70%	46%	78%
Nutritional	60%	15%	33%
OT/PT	90%	23%	67%
Physical	60%	46%	50%
Nursing	50%	38%	78%
SLP	50%	12%	50%
Vision	80%	46%	63%

Additionally, the section I Audit tool found that professionals were not contributing risk data specific to their expertise through the use of the integrated risk rating form. Teams were also not consistently identifying clinical indicators to be monitored in regards to risks.

A sample of ISPs, assessments, and the facility risk rating list were reviewed to determine if risks were being consistently identified and addressed by IDTs.

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		Overall, there had been improvement in the action plans written to address identified risks, though the quality of plans was not consistent. The concern still remained that not all risks were identified by IDTs through the assessment process. Although, the risk discussion was now held during the annual ISP meeting, the degree of integration varied widely in the three IDT meetings observed. • The annual ISP for Individual #274 was an excellent example of an integrated risk discussion. Team members discussed her risks in relation to her preference and supports that might be needed throughout her day. All team members contributed to the discussion and encouraged both the individual and her guardian's input on how to best provide supports that were in line with her preferences. The team discussed how the facility could provide supports to minimize her risks and what resources she would need to ensure long term supports in the community. • At the annual ISP meeting for Individual #322, instead, the physician read through the risk indicators and assigned risk ratings with very little input from other team members. The following are some examples where risks were not appropriately identified in documents reviewed, or where ratings conflicted with assessment information. ▪ Individual #400's risk assessment noted that he was at medium risk for challenging behaviors. The justification was that he took Zyprexa daily. Between 8/11/11 and 2/4/12, staff documented at least seven critical incidents involving his attempts to harm himself. Two resulted in serious injury requiring sutures. He should have been considered high risk. ▪ Individual #389's nursing assessment indicated that he was at risk for constipation and impaired skin integrity. His risk assessment was marked low risk in both areas with a note reading "no issues". Additional examples are listed at the end of section M5 and in section O2. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion.	

#	Provision	Assessment of Status	Compliance
		• Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. • Ensure that data collected regarding incidents and injuries is frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility's self-assessment indicated that the facility was not yet in substantial compliance for this provision based on quality of the risk rating system. The monitoring team agrees with this assessment.	
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 At Risk policy required that when an individual was identified at high risk, or if referred by the IDT, 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 IDT within 14 working days of the completion of the plan, or sooner if indicated by risk status. The facility self-assessment of I2 noted: • IDTs were not consistently meeting in response to changes in risk status. • Teams were not addressing risks with a sense of urgency. • The section I audit tool indicated a 54% compliance rate with provision I2 for January 2012, 41% compliance rate for February 2012, 55% compliance rate for March 2012, and a 52% compliance rate for April 2012. As noted throughout this report, it was still not evident that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. Additionally, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. Records of five individuals (Individual #126, Individual #258, Individual #68, Individual #94, and Individual #273) were reviewed to determine if changes in circumstance should have resulted in an assessment of current services and support, risk ratings, and/or plan revisions. Although it appeared that teams were usually meeting immediately following a critical incident, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time. ISPAs were	Noncompliance

#	Provision	Assessment of Status	Compliance
		used to document initial discussion when a change in status was identified. It was not clear that there was always recommendations made for a change in supports or consistent documentation of follow-up when recommendations were made by the IDT. None of the records documented an adequate assessment process was in place to address a change in health, functional, or behavioral status. The following is a summary of that review. • The risk action plan for Individual #126 was reviewed following a serious injury on 3/29/12. An action step was created 2/21/12 to re-measure her height for a more current measurement ASAP. On 3/29/12 the risk action plan update included the same recommendation. It was not clear if this had been done or what the findings from the assessment were. ▪ Individual #258 was rated at high risk for falls. The injury list provided by the facility indicated that she had numerous falls over the past year. Her IDT met in February 2012 to discuss her history of falls, but did not put additional supports in place. Her PNMP dated 3/30/12 stated, "I walk without help" and "Remind me to wear my glasses when I walk outside to help me not trip." There were no other supports in place to address her risk. She had at least two additional falls after the team met in February 2012. The team did not reconvene to review her supports until after a significant injury occurred in June 2012. ▪ The IDT met for Individual #68 on 12/1/11 following a behavioral incident that occurred on a home visit on 11/9/11. The team met and rescinded his community referral. It did not appear that he was reassessed or supports were revised until 3/23/12 when the team met again and agreed that he should move to a more structured home, citing the incident that occurred on 11/19/11. ▪ Individual #94 experienced a 21 pound weight gain in a year. Additionally, her lipid panels were checked quarterly and remained high. The nursing quarterly reviews noted the gradual weight gain and abnormal lab findings, but did not address it because the weight gain in any one quarter was not considered significant. The team should have looked at her cumulative weight gain and reassessed her nutritional status. ▪ For Individual #273, an MBSS indicated that she was demonstrating poor swallowing will all food consistencies on 4/5/11. A dysphagiagram was recommended on 7/22/11. On 9/6/11 her nursing assessment noted that results of the dysphagiagram were still not in her record. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces 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 based on adequate assessment.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility was not yet in compliance with this provision item.</td><td></td></tr>
<tr><td>I3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the ISPs that were reviewed included general strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the IDT in response to risk categories identified by the team.

According to data provided to the monitoring team, plans were not in place to address all risks for those individuals designated as high risk or medium risk in specific areas. The following is data collected by the facility in regards to plans in place to address risks. Adequacy of plans in place was not considered in the data collection.

<table>
<tr><th>Risk Area</th><th># of Plans in Place</th><th>% of Plans in Place</th></tr>
<tr><td>Aspiration</td><td>48/48</td><td>100%</td></tr>
<tr><td>Contractures</td><td>5/5</td><td>100%</td></tr>
<tr><td>Dental</td><td>54/61</td><td>89%</td></tr>
<tr><td>Osteoporosis</td><td>43/43</td><td>100%</td></tr>
<tr><td>Seizures</td><td>30/30</td><td>100%</td></tr>
<tr><td>Metabolic Syndrome</td><td>6/6</td><td>100%</td></tr>
<tr><td>PICA</td><td>11/11</td><td>100%</td></tr>
<tr><td>Dehydration</td><td>23/24</td><td>96%</td></tr>
<tr><td>Constipation/Impaction</td><td>56/57</td><td>98%</td></tr>
<tr><td>Skin Integrity</td><td>40/43</td><td>93%</td></tr>
<tr><td>Weight</td><td>81/83</td><td>98%</td></tr>
<tr><td>Falls</td><td>50/53</td><td>94%</td></tr>
<tr><td>Dysphagia</td><td>26/26</td><td>100%</td></tr>
<tr><td>GERD</td><td>50/55</td><td>91%</td></tr>
<tr><td>Respiratory Infections</td><td>40/43</td><td>93%</td></tr>
</table>

Most plans in the sample did not include the clinical indicators to be monitored. For example,
• The Risk Action Plan for Individual #126 included action steps to reduce her risk for weight, which also put her at risk in other areas, such as cardiac disease. She was to be weighed weekly and referred to the dietician, as needed. There were no clinical indicators for staff to know when she should be referred to the dietician. Similarly, her blood pressure and bowel functions were to be</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		monitored due to her risk for cardiac disease. Again, no clinical indicators were given so that staff would know when to make a referral to the appropriate clinician. • Individual #24 was at risk for constipation. Her risk action plan noted that staff should encourage adequate fluid intake. The plan did not direct staff as to how often or what quantity of fluid would be adequate. She also was at risk for weight gain. Her plan required staff to monitor her weight, but no parameters were given for when staff should seek further consultation. Additionally, plans were not always updated following a change in health status or adequately integrated into ISPs. It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. As noted throughout this report, intervention plans often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).
2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).
3. Ensure attendance or at least input by all relevant team members in the risk process (U1)
4. All health issues should be addressed in ISPs 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 (I1, I2, I3).
5. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).
6. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).
7. 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 (I1 and I2).

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 Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, nurses notes, psychiatry notes associated with the incident, documentation of any IST meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Any auditing/monitoring data and/or reports addressing the pretreatment sedation medication o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols o Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (note the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual ISP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who is monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examinations for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: anti-epileptic medication

	being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; Trazodone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who have had a REISS screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; ISP, and ISP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the psychiatrists' attendance at the IDT, ISP, ISPA, and BSP meetings. o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who had been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy

	o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o For the last 10 newly prescribed psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; Positive Behavior Support Plan (PBSP); HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication. o Name of every individual assigned to psychiatry clinic who had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months o Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months Documents Requested Onsite: o Section J presentation book o Minutes from the medical provider meeting o All data presented, doctor's orders, and Dr. Pharies' documentation for psychiatry clinics, regarding Individual #112 and Individual #142 o All data presented, doctor's orders, and Dr. Bazzell's documentation for psychiatry clinics, regarding Individual #9 and Individual #170 o These following documents for all of these individuals: Individual #9, Individual #34, Individual #170, Individual #206, Individual #9, Individual #99, Individual #48, Individual #142, Individual #237, Individual #38, Individual #153, Individual #385, Individual #203, Individual #193, Individual #112, and Individual #331 • Identifying data sheet (most current Face Sheet) • Social History (most current) • Annual Medical Summary and Physical Exam • Active Current Diagnoses Sheet • Current list of all medications (MAR) • X-ray/Lab section (for the last six months) • EKGs for the past year • Psychiatry section (for the last six months) • Neurology section (for the past year) • Comprehensive Quarterly Nursing Assessment (for the last six months) • Comprehensive Annual Nursing Assessment (most current) • Psychology Evaluation • MOSES/DISCUS results (for the last six months) • Reiss Screen • Pharmacy section (for the last six months)

	• Consent section for psychotropic medication and Human Rights approval • Consent section for pretreatment sedation • Integrated progress notes (for the last six months) • ISP and ISP addendums/reviews/annual (for the last six months) • Behavior Support Plan • Safety Plan/Crises Plan • Desensitization Plan <u>Observations Conducted</u>: o Psychiatry clinics conducted by Dr. Pharies o Psychiatry clinics conducted by Dr. Bazzell o Medical Provider meeting o Polypharmacy Meeting <u>Interviews and Meetings Held</u>: o Jennifer Quisenberry, psychiatry assistant and back-up psychiatry department head o William Earl Bazzell, M.D., facility psychiatrist o Hugh Scott Pharies, M.D., facility psychiatrist o Roy Guevara, R.N., facility psychiatry nurse o Constance M. Whorton, R.N., facility psychiatry nurse o Rebecca McKown, M.D., medical director o Rob Weiss, Psy.D., chief psychologist o Dana Robertson, POI Coordinator o Don Conoly, R.Ph., pharmacy director o Philip Rolland, Pharm.D., MHA, clinical pharmacy director
	Facility Self-Assessment: SGSSLC submitted documentation regarding section J for the self-assessment dated 5/1/12, titled "San Angelo Plan of Improvement." For the self-assessment, the facility was instructed to provide the activities engaged in to conduct the review of a particular provision item, the results and findings from these activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility did not have an assigned lead psychiatrist at the time of the review, therefore, the psychiatric assistant who was designated the back-up department head, provided the update for section J to the monitoring team. The facility self-assessment indicated what activities the facility engaged in to conduct the review. There was an improvement in the process because the activities the facility engaged in were beginning to reflect what the monitoring team outlined for the particular provision. For example, in J6 (each SSLC 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 facility summarized that "only 25% of individuals in psychiatric clinic have a comprehensive assessment in the

	Appendix B format." The conclusion was based on the results of the facility tracking the completion of the comprehensive assessments. The facility should consider revision of the "POI Monitoring Tool" to conduct the auditing of the content of the evaluations in line with a peer review process to determine if the quality of the documentation met generally accepted standard of care practices. Additionally, the facility should choose a representative sample per clinician monthly because the audits for this visit only consisted of "two individuals per clinician" being reviewed monthly. The action steps included in the self-assessment packet were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns and recommendations of the monitoring team. Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, such as those described in this monitoring report, are set out in their entirety. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. Overall, the self-assessment document should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at, and should be modified following a review of each subsequent monitoring report. For example, in J12, the self-assessment indicated an action step of "continue current QDRR audit, which captures a wide sample of completed MOSES and DISCUS." This would be evidenced by a review of completed QDRRs with the pharmacist being the responsible party. The requirement for this provision is actually more detailed. The review should include timeliness of the assessment tools, nursing training regarding administration of the assessment tools, physician review and completion of the assessment tool, physician documentation of the use of the clinical information derived from the assessment tools such as ADR reporting, and response to the side effects discovered. There should be a specified percentage of total cases reviewed with subsequent corrective action as necessary. In the comments/status section of each item of the provision, there was a summary of the results of the self-assessment and the self-rating. The psychiatry department self-rated as being in substantial compliance for only one provision item (J1). The monitoring team agreed with the self-rating provided by the facility and rated substantial compliance for only provision J1. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the psychiatry department (i.e., facility psychiatrists, psychiatry assistant, and psychiatric nursing staff), the medical director, and the director of psychology, the need for improved integration was noted. Most provision items in this section rely on collaboration with other disciplines. The facility would benefit from the eventual development of a self-monitoring tool that mirrors the content of the monitoring team's review for each provision item of section J as outlined in the monitoring report, that is, topics that the monitoring team commented upon, suggestions, and recommendations made within the narrative and/or at the end of the section.

	Summary of Monitor's Assessment: SGSSLC provided psychiatric services by qualified physicians by virtue of their board eligibility/certification status, therefore, were found to be in substantial compliance with the first provision item. The facility, however, continued to experience difficulty with the retention of psychiatrists. In the intervening period since the previous report, the lead psychiatrist retired. There was not a reappointment of a lead psychiatrist. As such, the primary goal must be to recruit and retain psychiatrists, such that the psychiatric program can be expanded to provide clinical services and integrated care with other disciplines to meet the requirements of the Settlement Agreement. Fortunately, the facility secured the services of a contract psychiatrist who had additional subspecialty training in child and adolescent psychiatry. This physician provided care to the youth and adults that required care. Although psychiatric consultations were occurring, SGSSLC was found to be in noncompliance with all but one item. Previously, there was some integration between psychiatry and primary care. With the vacancy in the lead psychiatrist position, the maintenance of any integration beyond what could be accomplished in psychiatry clinic was delegated to the psychiatric assistant and the two psychiatric nurses. These staff attempted to provide pertinent information to the physicians regarding knowledge about the individual's past and current symptoms in order for the psychiatrist to accurately complete the evaluation (i.e., comprehensive psychiatric evaluation and the QPMRs) that guided the IDT treatment plan. Psychiatry was interacting with psychology on some levels. The psychiatric clinic included representatives from all disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings. Given the lack of clinical resources, the facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration since most provision items in this section rely on collaboration with other disciplines. The evaluation, diagnosis, and justification for treatment with medication were improving due to the development of the quarterly psychiatric review process, however, there were an inadequate number of psychiatric assessments completed. This task was likely hindered by a lack of consistent and insufficient number of psychiatric resources. Thus, there was an overreliance on psychotropic medications, a paucity of non-pharmacologic interventions, and use of multi-agent chemical restraints. The different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT. The medical, dental, psychiatry, and psychology department staff provided data regarding pretreatment sedation that did not illustrate an integrative review. Effort must be made with respect to the development of individualized treatments or strategies and/or desensitization protocols. The psychiatry department's data collection regarding the Reiss screen improved significantly since the last review, but this list did not address if an individual was screened due to a change in status. Consideration should be given to establishing timelines for obtaining the psychiatric evaluation for those detected as experiencing psychiatric symptomatology.

	Psychiatry did not routinely attend meetings regarding behavioral support planning for individuals assigned to their own caseload, and was not consistently involved in the development of the plans. There were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, and collaboration regarding case formulation). The monitoring team was provided the number of individuals classified as receiving a polypharmacy regimen. Facility-level data must include the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intra-class and/or interclass polypharmacy. The prescriber must justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. It was good to see that the nursing staff had designed a database to reflect pertinent information regarding the tracking of the administration of the MOSES and DISCUS. There was the demand for the demonstration of the consistent administration of the standard assessment tools and for the appropriate utilization of this information in clinical decision-making. The monitoring team recommended that the psychiatric department work with the nursing department to address this provision (i.e., obtaining and applying pertinent medical history discovered about exposure to medications that cause TD). Psychiatry must utilize this information to make this process clinically applicable. In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation. On a positive note, there was the initiation of exchange of documentation between the psychiatrist and the community neurologist. The IDT inclusive of the psychiatrist, however, must routinely dialogue with the neurologist, as clinically indicated, to coordinate the use of medications when they were to treat both seizures and a mental health disorder. The facility made minimal gains in the area of informed consent. Psychology department was responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. The psychiatrists were receptive to being responsible for this medical duty.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications SGSSLC had two psychiatrists who were either board eligible or board certified in general psychiatry by the American Board of Psychiatry and Neurology. The contract psychiatrist, Hugh Scott Pharies, M.D., was also board eligible in child and adolescent psychiatry. The facility continued to provide services for minors, therefore, Dr. Pharies managed the treatment for these individuals. It was positive that the facility had a psychiatrist with this expertise in order to provide care to youth particularly under the age of 14 and/or prescribed polypharmacy with complex psychiatric conditions. As such, the professionals were qualified. In the intervening period since the last monitoring report, the facility lead psychiatrist retired. There was not a reappointment of a lead psychiatrist, but SGSSLC administration was attempting to recruit a physician to take over this role. Experience Both of the psychiatrists had experience treating individuals with developmental disabilities. Dr. Bazzell had prior experience caring for individuals with developmental disabilities due to services provided to MHMR programs in the state of Texas. His start date at SGSSLC was 12/1/09. Dr. Pharies' educational background included two years of additional training in child and adolescent psychiatry from 7/79-6/80. He provided psychiatric care for individuals in the MHMR programs in the state of Texas for numerous years (4/93-2/12). Monitoring Team's Compliance Rating Based on the qualifications of the two psychiatrists, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At SGSSLC, 184 of the 232 individuals (79%) received psychopharmacologic intervention at the time of this onsite review. Since last visit, an additional 19 individuals were prescribed psychotropic medication. The psychiatry department was encouraged to track reasons for the increase of individuals requiring psychiatric intervention (i.e., new admissions to the facility) to account for the increased percentage of those receiving psychopharmacologic treatment. There were a limited number of evaluations completed in Appendix B format (discussed in J6) due primarily to the lack of psychiatric staffing (addressed in J5).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Evaluation and Diagnosis Procedures Overall, evaluation and procedures regarding diagnostics were satisfactory (e.g., interviews, staff meetings, record reviews). Upon observation of several psychiatry clinics during the monitoring review, it was apparent that the team members attending the visit were interested in the treatment of the individual. Although there was much effort placed into the improvement of the clinic process regarding psychiatric documentation, the monitoring team had difficulty determining the current diagnoses due to systematic discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). It was recognized that many of the challenges to providing care in the facility system wide were out of the psychiatrists' control. During this review, the psychiatrist and the IDT reviewed medical contributants that had an impact on mental status presentation, when arriving at a psychiatric diagnosis and for selection of a psychopharmacologic regimen. This was nicely illustrated during the psychiatric clinic observed for Individual #112. Numerous individuals at SGSSLC required the coordination between the neurologist and psychiatrist for the use of medications when they were prescribed for the treatment of both seizures and a mental health disorder. Further discussion about the review of the content of the psychiatric assessment and treatment is summarized below in J13. The following comments were from a review of the record of Individual #112 and exemplify progress for evaluation and diagnostics. Dr. Pharies and the Psychiatric RN, Constance Whorton, in addition to other members of the IDT provided thorough documentation for the quarterly psychiatric evaluation. The psychology representative discussed the need for a more specific measure in addition to the BPRS to monitor for depressive symptomatology. It was good to see the group engaging in this type of consideration. The team also entertained an appropriate diagnostic differential for this individual who had an apparent neuropsychiatric condition. Dr. Pharies commented that the neurologist recommended an increase of the psychotropic medication, but Dr. Pharies was not certain of the reasons because this was not spelled out in the documentation. Dr. Pharies informed the monitoring team that he wanted to contact the neurologist to obtain further details before implementing the increase in medication. The monitoring team encouraged this type of collaboration and deemed it necessary for neurology and psychiatry to routinely work together in a formal neuropsychiatric clinic to address such issues (summarized in J15). Clinical Justification Discussions with the facility staff revealed an awareness of the variability in clinical documentation. The facility was in the process of updating the note-processing procedure. A review of a sample of 20 records revealed varying content in their	

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		completeness. The facility made progress in this section due to the implementation of the "Psychoactive Medication Review Quarterly." The PMRQ was a comprehensive document that captured the necessary elements of a psychiatric assessment. This form was completed by the assigned RN case manager, psychologist, and QDDP prior to the QPMR meeting. It was used by the team during the meeting. The documentation addressed pertinent medical information and included categories, such as a current medication list (non-psychotropic and psychotropic), laboratory data, ECG results, psychologist's quarterly report to the psychiatrists, and diagnostic summary of Axis I, II, and III that resulted in adequate attention to clinical care. The documentation in the PMRQ generally corresponded with DSM-IV-TR criteria. In one of the psychiatry clinics, the psychiatrist stated that the diagnosis in the record was not an active diagnosis in the DSM-IV-TR and, therefore, requested further review of the individual's case to determine the appropriate diagnosis (Individual #142). If diagnostics were not appropriately addressed in a clinically justifiable manner, the other provisions, such as polypharmacy regimens will not be successfully addressed. In summary, there was great stride of ensuring 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. <u>Tracking Diagnoses and Updates</u> Since the last review, the psychiatry department implemented a database under the direction of Jennifer Quisenberry, psychiatry assistant, to track diagnoses and capture diagnostic updates. For example, a numbered spreadsheet of individuals prescribed psychotropic medication listing Axis I, II, and III diagnoses were provided with dates of clinical contact. This was a vast improvement since the last visit. The information collected by the psychiatry department should guide diagnostic updates in an organized fashion facility wide. <u>Challenges</u> The facility made great strides with regard to the completion of the quarterly psychiatric assessments. Given the psychiatric staffing vacancies, including the retirement of the lead psychiatrist, this was particularly impressive. As they had managed to complete a large number of these assessments, it was necessary for this information to be utilized facility wide, specifically highlighting the justification of diagnosis, collaborative case formulation, treatment planning with regard to psychotropic medication, and the identification of non-pharmacological interventions in addition to the PBSP.	

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		Monitoring Team's Compliance Rating The monitoring team would like to acknowledge the hard work of the facility staff with regard to the implementation and completion of some of the quarterly psychiatric assessments in the new format. Based on the early stage of development for the psychiatrists to appropriately document delivery of care (i.e., new psychoactive medication review quarterly), and the lack of completion of evaluations to ensure that no individual received psychotropic medication without having been diagnosed in a clinically justifiable manner, this item was rated as being in noncompliance.	
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.	Treatment Program/Psychiatric Diagnosis Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. Per the review of 20 records, all had diagnoses noted in the record. Individuals prescribed psychotropic medication must have an active PBSP. In all records reviewed, individuals prescribed medication had a PBSP on file. The details of the content of the PBSPs are discussed in section K. There was no indication that psychotropic medications were being used as punishment, for the convenience of staff, or as a substitute for a treatment program. It will be important for ongoing collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. This process had begun due to the development of the PMQR (discussed in J2). In this process, the IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of psychopharmacologic medications. It was notable that the BSP documents included information regarding the psychopharmacological regimen, medication side effects, and medication changes that were not consistently developed in consultation with or collaboration with the individual's prescribing physician. This process further posed a systemic problem because the insufficient and inaccurate content of the medication information was then forwarded to the HRC for approval. Also, as noted in J9 below, PBSP documents reviewed for this monitoring period did not adequately identify non-pharmacological interventions. For instance, individuals require active engagement during the day. Lack of engagement must be addressed because it can lead to increased behavioral challenges including, but not limited to, self-injurious behavior, self-stimulatory behavior, and exacerbations of mood disorders. A team approach to psychiatry clinic was observed during the review; psychology	Noncompliance

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		representatives and other staff disciplines were present at clinic. There were efforts made to justify diagnostics and pharmacological interventions. An expansion to include a review of non-pharmacological interventions, either occurring or proposed for a specific individual, would be a natural outgrowth of this process. The IDT was encouraged to review the content of the BSP with the psychiatrist via psychiatry clinic on a periodic basis. This collaboration in the psychiatry clinic setting would also allow for discussion and subsequent documentation with regard to non-pharmacological interventions and details of pharmacologic indications in the BSP documents. <u>Emergency use of psychotropic medications</u> The monitoring team was provided a numbered spreadsheet of individuals requiring utilization of chemical restraints in the last six months. There were 129 incidents with dates of incidents ranging from 12/1/11 to 6/1/12. This was a decrease from the last review (148 incidents of chemical restraints from 6/1/11 to 11/30/11). Several individuals received more than one administration of this restrictive measure (i.e., Individual #24, Individual #316, Individual #52, Individual #206, Individual #9, Individual #346, Individual #11, Individual #188, and Individual #116). The chemical restraint upon each administration was frequently a combination of medications administered via intramuscular injection (Thorazine and Ativan, Haldol and Ativan). The psychiatry staff informed the monitoring team that they had discontinued the use of pro re nata (PRN) administration of medication for every individual at SGSSLC since the last review. During one of the psychiatry clinics, the psychiatrist stated Individual #9 occasionally refused the oral form of the psychotropic medication prescribed, therefore, was immediately administered the medication in an intramuscular form. The monitoring team inquired about the intention of such measure (i.e., was this a stat emergency medication or was this a PRN order). The monitoring team explained to the IDT that an individual has the right to refuse treatment unless other review measures were in place (i.e., court ordered treatment, necessity of emergency use of medication). The IDT was receptive to this feedback from the monitoring team. The treating psychiatrist elected to discontinue the standing order for Individual #9 (i.e., no longer routinely received an intramuscular agent upon refusal of medication). Individual #9 received chemical restraints numerous times this reporting period. Caution was advised to carefully monitor target symptoms and staffing practice to prohibit the emergency administration of psychotropic agents becoming an aid for staff convenience when someone experienced some difficulties. This was particularly important due to the complex side effects associated with a psychopharmacological regimen alone and in combination with other medications prescribed for medical purposes and/or pretreatment sedation.	

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		A review of the record of Individual #9 revealed that: • Despite Individual #9 receiving a restrictive intervention of administration of chemical restraints, the BSP dated 4/2/10 did not include the psychiatrist's signature as participating in the review. The absence of the psychiatrist in the review of the BSP resulted in a missed opportunity to foster strategies to reduce the use of emergency medication. • Nursing Quarterly Report to the Psychiatrist dated 6/5/12 did not capture emergency medication or medical refusal data that were discussed in the psychiatric clinic. This section in the nurse's document was blank. Staff should be aware of these details. Upon interview of several departments regarding the topic of chemical restraints, it was clear that there was not a systematic review and sharing of knowledge about this critical information. In the prior review, the monitoring team was informed that the lead psychiatrist was not a member of the committee that reviewed chemical and protective supports. There was confusion and tension among various disciplines including psychiatry, primary care physicians, pharmacy, and nursing staff about who were considered essential staff to review the most restrictive interventions for individuals at SGSSLC (i.e., chemical restraints) and elements to collect for reporting and monitoring. There was implementation of a Statewide Policy and Procedures (#001.1 replaced 001) titled "Use of Restraint" 4/10/12 with a section specifically outlining data collection and analysis that will be helpful for future reviews of this provision item. <u>Monitoring Team's Compliance Rating</u> As discussed above, there was a need for improvement of psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. This process had begun due to the development of the PMQR (discussed in J2). In this process, the IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of psychopharmacologic medications. The different departments (i.e., nursing, pharmacy, medical, psychology, psychiatry) must communicate with one another for addressing utilization of restrictive measures (i.e., emergency chemical restraints) to allow for appropriate assessment and intervention to take place by the IDT. Therefore, this item was rated as being in noncompliance.	

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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 services, and shall be monitored and assessed, including for side effects.	<u>Extent of Pretreatment Sedation</u> The facility reported a total of 20 instances of pretreatment sedation for medical purposes from 12/1/11 to 4/18/12. There was no administration of pretreatment sedation for dental procedures. A total of 12 individuals received pretreatment sedation with some individuals receiving as many as three administrations (Individual #126, Individual #38). No individuals were sent off campus for dental treatment. Interestingly, a document requesting examples for the last 10 individuals requiring medical/dental pretreatment had different names from those cited in the list provided. In summary, in order to evaluate the extent of pretreatment sedation utilized at SGSSLC, the calculation should include one comprehensive list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures that includes individual's name, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage, and route of the medication, and date of ISP that documents review of ways to minimize the need for the use of pretreatment sedation medication. Last review, documentation provided by SGSSLC required for tabulating the extent of pretreatment sedation was insufficient. During the last onsite review, the staff reported there were 28 uses of pretreatment sedation between 6/1/11-11/30/11. The number of uses occurred for a total of 21 individuals, with nine of those during the dental clinic. Individuals participating in psychiatry clinic who were prescribed psychotropic medication, such as Individual #38 and Individual #189, did not receive pretreatment sedation in coordination with the IDT. These two individuals' records were the examples provided by the facility for individuals participating in psychiatry clinic who required pretreatment sedation. The documentation submitted for both of these individuals did not reflect an interdisciplinary process as it was noted "no psychiatry note available" and "no PST documentation at this time." Further, Individual #38 received a combination of Zyprexa 10 mg and Haldol 10 mg on three separate occasions (2/2/12, 2/28/12, 3/29/12) due to medical procedure, in addition to the routine medical regimen prescribed that consisted of intraclass polypharmacy (i.e., Zyprexa and Haldol). There was a notification form incorrectly dated 12/23/12 and signed by the psychiatrist for a medical procedure 4/1/12. On a positive note, although the date was not accurate, there was an explanation provided about the individual not receiving systematic desensitization at this time. Individuals who were prescribed psychotropic medication were subjected to potential drug-drug interactions when they received similar medications for medical or dental procedures, therefore, required a concerted effort between disciplines. As medications	Noncompliance

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		utilized for pretreatment sedation could result in unwanted challenging behaviors, sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness, or mistaken as side effects from the regular medication regimen, communication regarding the utilization of pretreatment sedation must be improved. No desensitization plans were implemented for the individuals who received pretreatment sedation for the medical procedure. <u>Interdisciplinary Coordination</u> Interdisciplinary coordination should review if adjustments to the individual's existing regimen could be made in an effort to reduce the duplication of medications administered. For example, individuals scheduled for pretreatment sedation may require a reduction in dosage of scheduled benzodiazepines in order to avoid over-medication. To date, interdisciplinary coordination was minimal as evidenced in the lack of documentation regarding this. Upon the request for 10 examples of psychiatry consultation regarding pretreatment sedation, the facility noted that only five examples were available. Different departments were attempting to address this, sometimes in isolation, therefore, there was a disjointed approach to this. Interviews with psychology and psychiatry revealed an expectation that there should soon be improvement in collaboration with the dental department since the hiring of a full-time dental hygienist. For example, on 3/12/12 the dental department sent correspondence to psychology outlining 13 individuals referred for assessments and requested plans for those recommended for systematic desensitization. The facility should understand that the goal of this provision item is development of treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). <u>Monitoring After Pretreatment Sedation</u> A review of documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs, except for Individual #313. The monitoring team was informed there were no nurses' notes available at this time for this individual who received Ativan 4 mg and Benadryl 50 mg for an eye exam. Monitoring is warranted after pretreatment sedation when being administered sedating medications, particularly when utilized in combination with other medications prescribed for medical and/or psychiatric conditions (that may have a negative clinical outcome). The clinical pharmacist would also be instrumental in providing the	

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		medication interactions and potential interactions of pretreatment sedation agents with concurrently prescribed medication. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation were requested. There were no desensitization plans available for medical. For dental, there were no new plans developed since last review. Further effort must be made with respect to the interdisciplinary review of pretreatment sedation and development of desensitization programs. They must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual. Monitoring Team's Compliance Rating This item will remain in noncompliance because further effort must be made with respect to the development of individualized treatments or strategies and/or desensitization protocols. Plans must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual.	
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.	Psychiatry Staffing Approximately 79% of the census received psychopharmacological intervention requiring psychiatric services at SGSSLC as of 6/3/12. This was an 11% increase since last review. The monitoring team encouraged the psychiatry department to track reasons for the increase in utilization of psychotropic medications (e.g., new admissions, referrals to clinic due to Reiss screen). Of these, five individuals were younger than 18 years of age. There was one full time board eligible general psychiatrist employed at SGSSLC. Last review, there were two FTE psychiatric physicians providing services at the facility, however, the full time lead psychiatrist retired in April 2012. The facility was able to secure a locum tenens psychiatrist who had a specialty in child and adolescent psychiatry. This psychiatrist was scheduled to work four weeks at the facility and then to have four weeks off. Thus, this resulted in only one full time psychiatrist responsible for the treatment of those individuals requiring psychiatric services at SGSSLC for four consecutive weeks. Dr. Bazzell informed the monitoring team that he was responsible for psychiatric call coverage via telephone consultation after hours. Otherwise, each of these psychiatrists worked five days per week, a minimum of eight hours each day. It was noted that each psychiatrist attended IDT, ISPA, and other various meetings as needed. The psychiatry department reported that a minimum of three FTE psychiatrists would be required in order to allow the psychiatrist to provide care for the individuals. This would include enough time for the completion of the Appendix B comprehensive	Noncompliance

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		assessments, quarterly reviews, attendance at meetings (e.g., polypharmacy committee, IDT meetings, behavior therapy committee, physician's meetings, behavior support planning), other clinical activity, such as collaboration with primary care, nursing, neurology, other medical consultants, pharmacy, psychology, provision of emergency psychiatric consultation, and more frequent monitoring for individuals whose medication dosages or regimen had recently been adjusted. Two registered nurses (RNs) were delegated to work full-time in the psychiatry clinic to assist each psychiatrist with making rounds and gathering pertinent information for quarterly reviews and Appendix B comprehensive evaluations. The two nurses joined the psychiatric team in October 2011. During the interview with the monitoring team, they expressed a common goal inclusive of a commitment to improvement of clinical documentation, continuity of care with other disciplines, and facilitation of integration of services for the individuals served at SGSSLC. <u>Administrative Support</u> The psychiatric assistant, Jennifer Quisenberry, was assigned the back-up department head role due to the retirement of the lead psychiatrist. During this visit, there was no designated department head for psychiatric services. She was assigned to represent psychiatry for this review and provided information for section J. She previously worked in the psychology department and gained knowledge of completing various assessments such as the Reiss, desensitization programs, and other vital information as it relates to the psychiatry clinic. She collaborated with the other departments to address section J and diligently gathered requested documentation. Other duties included administrative support to the psychiatrists for scheduling evaluations, obtaining records and contact information, and collection of pertinent data. The monitoring team pointed out the psychiatry clinic also required medical oversight particularly with review of content of medical data. <u>Determination of Required FTEs</u> Overall, it appeared that SGSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. The number of hours for the conduct of the psychiatry clinic were developed to take into account not only clinical responsibility, but also documentation of delivered care such as quarterly reviews and Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, and participation in polypharmacy meetings).	

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		Monitoring Team's Compliance Rating The facility provided a self-rating of noncompliance in the self-assessment for this item because of the inadequate number of psychiatrists. SGSSLC had not yet demonstrated a consistent ability to employ or contract with a sufficient number of psychiatrists to provide the services required.	
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.	Appendix B Evaluations Completed SGSSLC reported that 33 individuals had psychiatric evaluations performed according to Appendix B. Given that 184 individuals received treatment via psychiatry clinic, an additional 151 individuals still required a comprehensive psychiatric assessment. Thus 18% of the evaluations, as described in Appendix B, had been completed. Given the remaining number of comprehensive psychiatric assessments, this provision will remain in noncompliance. Upon the request for review of 10 Appendix B style evaluations performed in the previous six months, the facility was only provided eight comprehensive assessments. The data indicated an average of 1.33 assessments were completed per month. At this rate, it would take more than nine years to complete all of them, without any new admissions to the facility. There were noticeable variations in the content and numbered outline in how the document was completed. The monitoring team had difficulty understanding the reasons for such variation in the template because one psychiatrist completed all of these evaluations. Perhaps the difference in content between the Appendix B evaluations was secondary to various team members completing different sections. Review of Completed Evaluations A sample of eight Appendix B style evaluations performed in the previous six months was submitted and reviewed for the following individuals: Individual #37, Individual #254, Individual #8, Individual #124, Individual #159, Individual #24, Individual #155, and Individual #269. Three evaluations of the eight submitted by the facility for this provision were identified as a "Psychoactive Medication Review Re-evaluation Initial" or "Psychoactive Medication Review Initial" rather than a Comprehensive Psychiatric Evaluation/Assessment Initial. These were Individual #24, Individual #159, and Individual #254. Therefore, the monitoring team reviewed the sample of the five Appendix B style evaluations. The psychiatrist adequately completed the assessments, yet further information should be outlined in order to assist the IDT in regards to diagnostic clarification and selection of an evidence-based treatment plan for each psychotropic medication prescribed. While	Noncompliance

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		the format was followed for the Appendix B outline and reflected an improvement in documentation, there were some sections that required attention, particularly the biopsychosocial formulation (case formulation). The case formulation should identify detailed reasons for the justification of the chosen diagnostics in line with the DSM-IV-TR. The biopsychosocial approach and language similar to the DSM-IV-TR would guide the reader about why another or additional diagnosis was considered, such as an assigned rule out condition. There was an improvement in documentation since the last review. The psychiatrist outlined, in the medical history, all of the current medications, inclusive of dosage. Medical data, such as status of labs (e.g., chemistry profile, lipids, thyroid function test and urine drug screen) were included in the comprehensive evaluation. Further information involving vital signs inclusive of orthostatic vitals (i.e., BP and pulse) and temperature must be included in the report for individuals receiving psychotropic medication. The psychiatrist must guide the team in concert with the PCP for what is required of the team in monitoring of vitals and parameters (e.g., hold the medication for pulse less than…), especially for individuals prescribed an antihypertensive agent in combination with psychotropic medications that can result in orthostatic hypotension and change in pulse, etc. For example, Individual #37 was noted to have abnormal EKG findings (i.e., sinus bradycardia, question of anteroseptal infarct and hypertension that was under control. This individual, with the noted cardiac history, received psychotropic medication that can alter cardiac function, therefore, it was important to monitor and document vital signs. It was good to see that the findings of the EKG were thoroughly documented and addressed. Upon further review, however, the medical findings were not consistently documented throughout the report. For example, in the Medical Disorders section, it was noted there were "none listed in records received" for Individual #37, but this contradicted the information on a separate page of the same report supporting the existence of medical disorders. • Medical information, such as weight with the weight range and results of EKG, should be documented in the report and tracked. • Treatment recommendations need to outline intention of each medication, review potential drug-drug interactions, and provide a risk benefit analysis of the particular regimen. • The psychiatrist must guide the IDT in a detailed fashion about what to monitor in order to determine medication efficacy in an evidence-based manner to avoid the use of polypharmacy unnecessarily.	

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		Monitoring Team's Compliance Rating The facility self-rated noncompliance due to Appendix B evaluations not being completed for the majority of individuals receiving psychiatric services. Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance.	
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.	Reiss Screen Upon Admission 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 current psychiatric assessment. The monitoring team received a list of eight individuals who were new facility admissions for the previous six months and whether a Reiss screen was completed. The psychology department informed the psychiatry department that the Reiss screen manual noted "a person must have known the individual for three months or more to complete the screen." In summary, in regards to the timeliness of the completion of Reiss screens, two individuals did not receive a Reiss screen in a timely manner (i.e., Individual #37, Individual #269). The psychiatry department documented that numerous attempts were made to obtain updated information about the status of the Reiss screens from the psychology department (i.e., 4/11/12, 4/23/12, 5/2/12). There was no information for two of the individuals (e.g., Individual #24 and Individual #362). The other four individuals had Reiss screens completed within 30 days of their admission date. The two departments must share this vital information and have similar data. Psychiatry should be aware of the findings of the Reiss screen in order to determine if the individual warranted psychiatric intervention. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) The psychiatry and psychology departments were in the initial stages of addressing this provision and were struggling with the intent for the administration of the screen. For example, if there was a current psychiatric assessment, the psychology department also obtained a Reiss Screen for those residing at the facility. The reason for completing such screens was not clear to the monitoring team and was not attributed to a change in the individual's status. This process placed undue burden on the psychology department. Further, some individuals were referred for a Reiss screen, but there was no indication as to what change in status had occurred that resulted in this referral. The psychiatry department's data collection regarding the Reiss screen improved	Noncompliance

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		significantly since last review. The data included, but were not limited to, a numbered, alphabetized list with the date of the screen, whether the individual was referred to psychiatry due to "score equated high in possible psychiatric condition," and if the individual was reviewed in the psychiatry clinic. This list did not address if an individual was screened due to a change in status. This provision requires 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. <u>Reiss Screen for Change in Status</u> There must be a rescreen if there is a change in status. If the screen so indicated, a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) was to be attained in a clinically justifiable manner. There was no specific process for determining when a change in status should result in a Reiss screen being implemented. The facility should become familiar with other state centers in regards to addressing time frames for those with an exacerbation of mental health symptoms following a change in status. Consideration should be given to reasonable time lines (e.g., within one week for initiation of consultation following a positive screen and no later than 30 days to complete the comprehensive psychiatric evaluation). <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Individuals who were referred for an evaluation due to the "score equated high" on the screen were either already enrolled in psychiatry clinic or were evaluated by psychiatry and deemed not in need of psychiatry services. <u>Monitoring Team's Compliance Rating</u> Given the challenges with individuals not being screened upon admission and those with a psychiatric diagnosis or prescribed psychotropic medication not receiving a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner, this provision remained in noncompliance.	
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	<u>Policy and Procedure</u> The SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." While this was stated by the policy, there were no specific procedural elements denoted for the physician to follow, therefore, there were no written documents to guide the	Noncompliance

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	other interventions through combined assessment and case formulation.	development and implementation of a system to integrate pharmacological treatment with behavioral and other interventions. The SGSSLC facility-specific policy and procedure dated 8/25/11 regarding psychiatric services did not address combined assessment and case formulation. Interdisciplinary Collaborative Efforts The monitoring team observed four separate psychiatric clinics held with four different IDTs. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (i.e., psychiatry, psychology, nursing, QDDP, direct care professional, and the individual). Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 30 minute) observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. The psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress, and reviewed the plan to make any medication changes, if any were needed. An IDT process (i.e., ISPA) essentially occurred within the psychiatry clinic, with representatives from various disciplines participating. This was good to see and showed continued progress. Combined Assessment and Case Formulation The components of the case formulation were outlined in Appendix B. The case formulation should consist of "sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan." These steps should include identification of factors (i.e., biological, psychological, social, and spiritual) with design of habilitation and interdisciplinary treatment processes to meet the individual's needs. Psychology and psychiatry need to formulate diagnoses and plans for the treatment of all individuals as a team. The psychiatrists were in the beginning phase of focusing on the particular psychiatric diagnosis and the reason the medication was prescribed. There was participation in the discussion and collaboration, but the team did not consistently ask for, or provide, data of the essential target symptoms that were deemed necessary for monitoring of the current psychiatric diagnosis. One area of progress was the discussion during the psychiatric clinics regarding results of objective assessment instruments. The use of objective instruments (i.e., rating scales and screens) that are normed for this particular population may be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom	

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		response to targeted interventions. Further, depending on what document was reviewed, there were varied diagnoses assigned between disciplines. These differences impacted the overall review of efficacy of pharmacological treatment and also altered the determination of specific behavioral and other interventions specific to the individual's needs. For example, for Individual #206: • 2/9/11 physician's annual medical review noted the new diagnosis of dementia. Unfortunately, numerous interdisciplinary treatment plans did not address this significant finding. • 8/26/11 BSP Diagnosis Axis I was Bipolar Disorder. There was lack of identification of the Dementia diagnosis in the BSP. The medication target behaviors were "bizarre behavior described as crying when unprovoked, sudden confusion about time/location, extreme paranoia and anxiety about her safety." • 10/17/11 and 11/14/11 Psychoactive medication review quarterly did not list a diagnosis. • Medication (i.e., Abilify) was prescribed for this individual with reported dementia and s/p cerebrovascular accident. The team did not review if the use of the agent justified the risk (e.g., Abilify carries a black box warning for increased mortality in elderly individuals with dementia-related psychosis and is associated with an increased risk of cerebrovascular adverse events). • 1/23/12 Comprehensive Nursing Assessment noted this individual was s/p infarction with cerebrovascular disease and listed a diagnosis of dementia on Axis III. It was appropriate to cite the cerebrovascular condition (i.e., infarction of the brain) on Axis III, however, the psychiatrist should guide the team if further Axis I diagnostics (i.e., dementia) should also be on Axis I. Conditions that may be a focus of clinical attention (i.e., dementia, delirium, amnestic, and other cognitive disorders) should be cited on Axis I. • 4/20/12 ISP addendum dated did not involve the participation of a medical staff (i.e., physician and/or psychiatrist). In summary the team had not integrated pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. It was difficult for psychology and psychiatry to establish a working relationship because of the staff turnover. For example, turnover resulted in different psychiatrists being responsible for the psychiatric care of an individual, and as a result, diagnostics and treatment regimens changed. When this occurs without the integration and support of the IDT, and without a history of combined case formulation, psychiatry and psychology	

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		will not be (and were not) aligned. As a result, for example, they did not identify similar content, and there were differences in the identification of the target symptoms (psychiatry) and target behaviors (psychology) that would be applicable to the assigned diagnosis. <u>Monitoring Team's Compliance Rating</u> Due to the absence of completed combined assessment and case formulation, this provision remained in noncompliance.	
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.	<u>Psychiatry Participation in PBSP</u> Psychiatrists did not routinely attend meetings regarding behavioral support planning for individuals assigned to their caseloads and were not consistently involved in the development of the plans. This arrangement negatively affected the decision making progress in regards to diagnostics, indications for utilization of psychotropic medication, and/or recommendations of other less intrusive measures. The monitoring team was provided two dates in December 2011 regarding psychiatry attendance at the behavior support plan committee. There was, however, psychiatrists' participation in IDT meetings. There were 37 entries documenting the psychiatrists' involvement in annual reviews, initial, and updated IDT meetings. Last review, there were 53 entries listed, however, since the last visit the full time lead psychiatrist had resigned. The psychiatrists stated a willingness to become more involved, but indicated that a lack of clinical time and requirements of their attendance at other meetings would likely make this impossible. Furthermore, there had been change of staff in the psychiatry department resulting in lack of knowledge about the individual's history and response to psychiatric treatment. To meet the requirements of this provision item, there needs to be evidence that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item and that the required elements are included in the document. The following example illustrated why psychiatry participation in the development of the BSP was necessary. Individual #8 received a comprehensive psychiatric evaluation dated 2/10/12 with an assigned diagnosis of a psychotic disorder and was prescribed an antipsychotic (i.e., Zyprexa). The PBSP developed 2/17/12 (seven days after the psychiatric evaluation) listed a different diagnosis of a mood disorder with symptoms of sadness and threats of self-harm. This discrepancy of information resulted in the development of a plan that will not adequately address the supports required to address the signs and symptoms of the individual's psychiatric condition. For example, an individual with psychosis may inappropriately process feedback provided, and if staff were not aware of the individual's	Noncompliance

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		condition, they may believe the individual was oppositional and resistant to the intervention. The psychiatrist thoroughly documented that the individual had difficulty interpreting and responding to verbal cues, problems interacting with peers, and display of incongruent affect (e.g., smiled when spoke of wanting to die) in the initial evaluation. This information should guide the IDT about whether such presentation was the result of an exacerbation of an Axis I disorder that would warrant further review of psychotropic medication or facilitate determination of noncompliance being secondary to other environmental contributants that would best be addressed via other interventions. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed during these already regularly scheduled quarterly clinics, with additional reviews as clinically indicated. The monitoring team noted that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The monitoring team provided summary in last report encouraging the psychiatrist to meet with the IDT <u>before</u> a proposed PBSP for individuals receiving psychiatric care is implemented. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> During the psychiatric clinics observed, the psychiatric staff and IDT engaged in discussion of non-pharmacological interventions provided to the individuals (e.g., participation in anger management classes and utilization of a replacement skills). It was positive to witness the IDT's efforts in thoroughly reviewing this. The ISP documentation for the member's signature lines were typed which made it easier to determine if a psychiatrist was in attendance. The psychiatrist was present for the ISP dated 12/7/11 for Individual #376. The plan for this individual, who had difficulty remaining in the community setting due to substance abuse issues, nicely illustrated the enrollment in group therapy, substance abuse therapy, and anger management. The psychiatric database listed the dates of the individual's ISP and PBSP and the psychiatrist assigned to the individual's care, but did not specify if the psychiatrist was	

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		present or not at these meetings. To adequately complete self-assessments for this provision item, SGSSLC should begin to collect data, such as number and percentage of meetings attended by the psychiatric staff (e.g., ISPs, ISPAs, PBSPs). <u>Monitoring Team's Compliance Rating</u> Psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Policy and Procedure</u> The SGSSLC facility-specific policy, "Psychiatry Clinics Policies and Procedures Manual" was dated 8/24/11, prior to the implementation of the updated statewide DADS policy and procedure. The responsibilities of the psychiatrist included leading the "discussion and case formulation, determine the appropriate target symptoms and diagnosis, weigh the risk/benefits of medications and decide whether the pharmacologic therapy is indicated…order the type of monitoring needed to determine efficacy and side effects of the medication." As indicated below, this was not being adequately addressed at SGSSLC. <u>Quality of Risk-Benefit Analysis</u> Comments regarding the risk/benefit analysis for treatment with psychotropic medications and restrictive programming were included in the positive behavioral support plans. These were, however, authored by psychology staff and, therefore, did not satisfy the requirements of this provision item or meet generally accepted professional standards of care. Per staff interview and record review, there had been minimal change in practice with regard to this provision since the previous review. The current review of the records of 20 individuals who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this item. The psychiatry department must utilize the findings in the quarterly drug regimen reviews (QDRRs) to enhance clinical care of the individual. The QDRRs were available as an ongoing tool developed for systematic review for those individuals receiving medication, such as psychotropics (section N). Again, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. The success of this process, however, will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring are provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the	Noncompliance

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		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. The psychology department, medical director, and the psychiatry department were receptive to changing this process that was reviewed during the previous visit and summarized the last monitoring report. There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The monitoring team stressed the importance of the psychiatrist and the IDT reviewing the content of this provision and, further, that is was not adequate to have medications outlined with generic statements along with the restrictive programming plan. In the consent process, the explanation of the medication, its class, dosage, and purpose should be specific for the individual. For example, individual #237 had a diagnosis of Bipolar Disorder, Manic NOS assigned 1/30/12, yet the consent dated 3/8/12 for Klonopin noted it was a benzodiazepine used to treat seizures and symptoms associated with panic disorders. The expected benefit was to "decrease agitation and aggression possibly caused by anxiety." Consequences of refusal to consent to the use of Klonopin noted exacerbation of anxiety symptoms yet this individual did not have an Anxiety Disorder noted on Axis I. <u>Observation of Psychiatric Clinic</u> The development of the risk/benefit analysis could be undertaken during psychiatry clinic. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the IDT, but did not thoroughly outline findings in the documentation in the records reviewed in the form of a risk/benefit analysis. The QPMRs listed a number of pertinent findings from various disciplines, but the psychiatrist will need to process the information and then decide risk/benefit and treatment decisions based on the results. This should be an ongoing process and not accomplished in only one clinic setting. The psychiatrists stated that this should be their role and enthusiastically participated in the psychiatric clinics observed.	

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		The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT by holding lengthier clinics (e.g., 45-60 minute, individual consult), accessing equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time would be necessary to set up the shell of the consent document. The availability of a projector or screen and typing the information during the clinic process is recommended. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. <u>Human Rights Committee Activities</u> A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). Clearly the descriptors presented to HRC for the consent example outlined in this section for Individual #237 did not meet generally accepted professional standards of care because it did not reveal sufficient documentation by the psychiatric physician of an individualized specific risk/benefit analysis, yet even so, it was approved on 4/10/12. <u>Monitoring Team's Compliance Rating</u> There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be effective, or potentially more dangerous, than the medication. The input of the psychiatrist and various disciplines must occur with supporting documentation 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	<u>Facility-Level Review System</u> SGSSLC held a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy. The facility made progress in documentation of the issues discussed in the meeting and tracked cancellation of scheduled meetings (e.g., 5/10/12). Last review, there were no minutes provided about the polypharmacy committee for the prior six months. This review, the polypharmacy committee did not address aggregate data until the monitoring team prompted this discussion. The committee mostly focused on a few individuals who were prescribed polypharmacy. The facility self-assessment entry for this provision noted there were 56 individuals prescribed polypharmacy. It was imperative for the facility to have detailed data of a facility-level review system to address the prescription of intraclass and interclass polypharmacy.	Noncompliance

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	the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The monitoring team attended the polypharmacy meeting. The meeting was well attended by numerous staff (i.e., pharmacy director, clinical pharmacy director, psychiatrists, psychiatric nurses, medical director, psychology representative). The monitoring team had to prompt the committee to reveal which individuals were prescribed the greatest number of psychotropic medications. The facility-level data must include the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intraclass and/or interclass polypharmacy. Data should also outline the names of individuals who received three medications, four medications, five medications, and so on. Of course, some individuals may require a polypharmacy regimen, but this should not be the norm. As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a lively discussion regarding reviews of the justification for polypharmacy derived during psychiatry clinic. This element was missing. The pharmacy department should be knowledgeable about the information that is collected in the psychiatry department and vise versa in regards to this provision. <u>Review of Polypharmacy Data</u> For onsite reviews by the monitoring team, it would be helpful for the facility polypharmacy review to always take place at the beginning of the week so that the monitoring team can provide feedback throughout the remainder of the week. Additionally, there should be a Pharmacy and Therapeutics Committee (P&T) at the beginning of the week. There was not a scheduled P & T meeting this review. The polypharmacy data from the March 2012 Pharmacy and Therapeutics Committee meeting (3/21/12) were provided to the monitoring team by the clinical pharmacy director. Regarding polypharmacy, there was one individual who received six psychotropic medications, five with five medications, 16 with four, and 30 with three. The names of the individuals were not provided in the P&T summary. The data compared from 11/1/11 to 3/21/12 illustrated an increase in polypharmacy prescription. In November 2011 there were 14 individuals prescribed four psychotropic medications. By March 2012, an additional 11 individuals (25) were prescribed four psychotropic medications. An additional seven individuals received five medications from January 2012 to March 2012 for a total of 11 receiving these agents. The monitoring team encouraged the committee to address the reasons for the elevated rates of utilization of this regimen (e.g., new admissions prescribed polypharmacy) to provide a facility level review system.	

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		The clinical indicators outlined for the review were not reflective of evidence-based practice for evaluating efficacy of the selected medication regimen. Thus, the team could not accurately detect if the medications were effective for the identified psychiatric illness because the data were not designed to capture such information. The facility should consider a psychiatric peer review system regarding polypharmacy in order to provide feedback to one another and to address this serious aspect of delivery of psychiatric services, particularly in SGSSLC's environment of staff changes in psychiatry. <u>Review of Polypharmacy Justifications</u> The intention of the facility-level review was to ensure that the uses of psychotropic medications were clinically justified, and that medications that were not clinically justified were eliminated. There was robust discussion and the group was generally receptive to feedback 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). A spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy and justification for polypharmacy did not list a start date. The most critical information of medications in process of active tapering was not put into the table. It was noted the facility completes all order renewals at 180 days resulting in all orders having a start date of 4/1/12. The justification rationale for the spreadsheet was reportedly extracted from the last completed psychiatric clinic, but the facility self-assessment noted the psychiatrist had not reviewed polypharmacy during the quarterly psychiatric reviews. The list provided the names of 56 individuals. While it was positive that the facility had drafted the framework for this provision, this was yet another example of how the facility did not capture or utilize the necessary information that would drive the next step of the psychiatrist reviewing the case and treatment regimen within an IDT format in clinic and in other settings to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated. The polypharmacy committee must be aware of all medications that the individual was prescribed in order to further determine the next plan of action. Individuals with a psychiatric illness, particularly those also with a neurological condition, such as a seizure disorder, must be analyzed in view of their overall medical condition in regards to potential drug-drug interactions. Additionally, case review and integration of data for individuals prescribed pretreatment sedation and polypharmacy were imperative in	

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		order to avoid further drug-drug interactions for those already prescribed numerous medications. Thus, the importance of ongoing monitoring for side effects, reporting of adverse drug reactions, and review of finding of the QDRRs (section N) remained very important. Monitoring Team's Compliance Rating The facility must have an effective process for monitoring and ensuring the review of polypharmacy. The psychiatrists were responsible for outlining the justification of such regimen. Given the ongoing challenges noted above with regard to the currently established system level of review of polypharmacy, ineffectively addressing that medications that are not clinically justified were eliminated, this provision was rated in noncompliance.	
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.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) Based upon the findings by the facility it was determined that the MOSES and/or DISCUS were not being completed due to lack of a conclusion by the psychiatrist. Additionally, the log of when the tool was administered was not maintained. The nursing and psychiatry department did not work in partnership to ensure that tools for monitoring side effects of psychotropic medication were obtained and completed correctly within a timely fashion. In response to the document request for a spreadsheet of individuals who have been evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and completion of evaluations dated November 2011 through April 2012. Review of this information revealed delay in completion of the MOSES and DISCUS given that the goal was administration every three months. For example, Individual #22, Individual #376, Individual #53, and Individual #12 each had a MOSES and DISCUS administered in November 2011, yet there was no follow-up MOSES and DISCUS entry since then for any of these individuals. It would be helpful to identify the reasons for not obtaining a follow-up with N/A and notation if the individual was discharged from the facility or was no longer receiving psychotropic medication, if this was the case. It was good to see that the psychiatry staff had designed the database to reflect this pertinent information. Psychiatry must utilize this information and work together with nursing to make this process clinically applicable and request the updated information if the individual have not been administered the screens. Five individuals were prescribed Reglan (Metoclopramide). Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. These individuals did not have a diagnosis of TD.	Noncompliance

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		• Individual #60-DISCUS was obtained 12/16/11 (score =0), but was not obtained again as of April 2012. • Individual #217-DISCUS was obtained 11/12/11 (score =0), but was not obtained again as of April 2012. • Individual #125 was administered a screen last year 3/9/11 (score =4), but did not receive a follow-up DISCUS from November 2011-April 2012. Individual #125's score of four indicated the abnormal movements occurred almost continuously and were easy to detect, indicated a possible diagnosis of Tardive Dyskinesia, therefore, another screen was warranted. <u>Training</u> For facility nursing staff, training occurred 2/1/12, 3/1/12, 3/30/12, and 5/1/12. A total of 18 nursing staff participated in the training. The facility had been making efforts, as such, to address this vital section. The facility should include training of ADR reporting, preferably with the MOSES/DISCUS education, in order for staff to associate the purpose of the monitoring/detecting flows into the reporting requirement. Once side effects were detected, reporting was to occur and response taken based on the individual's status. When an individual experienced an adverse drug reaction, reporting of the finding, such as by filling out an ADR, was to occur. ADRs (e.g., unexpected, unintended, undesired, or dangerous effect that a drug may have that occurs at doses used in humans for prophylaxis) are reviewed in section N. <u>Quality of Completion of Side Effect Rating Scales</u> The names of 10 individuals were provided to the monitoring team that had the diagnosis of tardive dyskinesia (TD). Progress was being made by the psychiatry staff in regards to identifying signs consistent with the diagnosis of Tardive Dyskinesia. For example, Dr. Bazzell added the diagnosis of neuroleptic induced tardive dyskinesia for Individual #170 on 3/31/12. The findings were reflected in the PMRQ mental status section (i.e., grimacing, excessive eye blinking, tongue thrusting) and in the Axis I diagnostics. Dr. Bazzell summarized the individual's history of being treated with neuroleptics. This was important to document since the knowledge about the history of exposure to prescribed medications, such as neuroleptics and metoclopramide, was an important category to assess the risk of TD. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (i.e., lowering DISCUS scores). Medication reduction or absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as Bipolar Disorder.	

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		Therefore, all diagnoses, inclusive of TD, must be routinely reviewed and documented. Monitoring Team's Compliance Rating Given the need for the demonstration of the consistent administration of the standard assessment tools and for the appropriate utilization of this information in clinical decision-making, this provision was rated as being in noncompliance. It is recommended that the psychiatric department work with the nursing department to address this provision (i.e., obtaining and applying pertinent medical history discovered about exposure to medications that cause TD).	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	Policy and Procedure Per a review of the DADS statewide policy and procedure "Psychiatry Services," effective 8/30/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision item. SGSSLC facility-specific policy and procedure was not updated since the release of the statewide policy. There was improvement via the development of a new process for the documentation of the quarterly psychiatry review, reflected in the facility-specific policy and procedure dated 8/25/11 as an attachment. The psychiatry department secured a locum tenens psychiatrist that took over the care for individuals previously provided by the lead psychiatrist. The two psychiatrists reviewed cases together prior to the lead psychiatrist's retirement. The facility informed the monitoring team that there was adequate transitioning and delegation of the new staff's responsibilities. Additionally, the psychiatric assistant informed the monitoring team about her assignment as the back-up department head. There was not an interim lead psychiatrist. Ms. Quisenberry was comfortable in numerous areas regarding this position and did a thorough job in preparing for the review. She was receptive to working with the psychiatrists and medical staff, but there clearly was not the appointment of medical oversight for psychiatric services at SGSSLC at the time of this review. The monitoring team inquired about this issue with the facility administrator and the medical director together and was told the medical director assumed the oversight of the psychiatry clinic from a medical standpoint. Treatment Plan for the Psychotropic Medication The treatment plan for the psychotropic medication would have to be designed in concert with accurate diagnostics across disciplines. The facility developed a policy entitled, "Establishing and Changing Diagnosis" (9/15/11) to improve and unify each individual's diagnosis. This was an important element to create cohesive treatment	Noncompliance

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		plans. If a psychiatrist changes a diagnosis, the IDT should be aware of the reasons for the choice of the new diagnosis over the old one, and allow the IDT to change the treatment plan accordingly. A review of documentation inconsistently justified the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (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) were not consistently outlined. Per record reviews for 20 individuals, some of the information required to meet the requirements of this provision item were included in the psychiatric evaluation or the quarterly psychiatric review. A satisfactory example of a treatment plan (i.e., establishing a revision of diagnostics, clarification of the indication of the medication selected, and other treatment interventions) was illustrated in the PMRQ by Dr. Pharies dated 5/25/12 for Individual #99. There were details outlining the case formulation, arrival at diagnostics (i.e., Bipolar Disorder Type I, Rapid Cycling) and reasons that an antidepressant may worsen the condition of Bipolar Disorder without the use of a mood-stabilizing agent. There was notation of what symptoms to monitor and how the individual could benefit from other less restrictive interventions, such as psychotherapy. Polypharmacy was utilized with the indications summarized for each medication and documentation commented on the ineffectiveness of monotherapy. Documentation outlining all individuals with a current psychotropic medication regimen, their diagnoses, and the frequency of their psychiatric clinic visits was provided. Per review of this documentation, there were numerous instances in which the last psychiatric clinic for an individual exceeded three months, indicating that several individuals were not seen in clinic on at least a quarterly basis. For example, Individual #367 had clinical contacts on 12/20/11 and 1/5/12, but no additional contacts were listed for this individual after the month of January 2012. It should be noted that while multiple individuals appeared to be out of compliance with regards to receiving quarterly clinic reviews, there were also many individuals who were, in fact, seen in clinic more frequently than quarterly. For example, Individual #371 had clinical contacts listed for 12/30/11, 1/23/12, 3/29/12, and 4/9/12. <u>Psychiatry Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process (addressed in J9). The facility had one full time psychiatrist and relied on contracted psychiatric providers. The schedules of the psychiatrists did not allow for their attendance for the majority of the ISP meetings.	

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		In an effort to utilize staff resources most effectively, the facility could consider incorporating some components of the IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT in psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization and management. This provision required that every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, must ensure that the treatment plan for the psychotropic medication addressed the cited requirements of this provision based on the individual's current status and/or changing needs, no less often than quarterly. <u>Psychiatry Clinic</u> The monitoring team attended several clinics. The psychiatry clinics were conducted in the home of the individual at SGSSLC, and provided an adequate work area for the IDT to review records, discuss data, write progress notes, and allow the meeting and interview with the individual to occur in a comfortable setting. The clinics were run efficiently and everyone was prompt for the scheduled appointment. This was the result of communication between the IDT members and the efforts of the psychiatric assistant and psychiatric nursing staff coordinating the clinic appointments with various staff members. Further, the teams did not rush clinic, spending an appropriate amount of time (i.e., 30 minutes) with the individual and discussing the individual's treatment. Pertinent medical information, weights, laboratory data, MOSES, and DISCUS results were reviewed. In all instances, the individual was present for the clinic. All treatment team disciplines were represented during each clinic. Improvements were noted regarding exchange of pertinent information during the psychiatric clinics. The team addressed the diagnosis and indications/target symptoms of the medication selected. This was an improvement compared to the last review when data predominantly focused on behavioral presentation (e.g., agitation, SIB, aggression towards others). Both of the psychiatrists displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information was in the initial phase of being spelled out in the psychiatric documentation.	

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		Medication Management and Changes The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be, and were, done thoughtfully, one medication at a time, so that based on the individual's response, the physician can determine the benefit, or lack thereof, of each medication adjustment. Monitoring Team's Compliance Rating Per a review of the facility self-assessment, this provision was rated in noncompliance. A review of a sample of 20 records revealed varying quality in documentation for the psychiatric reviews, with most of the deficiencies noted in the identification of a clinically justifiable diagnosis to ensure that the treatment plan for the medication was consistent with generally accepted professional standards of care. Therefore, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." The facility-specific policy "Psychiatric Services" dated 8/25/11 did not outline the psychiatrist's role in obtaining consent for psychotropic medications. Per this policy, "San Angelo State Supported Living Center must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications (or other restrictive procedures)." At SGSSLC, the psychiatric assistant informed the monitoring team that psychology obtained consents for psychotropic medications. The psychology staff had been responsible for the coordination of consent for psychotropic medication due to difficulty with the hiring and retention of psychiatry staff (see J1 and J5). Both the medical and psychology departments were receptive to the prescribing physician being responsible for obtaining consent for psychotropic medication. The monitoring team is in agreement with this plan. At SGSSLC, the psychology department summarized details of restrictive procedures inclusive of psychotropic medications, not the medical department, in the BSP. The monitoring team informed the psychiatry staff that the prescribing practitioner for the	Noncompliance

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		medication regimen was the party responsible for establishing the content of the consent process as it relates to the prescription of the psychopharmacological agents. The facility should handle this medical consent consistent with other medical policy and procedures for obtaining consent. <u>Current Practices</u> The psychiatrists had initiated obtaining some of the consents, particularly for the new prescription of a psychotropic medication, but this was not yet implemented facility wide. For example, both Dr. Pharies and Dr. Bazzell informed the monitoring team during their clinics that they wanted to handle obtaining their own consent for individuals with new orders. The monitoring team observed Dr. Pharies being told by the psychology representative that the psychologist was to fill in the content for the consent. The monitoring team encouraged the psychiatrists to oversee the medical content required for consent. Both of the psychiatry and the psychologist department agreed with this recommendation. The monitoring team requested 10 examples of consent for those who were prescribed new psychotropic medications. One of these individuals (Individual #362) received recommendations to begin a new regimen, but the monitoring team was informed there was no consent for use of psychotropic medication received as requested. Individual #269 had an entry that there was "no HRC documentation of consent explanation and consent for use of psychoactive medication…it is scheduled and added to the agenda." The BSP dated 3/28/12 noted Individual #269 exhibited delusions, hallucinations, paranoia, with voices telling him to harm himself. The report was signed by the associate psychologist, but did not cite other signatures to denote if the psychiatrist participated in the development of the BSP prior to implementation. The psychologist noted the findings of the psychiatrist's initial psychoactive medication review on 3/22/12 in the relevant medical section of the BSP that was definitely progress in integration. Further, this individual received a thorough PMRQ dated 3/30/12 per Dr. Mercer. Recommendations were to initiate an antipsychotic medication (e.g., Seroquel) for this individual with a psychotic condition. There was a delay of nearly four weeks from the date of the initial recommendation and the date of the signed consent (4/26/12). The consent documents did not include the name or discipline of the person giving explanation. Further, staff must review the estimated duration of the validity of consent for the medication, consistent with state consent guidelines and whether this should be less for specific measures (i.e., pretreatment sedation). A consent form, once completed, was then presented to the Human Rights committee for review before a non-emergency medication was given.	

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		In an effort to address the inadequacies in 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. This should not preclude the facility from proceeding with implementation of informed consent by the physician because a psychiatrist should be competent in this task without the direction of a specific policy and procedure. Monitoring Team's Compliance Rating This provision remained in noncompliance due to the inadequate informed consent practices noted above.	
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.	Policy and Procedure Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medications are prescribed to treat both seizures and a mental health disorder." There was also a facility-specific policy and procedure "Communication with Neurologist" dated 4/7/11 with the purpose to ensure appropriate communication between the physicians and neurologist. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic The monitoring team received a numbered alphabetized list of 63 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 52 individuals who required neuropsychiatric intervention. At the time of the prior visit, there were 74 individuals. The accuracy of this count of individuals who would require the coordination of care by a neurologist and a psychiatrist to treat both seizures and a mental health disorder was important in order to determine the necessity of consultation services. Adequacy of Current Neurology Resources There had been efforts to coordinate care with neurology. Psychiatry staff stated information pertaining to psychotropic medication and/or other concerns were provided to the neurologist for every individual who received psychiatric services from psychiatry since December 2011. While this collaboration was a movement in the right direction, to date, there had been no reference that a neuropsychiatric clinic was ever scheduled. Neuropsychiatric consultation requires the participation of a neurologist and a psychiatrist. The treating psychiatrists did not meet with the neurologist because individuals requiring neurological consultation were evaluated in the community setting. Neurology clinics occurred a couple of times per month. The monitoring team was	Noncompliance

#	Provision	Assessment of Status	Compliance
		informed that Dr. Chris Vanderzant, one of the community neurologists, knew many of the individuals because he had provided neurology care for them for many years. Three additional neurologists were listed as providing services to a total of three individuals. SGSSLC should consider ways of formalizing the consultation between the neurologist and the psychiatrist through the IDT process to routinely coordinate the care of these individuals. Scan calls between the IDT inclusive of the psychiatrist and primary care physician with the neurologist would be beneficial in delivery of care and review of polypharmacy. For example, everyone participating in the conference call would have a current list of all medications, the individual's medical record, neurology record, psychiatric information, etc. to make informed decisions about necessary medication regimen and indications for the all of the medications. An example of progress in this section was reflected in the review of Individual #331. The PMRQ dated 2/24/12 listed the Axis I, II, and III diagnoses inclusive of the individual's genetic disorder (i.e., Cornelia DeLange Syndrome) and other medical conditions (i.e., cardiac findings, seizure disorder) in addition to behavioral characteristics. There was a complete current list of all medications. This was important to review due to one medication change potentially affecting the level of the other medication prescribed, inclusive of but not limited to the psychotropic regimen (i.e., increase or decrease). The AED medication (i.e., Keppra) was labeled to target the seizure disorder. One area of the consultation that accentuated collaboration between the neurologist and psychiatrist was the psychiatrist's documentation of the Keppra potentially contributing to "an increase in behaviors" therefore tapering of this agent was considered. This intervention was within generally accepted professional standards of care. It was excellent that the two disciplines were providing a thorough medical work-up for this individual who potentially did not have a "true" seizure disorder and wanted to simplify the regimen. The psychotropic polypharmacy regimen consisted of three agents in addition to the AED. If in fact, this individual had an improved mental status presentation upon taper and discontinuation of the AED, then psychiatry could consider simplification of other medications that were prescribed for agitation and sleep. Drug- drug interactions and adverse drug reactions require thorough review particularly for individuals with neuropsychiatric disorders because of the impact on the seizure disorder and mental status presentation. The indications for the medications need to be discussed because an AED for seizure disorder may not be warranted for the Axis I disorder and, therefore, the indication would only be for the seizure disorder. The last review, there was a pervasive pattern noted throughout the record review and upon observation of the psychiatric clinics and	

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		team meetings that numerous individuals received an AED medication, yet the team was not able to confidently state the purpose of the medication. During this review, there was an improvement, captured in the spreadsheet outlining the indication for the AED and the psychotropic medications provided by the psychiatry department. The recommendation to discontinue a medication, such as a benzodiazepine or an AED prescribed for an Axis I disorder may result in occurrence of increased frequency of seizure activity because these medications also target seizures. Thus, the psychiatrist should obtain consultation with the IDT, including the neurologist, prior to discontinuation of an anti-epileptic agent, particularly for individuals with a seizure disorder. Similarly, the neurologist choosing an agent without psychiatrist involvement is not encouraged due to the potential exacerbation of the individual's psychiatric presentation. Regardless, the change in medication, whether AED from the neurologist or adjustment of psychotropic from the psychiatrist, should occur with the plan of one medication change at a time while monitoring seizures, side effects, drug-drug interactions, and mental status. <u>Monitoring Team's Compliance Rating</u> The facility remained in noncompliance with this provision item due to the facility being in the beginning stages of the neurologist and psychiatrist coordinating the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	

Recommendations:

1. The facility should utilize a database to track essential elements of the delivery of services by the psychiatry department, including but not limited to, information confirming current diagnostics, indications of treatment regimen, and tracking of consultation dates in order to ensure individuals were evaluated in a clinically justifiable manner (J2).

2. Revision of the psychiatry policy and procedure to reflect process that occurred within the psychiatric clinic at SGSSLC, in order to instruct the IDT about expectations of material to be presented to the psychiatry team (J2).

3. Improve data collection regarding the use of emergency psychotropic medications. Include PRN medication in the count of psychotropic medication, with the following information: the name of the medication, dosage, duration of use, indication, date consent was obtained, and by whom (J3).

4. It will be important for collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. In this process, the IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of emergency medications. It was also imperative that this information was documented in the individual's record in a timely manner (J3).

5. Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options. The clinical pharmacist can provide the potential interactions of pretreatment sedation agents with concurrently prescribed medication to the IDT (J4).

6. Develop work-load indicators to determine optimal utilization of present 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 ISP, discussions with nurses assigned to psychiatry, call responsibility) (J5).

7. Complete the comprehensive psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. The lead psychiatrist and psychiatry assistant should establish a schedule and procedure for Appendix B evaluations to be completed. The psychiatry staff should utilize a consistent numbering system with the same categories in the same order to address all of the components as outlined in Appendix B (J6).

8. Administer the Reiss screen for each individual as outlined in provision J7. The facility to determine the mechanism for referral and documentation for those individuals requiring a psychiatric evaluation following a positive Reiss Screen or following a change in psychiatric, behavioral, and/or medical status. The facility to clarify timelines within which the Reiss screen and Appendix B evaluations (if clinically indicated) will be completed (J7).

9. Ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate (J2, J8, J13).
    a. If DSM-IV-TR diagnosis was met, utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with behavioral intervention.
    b. 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. These data must be presented in a manner that is useful to the physician (i.e., graph format, with medication adjustments, identified antecedents, and specific stressors identified).
    c. For each individual, this information must be reflected in the case formulation and psychopharmacological treatment plan with illustration of collaboration with the IDT. The team integration should be measured via consistency in the records across disciplines.

10. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows (J3, J8, J9, J13):
    a. In discussions regarding treatment planning and behavioral support planning;
    b. Utilize the psychiatric treatment plan for psychotropic medications written per the psychiatrist in the overall team treatment plan;
    c. Ensure the individual's psychiatric diagnosis is consistent across disciplines;
    d. Involve psychiatrists in decisions to utilize emergency psychotropic medications;
    e. Psychiatry should be consulted regarding non- pharmacological interventions.

11. Formalization of the ISP process to include review of the risk/benefit ratios for the prescription of psychotropic medications and to be authored by psychiatry. Individualize the risk versus benefit for each psychotropic medication prescribed. The risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these

data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis (J10).

12. Ensure a multidisciplinary, facility level review of polypharmacy trends, aggregate data, prescribing practices, and justification of individual psychotropic medication regimens.

13. The psychiatrist should utilize the findings obtained via the polypharmacy review committee and the QDDR as it relates specifically to the review of the prescribing psychiatrist's practice pattern regarding polypharmacy. Continue efforts to 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 (J11).

14. Code Medication-Induced Movement Disorders on Axis I. Provide a numbered alphabetized list of individuals who received a DISCUS and MOSES with the dates of completion for the past two evaluations inclusive of the scores of each screen (J12).

15. Any change in diagnostics should summarize the symptoms and criteria met according to DSM-IV-TR to justify the diagnosis. The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication (J2, J8, J13).

16. The facility must consider options for implementing a formal neuropsychiatric clinic consultation. It would be helpful for the facility to learn how other centers are addressing necessary interaction between psychiatry and neurology to implement clinical coordination of care (e.g., monthly neuropsychiatric clinic. The facility needs to determine the amount of clinical neurology and psychiatry time needed via an examination of the number of individuals requiring review when prescribed medication to treat both seizures and a mental health disorder (J15).

17. Consider appointing a mentor for the facility psychiatrists, specifically a psychiatrist at another facility who was familiar with the requirements and challenges of working in the DADS system. This could include the development of a peer review process across several facilities (J2).

18. Develop a recruitment/retention plan for psychiatry (J1, J2, J5, J14, J15).

19. Continue to recruit for a facility lead psychiatrist (J5).

20. The new lead psychiatrist (department head) should work closely with the psychiatry assistant and medical director developing and implementing a system of psychiatric care and services with other disciplines as outlined in the Settlement Agreement. The lead psychiatrist should develop a system level of integration between the psychiatric practitioners and psychology staff (J2, J3, J4, J8, J9).

21. All lists and data submitted to the monitoring team must include a date, title, and department submitting the information on the document. Numerous documents received by the monitoring team were not dated and, therefore, it was difficult for the monitoring team to interpret percentages of completion of tasks within the time frame since the last monitoring visit (J3, J4, J6, J7, J11).

22. The facility to address the deficits as outlined in the report regarding informed consent process for psychotropic medications (i.e., prescribing practitioner responsibility; revision of consent form to include all of the necessary components). In an effort to address the deficit regarding

informed consent practices, it is recommended that the facility also consult with the state office that, in turn, may want to consider a statewide policy and procedure outlining how to obtain appropriate informed consent that comply with Texas state law and generally accepted medical practice (J14).

23. Psychiatry to author the risk versus benefit for each the psychotropic medication prescribed. For example, if an individual has diabetes mellitus, and was prescribed a medication that exacerbated Diabetes (e.g., Zyprexa, an atypical antipsychotic), then outline justification (J10).

24. Improve data collection regarding the use of emergency psychotropic medications (J3).

25. To adequately complete self-assessments, collect data such as number and percentage of meetings attended by the psychiatric staff (i.e., ISPs, ISPAs, PBSPs, etc.). The psychiatric database lists the dates of the individual's ISP and BSP and the psychiatrist assigned to the individual's care, but did not specify if the psychiatrist was present or not at the meetings (J3, J9).

26. Consider the use of typed notes, projectors for clinic data, and other means of making the psychiatric service provision more efficient (J2, J10, J13).

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 Positive Behavior Support Plans (PBSPs) for: • Individual #215 (2/7/12), Individual #150 (1/11/12), Individual #203 (1/11/12), Individual #200 (2/8/12), Individual #128 (2/29/12), Individual #145 (4/26/12), Individual #239 (2/27/12); Individual #386 (6/15/12); Individual #48 (3/16/12); Individual #64 (4/26/12) o Six months of notes on PBSPs progress for: • Individual #215 (2/7/12), Individual #150 (1/11/12), Individual #203 (1/11/12), Individual #200 (2/8/12), Individual #128 (2/29/12) o Annual Psychological updates for: • Individual #205 (4/6/12), Individual #232 (2/16/12), Individual #173 (4/13/12), Individual #148 (12/2/12), Individual #331 (2/24/12), Individual #239 (3/5/12), Individual #154 (3/19/12), Individual #388 (3/8/12), Individual #247 (2/20/12), Individual #384 (4/12/12), Individual #41 (4/30/12), Individual #409 (5/25/12) o Skill Acquisition Programs (SAPs) for: • Individual #311, Individual #173, Individual #386 o Minutes of Internal and External Peer Review meetings during the last six months o Minutes of psychology meetings during the last six months o Status of enrollment in BCBA coursework for all psychology staff, undated o A list of all individuals psychological evaluations, undated o Policy and Procedures for Positive Behavior Support Committee, dated 12/16/10 o Policy and Procedures for Session Psychology, dated 10/6/11 o Policy and Procedures for Competency, Reliability, and Interobserver Agreement Assessment, dated 10/6/11 o Policy and Procedures for Psychology Internal Peer Review Committee (PIPRC), dated 1/27/11 o Policy and Procedures for Psychology External Peer Review Committee (PEPRC), dated 8/25/11 o A list of all functional assessments completed in the last six months o A list of all individuals with a PBSP, undated o List of individuals receiving therapy/psycho-educational therapies, undated o Sessions Treatment Plan and Progress Summary for: • Individual #22, Individual #398, Individual #377, Individual #48, Individual #29, Individual #169, Individual #193, Individual #200, Individual #353, Individual #114, Individual #119 o SGSSLC plan of improvement, dated 5/1/12 o SGSSLC action plans, dated 5/1/12 o Section K Presentation book, undated

	o SGSSLC PBSP Monitoring Checklist, undated o SGSSLC Scan card, January 20, 2012 o Scan Data Card Monitoring sheet, dated 4/20/12 o SGSSLC APES Monitoring Checklist, undated o SGSSLC Comprehensive Psychological Evaluation Monitoring Checklist, undated o Comprehensive Psychological Evaluation format, undated o Annual Psychological evaluation Summary format, undated o SGSSLC Monthly Psychology Progress Note Review, undated o Positive Behavior Support Plan Competency, undated o Session Psychology Services Referral Form, summer semester 2012 o SGSSLC Monthly Psychological Progress Note Review, 2/12 o Treatment Integrity Monitoring Tool, dated 3/19/12 <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., Chief Psychologist o John Church, Assistant Chief Psychologist o Dana Robertson, Provision Coordinator o Felicia Lindsey, Psychology Assistant; Mary Jane Bajaj, M.A., LPC, LSOTP; Lynn Zaruba, BCBA, Clinical Supervisor o Robb Weiss, Psy.D., Chief Psychologist; John Church, Assistant Chief Psychologist; Lynn Zaruba, BCBA Clinical Supervisor; Neal Perlman, Associate Psychologist <u>Observations Conducted</u>: o Behavioral Systems task group • Staff present: Jimmy Barnes, Associate Psychologist; Sim Nyakunika, Associate Psychologist; Erick Ybarra, Associate Psychologist; Dr. Weiss, Chief Psychologist o Psychiatry Clinic Rounds • Attending Psychiatrist: Dr. Bazzell • Individual Presented: Individual #9 o Group therapy SOTP session (6/5/12) • Individuals participating: Individual #255, Individual #327, Individual #337, Individual #42 • Staff facilitating: Mary Jane Bajaj, M.A., LPC, LSOTP; Robbie Potter, Psychological Assistant o Group therapy Self-esteem for men (6/6/12) • Individuals participating: Individual #95 and Individual #376 • Staff facilitating: Amber McWilliams, Psychological Assistant; Elsa dela Garza, translator o Psychology Internal Peer Review Committee • Staff attending: Robb Weiss, Chief Psychologist; Spencer Washington, Associate Psychologist; Patricia Campbell, Associate Psychology; Sim Nyakunika, Associate Psychologist; Cleo Ortiz, Associate Psychology; Irma Rangel, Psychology Secretary; John Church, Assistant Chief Psychologist; Lynn Zaruba, BCBA Clinical Supervisor; Erick Ybarra,

	Associate Psychologist; Neal Perlman, Associate Psychologist; Jayne Bryan, Associate Psychology; Jimmy Barnes, Associate Psychologist; Debra Rosenthal, Associate Psychologist; Adrianna Henderson, Associate Psychologist; Amanda Bankston, Associate Psychologist; Kelli Crouch, Psychological Technician • Individual Presented: Individual #292 o Behavior Support Plan Committee (BSPC) Meeting • Staff Attending: Lynn Zaruba, BCBA Clinical Supervisor; Angela Kissko, QA Director; John Church, Assistant Chief Psychologist; Neal Perlman, Associate Psychologist; Jimmy Barnes, Associate Psychologist; Susan Holler, Speech/Language Pathologist; Mandy Rodriquez, Unit Manager • Individuals Presented: Individual #311, Individual #134, Individual #173 o Psychology Department Meeting o PBSP training (6/6/12) • Instructor: Jimmy Barnes, Associate Psychologist • Staff trained: Lorenzo Moutez, DCP; Alyssa Moreno, DCP; Paul Valdez, DCP; Roger Abalos, DCP • PBSP trained: Individual #386 o Psychiatry Clinic Rounds (6/7/12) • Attending Psychiatrist: Dr. Pharies • Individual Presented: Individual #369 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
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document, separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. It should include, however, activities that are identical to those the monitoring team assesses, as indicated in this report. For example, for K4, SGSSLC's self-assessment included "…review of POI Monitoring tool…" This self-monitoring tool included several items, some of which were identical to those reviewed by the monitoring team, as well as some that were not directly relevant to this provision of the Settlement

	Agreement and, therefore, it is not clear what a specific percentage of compliance really meant in terms of compliance with K4. As the report below indicates, the critical items for K4 (and, therefore, the items that it is suggested to be reviewed in the self-assessment) are: • A data system that includes the collection of target and replacement behaviors. • A data system that is simple and flexible. • Evidence that data collection is reliable. • Evidence that interobserver agreement (IOA) is collected, reliability goals are established, and attempts are made to ensure that those goals are achieved. • Graphing of data and progress review occur at least monthly, with more frequent graphing as necessary. • Evidence of progress, or evidence of some activity (e.g., modification of PBSPs, retraining of staff) to address lack of progress. • Evidence that data are used to make treatment decisions in psychiatric clinics, peer review meetings, ISP meetings, etc. Thus, to reiterate, to take this process forward, the monitoring team suggests that the self-assessment review, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the psychology department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychology department and believes that the facility was proceeding in the right direction. This was a good first step. SGSSLC's self-assessment indicated that two items (K2 and K8) were in substantial compliance. The monitoring team's review of this provision, however, found three items (K2, K8, and K3) were in substantial compliance. The self-assessment 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 throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team recommends that the facility staff establish, and focus their activities on, selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.

	Summary of Monitor's Assessment: Although only three of the items in this provision were found to be in substantial compliance, there were several improvements since the last onsite review. These included: • Occurrence of internal peer review weekly, and external peer review monthly (K3) • Improved data collection (K4) • Initiation of the collection and graphing of replacement behaviors (K4) • Initiation of the collection of data reliability, and inter-observer agreement (IOA) data (K4, K10) • Improvements in the comprehensiveness of annual psychological assessments (K7) • Improvements in the quality of PBSPs (K9) • Initiation of the collection of treatment integrity data (K11) The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Track data collection reliability, establish data reliability goals, and ensure that those levels are achieved (K4) • Track IOA scores, establish IOA goals, and ensure that those levels are achieved (K4, K10) • Track treatment integrity scores, establish treatment integrity goals, and ensure that those levels are achieved (K11) • Expand the collection and graphing of replacement behaviors to all individuals with a PBSP (K4, K10) • Increase the number of individuals with functional assessments (K5) • Increase the number of individuals who have annual psychological assessments (K7) • Ensure that all Positive Behavior Support Plans (PBSPs) are based on the hypothesized function of the target behavior (K9) • Ensure that all training of PBSP implementation includes a competency-based component (K12)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, the majority of psychologists at SGSSLC who wrote Positive Behavior Support Plans (PBSPs) were not certified as applied behavior analysts (BCBAs). At the time of the onsite review, one psychologist was a BCBA, and 11 of 12 psychologists who wrote PBSPs (92%) were either enrolled in, or completed, coursework toward attaining a BCBA. This represented a slight decrease from the last review when 100% of the psychologists that wrote PBSPs were either enrolled in or completed BCBA coursework. The facility provided supervision of psychologists enrolled in the BCBA program by the on-staff BCBA. 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. To achieve compliance with this item of the Settlement Agreement the department needs to ensure that all psychologists who write PBSPs attain BCBA certification.	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 (chief psychologist) had a Psy.D. and was licensed in several states, including Texas. He was a member of the Psychological Association of Greater West Texas, and had over 15 years of experience working with individuals with intellectual disabilities. Additionally, Dr. Weiss was recently approved to sit for the BCBA exam based on his training and experience. Finally, under Dr. Weiss' leadership, several initiatives had begun toward the attainment of substantial compliance with provision K.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The facility consistently provided weekly internal peer review and monthly external peer review since January 2012. Therefore, this item is now rated as being in substantial compliance. 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. The facility had recently modified the Psychology Internal Peer Review Committee (PIPRC) meetings to address the opportunity to present cases that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #292's functional assessment and PBSP, and included participation by the majority of the psychology department. The peer review meeting included active participation among the	Substantial Compliance

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		psychologists, and resulted in the identification of several new interventions to address this individual's target behaviors. Meeting minutes indicated that internal peer review occurred weekly since January 2012. Additionally, the facility recently expanded peer review by conducting Psychology External Peer Review Committee (PEPRC) meetings. These meetings included a participant from outside the facility, thereby, achieving the requirement of monthly external peer review meetings. Meeting minutes indicated that external peer review occurred monthly since January 2012. Operating procedures for both internal and external peer review committees were established. The monitoring team will review meeting minutes to ensure that internal peer review consistently occurs weekly, and external peer review consistently occurs at least monthly to maintain substantial compliance with this provision item.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted continued improvements regarding this provision item. In order to achieve substantial compliance, however, the facility needs to ensure that PBSP data are reliable by expanding the collection of data collection reliability and interobserver agreement (IOA) to all individuals with a PBSP, establishing acceptable data reliability and IOA levels, and ensuring that those levels are achieved. Additionally, the facility needs to expand the collection and graphing of replacement/alternative behaviors to all individuals with a PBSP, and ensure that all treatment decisions are data-based. As discussed in the last report, the facility used a PBSP data collection system that included the use of scan cards. Scan cards were preprinted individual cards, containing categories of target behaviors that direct care professionals (DCPs) used to record target behaviors. The cards could then be scanned and used to produce graphs of the data. Since the last review, the facility began to collect replacement/alternative behaviors on the scan cards, however, not all individuals' replacement behaviors were being collected at the time of the onsite review (e.g., Individual #39, Individual #27). It is recommended that the occurrence of replacement/alternative behaviors be collected for all individuals with PBSPs. Additionally, the scan cards reviewed did not contain preprinted codes for replacement behaviors. Instead, for individuals for whom replacement behaviors were being collected, DCPs were given codes on a separate piece of paper to record the occurrence of replacement/alternative behavior on the scan cards. The monitoring team found that several DCPs responsible for recording individual PBSP data (in 509B, 502, and 505A) were not aware of the replacement behavior codes and, therefore, did not record them. It is recommended that preprinted replacement behaviors (as is done for the target	Noncompliance

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		behaviors) be added to the scan cards. The ease of implementation (e.g., all DCPs were observed carrying the cards with them) and the simple process from data collection to graphing were clear advantages of this system of data collection. The data system required DCPs to record a predetermined code in each recording interval (15 minutes) if target or replacement behaviors did not occur. This procedure ensured that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. This requirement also allowed for the review of data cards to determine if DCPs were recording data at the intervals specified (i.e., data collection reliability) mid-shift by their supervisors. The monitoring team did its own data collection reliability by sampling individual scan cards across several homes, and noting if data were recorded up to the previous recording interval for target behaviors. The target behaviors sampled for nine of nine scan cards reviewed (100%) were completed within the previous 45 minutes. This represented an improvement from the last review when 70% of the scan cards were completed within 60 minutes of the behavior occurring. These results were encouraging, and increase confidence in reported data because it was an indication that staff were recording data soon after it occurred, rather than attempting to recall it hours later. Another area of improvement was the plan for the facility to initiate its own data collection reliability for all target behaviors (and replacement behaviors when those data are added to the scan cards) collected in each home and day/vocational site. The monitoring team observed a work group meeting finalizing the tools used for data collection reliability, and found the methodology chosen to be appropriate. It is recommended that the facility begin the collection of data reliability. Additionally, data collection reliability goals should be established, and DCPs should be provided performance feedback to ensure that those goals are achieved. The facility was also planning to begin the collection of inter-observer agreement (IOA) measures. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with IOA 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. Once IOA is collected, the facility needs to establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals. Because the systems necessary to track and increase data collection reliability, IOA, and treatment integrity (see K11) require the cooperation of departments other than psychology (e.g., DCPs, unit directors) and require the development of new tools (e.g., tracking systems), it is suggested that the facility pilot the	

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		tracking of these behavioral systems in one or two homes. This will allow the facility to work out the logistical challenges, and better assess the additional resources that will be necessary to implement it across all the homes and day/vocational sites. Another area of continued improvement was the flexibility in the graphing of data in increments based on individual needs (rather than all individuals' data graphed in increments of one month). For example Individual #215's target behaviors were graphed in weekly increments to better understand the effects of medications on her undesired behaviors. These potentially useful graphs, however, were not consistently present in the psychiatric meetings observed by the monitoring team. For example, in Individual #9's and Individual #369's psychiatric meetings, graphed target behaviors represented data that were five weeks old, and no replacement data were presented. As discussed in previous reports, current graphed data is very important for ensuring data-based medication decisions. In order to achieve substantial compliance with this provision item, the psychology department will need to ensure that all treatment decisions are data-based. Specifically, they need to ensure that data accurately and reliably capture target and replacement behaviors, and demonstrate the value of data to staff by consistently graphing and presenting data in increments that encourage data-based treatment decisions. Progress notes were available for five of the 10 (50%) PBSPs reviewed. All PBSPs should have monthly progress notes. In reviewing six months of PBSP data for these five individuals, three (60%) indicated improvement, or stable and low levels, of severe target behavior, such as aggression or self-injurious behavior (i.e., Individual #150, Individual #128, and Individual #203). This represented a positive trend in the improvement of dangerous behaviors at SGSSLC. In the May 2011 review, 14% of the PBSP data reviewed indicted decreases or low stable levels of severe target behaviors, while 40% was reported in the last review (December 2011). Finally, there was no indication that when progress was not occurring, action to address the lack of progress was occurring (e.g., modification of the PBSP or retraining of staff). If an individual is not making progress, an analysis of the potential reasons for the lack of progress should be undertaken, and based on the results of this analysis, appropriate corrective actions should be initiated. Additionally, this action should be reported in the progress note or PBSP. The monitoring team 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 recognizes the substantial efforts the facility had made on this provision item. Clearly, there had been a meaningful improvement, and SGSSLC	

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		appeared to be on a very productive course toward future improvement in this area.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for each individual, and the absence of functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> A list of all individuals and dates of their full psychological assessments indicated that 25 of the 232 individuals at the facility (11%) did not have an initial (i.e., full) psychological assessment. No full psychological assessments were reviewed because none were completed since the last review. All individuals at SGSSLC should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include 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 noted in the last report, the chief psychologist had indicated that not all individuals with a PBSP had a functional assessment at SGSSLC. All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors. No functional assessments were reviewed during this reporting period because none were completed since the last review. As indicated in past reports all functional assessments should include: • Direct and indirect assessment procedures • Identify potential antecedents and consequences of the undesired behavior • A clear summary statement Additionally, a revision of the functional assessment should be completed when new information is learned concerning the variables affecting an individual's target behaviors (with a maximum of one year between reviews).	Noncompliance

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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.	The majority of SGSSLC's initial (full) psychological assessments were not current and, therefore, this provision item was rated as being in noncompliance. Only nine of the 232 individuals with full psychological assessments (4%) were conducted in the last five years. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	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 procedures.	In addition to the initial or full psychological assessment, an annual psychological update should be completed each year. The purpose of the annual psychological assessment, or 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) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's individual support team for the upcoming year. A list of annual assessments indicated that they were not completed, or more than 12 months old, for 194 of the 232 individuals (84%) at SGSSLC. All individuals should have an annual assessment. The monitoring team reviewed 12 of the 28 (43%) annual psychological assessments that were completed since the last onsite review, to assess their comprehensiveness. Eleven of the 12 (92%) annual assessments reviewed contained all of the components described in K5. The lone exception was the absence of medical status in Individual #148's annual assessment. This represents a dramatic improvement in the comprehensiveness of annual assessments from the last review when none were judged to be complete. All psychological updates will need to contain all of the components described in K5. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions to the facility in the last six months (i.e., Individual #41 and Individual #409) indicated that this component of this provision item was in compliance.	Noncompliance

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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.	The facility continued to be in substantial compliance with this item. As discussed in the last review, multiple therapies and psycho-educational classes, and individual therapies were offered at SGSSLC. Ten individual treatment plans and progress summaries were reviewed to assess compliance with this provision item. Additionally, the monitoring team observed two group therapies/classes. The facility developed a referral form that documented the need for services. Observations of group sessions (i.e., SOTP and Self-esteem for men) indicated that there were clear objectives for each class, measureable progress toward that goal was recorded, and that therapies/classes reflected evidence-based practices. Additionally, staff who facilitated the sessions were qualified to do so through specialized training, certification, or supervised practice. Seven of the 10 treatment plans reviewed (70%) were found to be goal directed, with measurable objectives, and specific treatment expectations. There was also documented review of progress, and these seven plans included a "fail criterion" as well as a plan for the generalization of acquired skills. The other three treatment plans (i.e., for Individual #22, Individual #398, and Individual #169), although derived from evidence-based practices, did not have measurable goals, a fail criterion, or a plan for generalization in the treatment plan. The incomplete training plans all were from sex offender treatment plan (SOTP) sessions. The monitoring team spoke to the SOTP therapist about the treatment plans, and observed an SOTP session. It appeared that measureable objectives and specific treatment expectations, as noted in the last review, continued to be a component of all SOTP sessions, however, they were not included in each individual's treatment plan. In order to maintain substantial compliance for this provision item, the facility will need to ensure that all psychological services other than PBSPs contain <u>all</u> of the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	Substantial Compliance

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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 the majority of PBSPs were not updated (at least annually), and several of those reviewed did not contain interventions that were based on functional assessment results. A list of individuals with PBSPs indicated that 212 individuals at SGSSLC had PBSPs. One hundred and twenty-four of these (58%) were more than 12 months old. All PBSPs should be reviewed when necessary, and at least annually. Fifty-nine PBSPs were completed since the last review, and 10 (17%) of these were reviewed to evaluate compliance with this provision item. All 10 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed included descriptions of target behaviors, and all of these were operational (100%). This represented a dramatic improvement in operational definitions from the last two reports when 8% and 33% of the target behaviors were operationally defined. All 10 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but four (i.e., Individual #203, Individual #128, Individual #386, and Individual #145) of these (40%) identified consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This represented a decrease in the effectiveness of antecedent and consequent procedures reported in the last review when 25% were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #145's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). The antecedent procedure was consistent with his hypothesized function and included prompting Individual #145 to tell staff "I don't want to…." The consequent interventions in Individual #145's PBSP included removing him from the environment following an episode of physical aggression. If, however, avoiding undesired activities was reinforcing for Individual #145 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his disruptive behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression represented an effective antecedent intervention. After the targeted behavior occurred, however, Individual #145 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication (i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired	Noncompliance

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		activity should be avoided, whenever possible and practical, because it encourages future undesired behavior. 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 #215's PBSP hypothesized that one function of her aggressive behavior was to gain others' attention. Antecedent interventions included providing her with staff attention (and a token used to purchase preferred items) when she exhibited appropriate behaviors, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., asking to talk to staff) before she was aggressive. Her intervention following aggression included ensuring safety, but minimizing attention to Individual #215 as much as possible during the aggressive episode. 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. Replacement behaviors were included in all of 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 the reinforcer for alternative behavior is practical. As reported in the last review, 100% of the replacement behaviors that could be functional were functional. Eight of the 10 functional replacement behaviors discussed above appeared to represent behaviors that staff needed to encourage and reinforce (i.e., skills that the individual already had in his or her repertoire), rather than new skills the individual needed to acquire. For example: • Individual #150's replacement behavior was moving to another area, or asking staff to help him find a quieter area. The PBSP included instructions for staff to encourage Individual #150 to move to a calmer, quieter place, and to accommodate him whenever possible. The two examples of a functional replacement behavior that appeared to require the acquisition of a new skill were: • Individual #386's replacement behavior, which consisted of teaching him to use gestures and pictures to ask for desired items. • Individual #128's replacement behavior consisted of teaching him to indicate	

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		that someone was too close and he wanted to move to another area by extending his arm out. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were currently in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (SAP). Thus, the monitoring team was encouraged to find, as had been recommended in past reviews, several replacement behaviors written as SAPs (e.g., Individual #386). These SAPs, however, were not in the new SAP format used by the facility (see section S1). It is recommended that all replacement behaviors that require the acquisition of new behaviors, be written in the same format as all new SAPs at SGSSLC. Regardless of whether a replacement behavior is part of an individual's repertoire or requires the acquisition of a new behavior, it needs to reinforced when it occurs. The explicit reinforcement of functional replacement behaviors was included in all 10 of the PBSP reviewed. This represented another area of improvement for SGSSLC, when the majority of PBSPs reviewed in the last review did not specify the reinforcement of replacement behaviors. An example of a PBSP that clearly specified the reinforcement of the replacement behavior was: • Individual #215's PBSP specified, "… if she states I need a break, allow her to walk away from the area…" Overall, six (Individual #215, Individual #150, Individual #200, Individual #64, Individual #48, and Individual #239) of the 10 PBSPs reviewed (60%) represented examples of complete plans that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a dramatic improvement over the last two reviews when only 8% (i.e., May 2011 review) and 25% (December 2011 review) of the PBSPs reviewed were judged to be acceptable. The monitoring team was encouraged by the overall progress in the quality of PBSPs at SGSSLC, and looks forward to continued improvements in this provision item.	

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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.	The monitoring team was encouraged by the initiation of the collection of IOA data at SGSSLC (see K4). In order to achieve substantial compliance with this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated. Target behaviors were consistently graphed, and replacement behaviors were beginning to be graphed at SGSSLC (see K4). Five of the 10 PBSPs reviewed (50%) contained graphed replacement behaviors. It is recommended that replacement/alternative behaviors be graphed for all individuals with PBSPs. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. As discussed in K4, the quality and usefulness of these graphs had improved.	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.	Another area of improvement since the last review was the plan to begin the collection of treatment integrity. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, treatment integrity was not consistently collected and recorded across the entire facility. SGSSLC continued to monitor PBSPs to ensure that they were written so that DCPs could understand and implement them. Two (Individual #215 and Individual #48) of the 10 PBSPs reviewed (20%), however, contained six or more target behaviors. That number of target behaviors would decrease the likelihood that DCPs would record or implement the plans with integrity. This does, however, represent an improvement from the last report when 42% of the PBSPs reviewed contained more than six target behaviors. It is recommended that the facility attempt to reduce the number of target behaviors (many appeared to be part of the same response class, so could be combined). The only way to ensure that PBSPs are implemented with integrity, however, is to regularly collect treatment integrity data. At the time of the onsite review, the facility was meeting to finalize a treatment integrity tool. The monitoring team attended a work group meeting discussing the new treatment integrity methodology, and believes that the SGSSLC was moving toward the development of an effective treatment integrity tool that would satisfy the requirements of this provision item. In order to achieve substantial compliance with this provision item, the integrity data should be tracked and reviewed regularly, and minimal acceptable integrity measures established and maintained. As discussed in the last report, these integrity data need to include direct observations of staff implementing PBSPs. The monitoring team looks forward to reviewing integrity data during the next onsite review.	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 previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. At the time of the onsite review, however, these trainings did not contain a competency-based training component. Therefore, this item is rated as being in noncompliance. The monitoring team observed the training of DCPs on Individual #386's PBSP. The training included a review of the PBSP by the psychologist, role-playing, an opportunity for DCPs to ask questions, and written questions covering varying aspects of the PBSP. The training did not, however, include a competency based training component that allowed the psychologist to observe the staff implementing the plan, and an opportunity for the psychologist to provide performance feedback to the DCPs. It is recommended that the facility expand the competency-based component (i.e., treatment integrity) to all PBSP trainings. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, there needs to be evidence that the training included a competency-based component. Finally, the facility should track DCPs who require remediation, and document that they have been retrained, and subsequently demonstrated competence 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 232 individuals and employed 12 psychologists responsible for writing PBSPs. Additionally, the facility employed three psychology technicians and four psychology assistants to assist those psychologists. As discussed in K1, the facility had one psychologist with a BCBA. In order to achieve substantial compliance with this provision item, the facility must have at least 12 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. It is recommended that the occurrence of replacement/alternative behaviors be collected and graphed for all individuals with PBSPs (K4, K10).
3. Preprinted replacement behaviors should be added to the Scan Cards (K4).
4. Begin data collection reliability, establish goals, and ensure that those levels are achieved (K4).
5. Begin the collection of IOA data, establish IOA goals, and ensure that those levels are achieved (K4, K10).
6. Ensure that all treatment decisions are data-based (K4).
7. All PBSPs should have monthly progress notes (K4).
8. If an individual is not making expecting progress, the progress note or PBSP should indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
9. All individuals at SGSSLC should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include 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 (K5).
10. All individuals with a PBSP should have a functional assessment (K5).
11. All functional assessments should include (K5):
    - Direct and indirect assessment procedures
    - Identify potential antecedents and consequences of the undesired behavior
    - A clear summary statement
12. Functional assessments should be revised when new information is learned concerning the variables affecting an individual's target behaviors (with a maximum of one year between reviews) (K5).
13. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).
14. All individuals should have an annual psychological assessment (K7).
15. All annual psychological assessments need to contain all of the components described in K5 (K7).

16. All psychological services other than PBSPs should contain the following (K8):
    - A treatment plan that includes an initial analysis of problem or intervention target
    - Services that are goal directed with measurable objectives and treatment expectations
    - Services that reflect evidence-based practices
    - Services that include documentation and review of progress
    - A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention
    - A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings

17. All PBSPs should be reviewed when necessary, and at least annually (K9).

18. 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 (K9).

19. It is recommended that all replacement behaviors that require the acquisition of new behaviors be written in the same format as all new SAPs at SGSSLC (K9).

20. The facility should attempt to reduce the number of target behaviors in PBSPs (K11).

21. It is recommended that the facility consistently implement treatment integrity measures throughout the facility, ensure that data are regularly tracked and maintained, establish minimal acceptable integrity scores, and ensure that those levels of treatment integrity are achieved (K11).

22. The facility needs to provide documentation that all staff assigned to work with an individual have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. This training should include a competency-based component. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP (K12).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 4/19/12 o DADS Policy Preventive Health Care Guidelines, 8/30/11 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 #044.2: Emergency Response, 9/7/11 o SGSSLC Policy/Procedure: Medical Care, 6/23/11 o SGSSLC Policy/Procedure: Establishing and Changing Diagnosis, 9/2/11 o SGSSLC Policy/Procedure: Pretreatment Sedation Notification, 2/22/11, rev. 11/16/11 o SGSSLC Policy/Procedure: Consultation Process, 12/8/09, rev. 8/25/11 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC Policy/Procedure: SGSSLC Policy/Procedure: Routine Lab Tests and Screenings, 11/18/10 o SGSSLC Lab Matrix, 9/15/11 o SGSSLC Policy and Procedure, Seizure Management Guidelines, 11/2/11 o DADS Clinical Guidelines: o Aspiration Risk Reduction Interdisciplinary Protocol o Enteral Feedings Interdisciplinary Protocol o Constipation/Bowel Management o Constipation Interdisciplinary Protocol o Urinary Tract Infections o Assessment and Management of Urinary Tract Infections for DSPs o Assessment and Management of Urinary Tract Infections for Nurses o Seizure Management Interdisciplinary Protocol o Seizure Management Instruction for the PCP o Seizure Management Instruction for DSP o Seizure Management Instruction for Nurse o Diabetes Mellitus o Osteoporosis o Anticoagulation Therapy o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders

	o Listing, Individuals hospitalized and sent to emergency department o Report of external and internal medical reviews conducted in March 2012 o Listing of Medical Staff o Medical Caseload Data o Mortality Review Documents o Daily Provider Meeting Notes o Onsite Clinic Schedule o Neurology Clinic Schedule o Physician Orders, December 2011 – May 2012 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, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #277, Individual #163, Individual #203, Individual #188, Individual #168 Individual #186, Individual #76, Individual #93, Individual #377, Individual #231 o Annual Medical Assessments the following individuals: • Individual #184, Individual #41, Individual #95, Individual #9, Individual #169, Individual #73, Individual #200, Individual #18, Individual #154 Individual #307, Individual #78, Individual #278, Individual #17, Individual #268 o Neurology Notes for the following individuals: • Individual #164, Individual #203, Individual #26, Individual #313, Individual #69, Individual #46, Individual #288, Individual #129, Individual #66, Individual #112 o Consultation Referrals and IPNs and for the following individuals: • Individual #385, Individual #339, Individual #380 Individual #211, Individual #321, Individual #73 Individual #104, Individual #145 <u>Interviews and Meetings Held</u>: o Rebecca McKown, MD, Medical Director o Joel Bessman, MD, Primary Care Physician o Kimberli Johnson MD, Primary Care Physician o William Bazzell, MD, Staff Psychiatrist o Angela Garner, RN, Chief Nurse Executive o Lisa Owen, RN, Quality Enhancement Nurse o Sheila Cunningham, RN Medical Compliance Nurse o Dena Johnston, OTR, Habilitation Therapies Director <u>Observations Conducted</u>: o Informal observations of medical rounds o Daily 4:30 pm Provider Meeting o QI Council meeting o Clinical Interdisciplinary Team Meeting

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. For the self-assessment, the facility described for each of the four provision items, mostly one or two activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. For Provisions L1 and L2, the activities were limited to medical audits. The results discussed the audit findings and action plans. During the week of the onsite review, the monitoring team made an effort to ensure that staff understood the self-assessment process and had an opportunity to ask questions. To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility rated itself in noncompliance with all four provisions. The monitoring team concurs with the facility's self-rating.
	Summary of Monitor's Assessment: The medical department made little progress since the last compliance review. The advanced practice registered nursed resigned and a locum tenens physician was working at the facility. This arrangement appeared to work well. The medical director continued to report that staffing was a challenge, although at the time of the visit, staffing was equivalent, or had even improved, with the presence of a second physician. Individuals received basic medical services, such as immunizations, vision, and hearing screenings, but for the most part, they did not receive cancer screenings in accordance with facility and state medical policy. When problems were brought to the attention of the medical staff, they addressed them. All of the physicians were noted to respond promptly to concerns during the week of the review, and records indicated that they responded to the needs of individuals. Verbal orders were excessively utilized and many were never signed. There were many problems with medication orders due to incomplete orders and other issues. Treatments were provided to individuals through standard operating procedures, but in many instances, physicians never signed the orders. It was

	also not clear, in some cases, if they were aware of the individual's medical problem. Annual Medical Summaries were completed in a timely manner, but Quarterly Medical Summaries did not appear to be done as required. IPN entries were generally written in SOAP format, but were brief. Some providers included all positive and negative findings, while others did not. Most notes were legible. External and internal medical audits were conducted. Medical management audits were also conducted. Corrective action plans were implemented for both. The medical audits remained focused on processes with no assessment of the clinical outcomes for individuals. The medical department, however, had taken no reasonable actions to demonstrate movement towards compliance with the Settlement Agreement in several areas. The medical director was not prepared for meetings with the monitoring team, did not provide all of the information expected or requested, and made statements without sufficient examples, evidence, or documentation. In previous reviews, the medical director had simply reported that the facility elected not to follow some recommendations. The monitoring team acknowledged that this was acceptable, however, compliance needed to be achieved through other mechanisms. The monitoring team noted that little was done to address concerns related to DNRs, mortality reviews, and medical quality at the facility level. The list of DNRs remained unchanged and it appeared that such long standing DNRs were not consistent with proposed DADs policy. There was no evidence that the monitoring team's concerns related to this problem were addressed. The pattern of completing mortality reviews and finding absolutely no issues, concerns, or opportunities for improvement related to the deaths continued. The monitoring team disagreed with the lack of recommendations for the most recent two deaths. The medical department had not selected any indicators to be used as measures of medical quality, was not tracking key quality data and had not trained the medical staff on the clinical guidelines issued by state office. Based on comments made in interviews and documentation in the self-assessment, the medical director was certainly aware of the need to perform these important tasks.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of a medical director and two full time primary care physicians (one locum tenens and one full time employee). The full time advanced practice registered nurse resigned and that position was filled with a locum tenens PCP. The long-term locum tenens physician who worked every other week continued his duties, which varied, but primarily consisted of completing annual assessments and providing coverage as needed. The medical director did not carry a primary caseload. The locum tenens PCP carried a caseload of 102 while the full time PCP carried a caseload of 137. A medical compliance nurse was hired in April 2012 and completed new employee orientation in June 2012. At the time of the review, medical services were being provided with two full-time primary providers and a medical director. A contract physician was reported to continue to perform quarterly summaries. This resulted in two part-time contract physicians providing support services. The facility should consider, if possible, the use of three full-time, or the equivalent of 2.75 FTE, physicians to provide consistent medical coverage. **Physician Participation In Team Process** The medical staff conducted medical rounds throughout the day, participated in annual meetings, and in various other meetings as required. The facility continued the daily 4:30 pm daily medical meetings. The full time PCP facilitated these meetings, which were attended by multiple disciplines, including the medical staff, medical compliance nurse, nursing representatives, clinical pharmacist, hospital liaison nurse, psychology, dental representatives, dietary representative, and residential services. The monitoring team attended several of these meetings and observed that the process provided a forum for sharing information regarding events that occurred over the past 24 hours. Nonetheless, meetings of this nature typically provide the most value when they occur at the beginning of the day. Minutes were taken at this meeting and were reviewed by the monitoring team. There was no follow-up to many issues documented in the minutes, and the medical director did not, but should, review these minutes for accuracy. The comments captured in many	Noncompliance

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		cases were inappropriate, medical terminology was grossly inaccurate, and overall the quality of this document was poor. Moreover, there were serious medical issues that surfaced that did not appear to have documentation of appropriate resolution or closure. **Overview of the Provision of Medical Services** The medical staff conducted rounds in the homes of the individuals. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite ophthalmology and shoe clinics once a month. Podiatry clinic was held twice a month. Dental clinic was conducted daily. Individuals who required neurology services were seen off campus. There was currently no process to have a joint neurology–psychiatry clinic. Individuals who needed acute care and/or admission were usually admitted to the local Shannon Medical Center. The relationship between the SGSSLC medical staff and staff at Shannon Hospital did not appear optimal based on comments made in medical provider meetings as well as documentation found in meeting minutes. Medical provider minutes repeatedly documented statements, such as doctor "will not speak to the staff at the hospital as they do not want any advice from us." The same minutes (4/10/12) also indicated that diet restrictions were not being followed, although a copy of the PNMP and dining plan was sent with the individual. These minutes did not state who was responsible for addressing the issue and ensuring that the safeguards were in place to protect the health and well being of the individual while hospitalized. The individual subsequently aspirated. This is discussed below in case reviews. 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. After hours, roentgenograms were completed through emergency department assessment at the local hospital. This was a reasonable arrangement. Throughout the week, the monitoring team interacted with the medical staff at many levels. It appeared that they were concerned about the individuals. There was evidence that some good care was provided and there were examples of care that needed improvement. Individuals who were hospitalized did not receive consistent follow-up care. Neurology follow-up was not always prompt. Individuals did not always have screening for osteoporosis as needed. ACE/ARBs were not always prescribed to diabetics who qualified for this treatment. Many individuals received treatments, but never had medical evaluations, and compliance with several cancer screenings were	

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		unfortunately very low. The various sections of this report will provide examples of both the high and low points noted during this review. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 8 of 10 (80%) AMAs were current • 9 of 10 (90%) AMAs included comments on family history • 9 of 10 (90%) AMAs included information about smoking and/or substance abuse history • 9 of 10 (90%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 13 of 15 (87%) AMAs were completed in a timely manner. • 15 of 15 (100%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 14 of 15 (93%) AMAs included information regarding the potential to transition It could not be determined if the AMAs in the record sample were completed within 365 days of the previous assessment because the previous assessment date was not known. For the purpose of this review, the AMA was considered timely if it was completed within 365 days of the previous summary. The quality and content of the AMAs varied among providers. Overall, they were adequate in most areas with the exception of the plan. These usually did not provide adequate information because many stated, "continue current plan." When barriers existed, there usually was no strategy that outlined how that barrier would be overcome. One individual with an abnormal pap smear refused follow-up. The AMA	

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		stated, "apparently, it's not done." It was very important for this individual to have follow-up. The monitoring team recommends that each assessment be finalized by listing the active problems with a plan of care that addresses each problem. The reader should be provided adequate information on overall management. <u>Quarterly Medical Summaries</u> Based on the records reviewed, Quarterly Medical Summaries were not being completed as required by the Health Care Guidelines and in accordance with state issued medical policy. For the records contained in the record sample: • 1 of 10 (10%) records included QMSs The IPNs of eight additional records were reviewed to assess compliance with documentation consultation reports. The IPN of Individual #385 contained a QMS dated 3/29/12. Quarterly Medical Summaries were not observed in the other seven records. <u>Active Problem List</u> For the records contained in the record sample: • 1 of 10 (10%) records included an APL During the last review, the APL had not transitioned to a separate document. The medical director reported that the APL was being placed adjacent to the physician orders for easy access. One record submitted included the document. These documents were not provided with the other records. They were cited as not present. This may have been a filing issue or due to a change in location in the active record. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed and dated. Times were often omitted from notes, but this was a provider specific pattern. Most, but not all, providers wrote very brief notes that lacked the required positive and negative findings. Vital signs were usually not included in the notes even when they were an important part of the assessment. Comments, such as "no fever" or "afebrile" were found. Pre-hospital notes were often not found and post hospital documentation was inconsistent. <u>Physician Orders</u>	

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		As with previous reviews, the monitoring team noted that there was a heavy reliance on the use of verbal physician orders. There was no improvement in this practice. Many of these orders were written during normal business hours. There were routine orders that could have, and should have, been addressed during routine medical rounds. The result of overuse of verbal orders was that numerous orders were not clear and required clarification. Moreover, more than one hundred orders, within the sample, were not signed. Even when medical providers wrote orders, they were frequently not clear, were incomplete, or lacked indications. The monitoring team identified orders with wrong doses, orders written for drugs when allergies were documented, and numerous other problems. Some providers repeatedly omitted the times that orders were written. Medication orders are discussed further in section N1. The following unsigned verbal medication orders were noted in the order sample: • Individual #48, 5/2/12; Individual #312, 5/2/12; Individual #21, 4/30/12, 5/1/12; Individual #97, 5/1/12; Individual #38, 5/2/12; Individual #31, 5/3/12; Individual #233, 5/3/12; Individual #170, 5/4/12 These orders were noted over the span of less than five days through the review of less than 15 order forms. These orders remained unsigned as of early June 2012 when copied for submission to the monitoring team. This pattern was noted throughout the remainder of the sample reviewed. Through record reviews, the monitoring team also noted orders, for many individuals, of treatments given through the use of standard operating procedures (SOP) for which there was no physician or medical evaluation. These orders were frequent and most were never signed by a physician. It was not clear if a physician was notified of the problems even though medications were given for a variety of problems, such as diarrhea, cough, URI symptoms, and other issues for which a medical provider should have been notified. The facility was aware of this problem because it was also detected during the external medical audits. <u>Consultation Referrals</u> The medical department utilized a stamp to track consultation reports once they returned from the providers. The stamp documented a number of important items, such as date received, PCP review date, and the need for PCP rounds, psychiatry review date, and filing date. The size of the stamp required that it be placed on the <u>back</u> of each consult. In order to review compliance with requirements of the Health Care Guidelines, the monitoring team requested that both the front and back copies of all consultations were provided. This was not consistently done, which significantly decreased the sample size of consultations available for review.	

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		The consults and IPNs for 10 individuals were requested. A total of 40 consults completed after November 2011 (including those from the record sample) were reviewed: • 22 of 40 (55%) consultations were summarized by the medical providers in the IPN o 16 of 22 (73%) consultations were documented in the IPN within five working days Generally, providers summarized the recommendations of the consultants and stated agreement or disagreement with the recommendations. The monitoring team recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Dermatology Consult, 1/1/12). **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Screening for prostate cancer and breast cancer, however, were relatively low. Less than half of the individuals who qualified for cervical and colorectal cancer screening completed those studies. The medical director indicated that most were at high risk for complications related to sedation. The Preventive Care Flowsheets were not available in several of the records reviewed. The medical director reported that new databases had been developed to track preventive care data and chronic disease data, such as diabetes mellitus because the old data tracking systems were not adequate and did not accurately capture data. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 6 of 10 (60%) records included PCFSs • 2 of 6 (33%) forms were updated, signed, and dated <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations	

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		Immunization records were cited as "not present" in three of the records submitted. The Annual Medical Assessments usually included information on the core vaccinations. Additionally, most providers were verifying antibody titers for hepatitis and varicella. The two individuals who lacked immunity to hepatitis B were re-vaccinated. Overall, this remained a strength for the facility. <u>Screenings</u> • 10 of 10 (100%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 4 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The list included 34 males: • 22 of 34 (65%) males had current PSA results documented • 9 of 34 (26%) males had no PSA results documented • 3 of 34 (9%) males were overdue for PSA testing <u>Breast Cancer Screening</u> • 2 of 6 females met criteria for breast cancer screening • 1 of 2 (50%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 45 females, the date of the last mammogram, and explanations for any lack of testing: • 27 of 45 (60%) females completed breast cancer screening in 2011 or 2012 • 0 of 45 (0%) females completed breast cancer screening in 2010 • 5 of 45 (11%) females completed breast screening in 2009 or earlier • 13 of 45 (29%) females had no documentation of breast cancer screening <u>Cervical Cancer Screening</u> • 6 of 6 females met criteria for cervical cancer screening • 2 of 6 (33%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 93 females, the date of the last pap smear, and explanations for lack of testing: • 0 of 93 (0%) females completed cervical cancer screening in 2012 • 36 of 93 (39%) females completed cervical cancer between in 2010 and 2011 • 15 of 93 (16%) females completed cervical cancer screening in 2009	

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		• 12 of 93 (13%) females completed cervical cancer screening prior to 2009 • 27 of 93 (30%) females had no documentation of cervical cancer screening • 2 of 93 (2%) females had undergone hysterectomies <u>Colorectal Cancer Screening</u> • 4 of 10 individuals met criteria for colorectal cancer screening • 2 of 4 (50%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 90 individuals: • 37 of 90 (41%) individuals had completed colonoscopies • 53 of 90 (59%) individuals did not have documentation of colonoscopy o 34 of 53 (64%) individuals had risks greater than benefits cited as the reason o 8 of 53 (15%)individuals refused o 8 of 53 (15%) individuals had colonoscopies ordered <u>Additional Discussion</u> During interviews with the medical director, the monitoring team was informed that many individuals were at high risk for aspiration during many procedures that required sedation. The monitoring team acknowledges that there can be challenges associated with completing many diagnostic procedures. Consistent with the Health Care Guidelines, however, when preventive care services are not provided, the record of the individual must document a through assessment of the risk and benefits and include a clinically justifiable reason for electing not to provide the required screening. The typical documentation statement of "risk greater than benefit" did not meet the requirement. **Disease Management** State office issued numerous multidisciplinary clinical guidelines. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>Diabetes Mellitus</u> Three records were reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy (3) annual eye examinations, and (4) administration of yearly influenza vaccination:	

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		• 2 of 3 (67%) individuals had adequate glycemic control • 3 of 3 (100%) individuals had urine microalbumin documented • 3 of 3 (100%) individuals had eye examinations in 2011/2012 • 3 of 3 (100%) individuals received the yearly influenza examination The facility's database contained the names of 64 individuals with the diagnosis of diabetes or metabolic syndrome. This was almost <u>double</u> the number of individuals reported since the last visit. Most of these individuals were receiving atypical/new generation antipsychotic medications. This is discussed in section N. With regards to the management of diabetes, additional work needs to occur in this area in spite of the good compliance noted for these three individuals. For example, QDRRs showed that some individuals might need to be considered for treatment with ACE inhibitors or an ARB in order to provide renal protection. More importantly, the facility must ensure that emphasis is placed on risk assessment and mitigation prior to the development of the actual diagnosis of diabetes. The medical staff should consider the addition of a thorough risk review in the annual assessment of all risk factors as one way of accomplishing this goal. <u>Pneumonia</u> The facility provided a list of 10 individuals with the diagnosis of pneumonia, which was considerably fewer individuals than noted on the hospital list. The accuracy of the list provided was therefore questionable. The monitoring team discussed this with the medical director who indicated that the infection control nurse was in the process of revising the list. Throughout the conduct of the review, there were many discussions with the infection control nurse, the PNMT nurse, the director of habitation services, and the medical staff. The monitoring team identified several areas of concern regarding the facility's overall strategy for dealing with issues related to pneumonia: • There was no definitive process to determine how individuals were added to or removed from the pneumonia list. The medical staff appeared to, in good faith, use available information to make decisions related to the appropriateness of the diagnosis. Information was difficult to obtain, the process was not organized, and it remained without clear oversight. During the December 2011 review, there appeared to be discussion regarding implementation of a process for reviewing these cases with the use of a checklist. This discussion was part of the pneumonia PET. During this review, the medical director reported the project was "shut down." No further explanation was provided for this action. The monitoring team found this unusual given a 39% compliance score was reported for the medical pneumonia compliance audit (also see section E). • A physician participated in the PNMT committee/group, but the monitoring team was quite surprised, and rather concerned, to discover that the director of	

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		habilitation services was not aware of the aspiration risk reduction protocols that were issued from state office. These protocols included information related to management of issues reviewed by the PNMT and it would be important to ensure that all disciplines were using similar principles in the management of similar issues and that these were consistent with those issued by state office. This finding certainly was not indicative of integration of clinical services. The monitoring team recommends that the facility develop a formal process to review all cases of pneumonia. The core participants of this committee should include medical, nursing, infection control, the medical compliance nurse, and the QA nurse. The members must conduct a through review of clinical events, laboratory, and x-ray findings before making a determination about pneumonia cases. There should be documentation of the discussion and the IDT should be notified of the findings. The facility must also proceed with localizing the pneumonia guidelines issued by state office. **Case Examples** Individual #76 • The individual was hospitalized again in April 2012 with an atonic colon. Bowel obstruction was ruled out. A bronchoscopy showed that the individual had gastritic particulate matter in the lungs. The medical staff at the hospital documented that the SGSSLC PCP stated that the individual could not have a PEG tube because it would be pulled out. Although a MBSS showed penetration, the individual was returned to a regular diet because there were no signs of aspiration exhibited during meals. Bowel management appeared problematic with the GI consultant noting that a total colectomy was the only surgical option available so medical management would need to be aggressive. He further noted in the May 2012 consult that "it did not appear that the individual was getting the medication as required. • Following discharge from the hospital on 3/12/12, a summary note was written by the accepting MD. This was a relatively detailed note written in SOAP format. The primary provider wrote a four-line note on 3/13/12. There was no other medical documentation until 3/23/12. At that time, a new provider wrote a detailed note addressing a new problem. • This individual had multiple lithium levels that were elevated, had chronic kidney disease and evidence of lithium toxicity. This ultimately resulted in hospitalization. Consultants documented acute and chronic lithium toxicity. This was reported as an adverse drug reaction. The records available to the	

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		monitoring team were limited to the active record. This was a case that should have been reviewed further to determine if the use of the drug lithium was even appropriate for this individual given the evidence of chronic kidney disease. More historical data would be needed to make that determination. Individual #231 • This individual had a history of diabetes mellitus, hyperlipidemia, and hypothyroidism. The individual received basic preventive care, such as immunizations and screenings, but did not have a colonoscopy done. The individual's AMA stated as the plan for diabetes "continue meds and diet." The AMA, which was done in 2012, did not summarize the diabetes care, did not list a Hba1c, and did not provide information on renal function, such as a creatinine, microalbumin, urine/creatine ratio, or podiatry exam. The individual did not receive the important treatment with an ACE or ARB for renal protection. A 2011 QDRR recommendation was made to add an ACE inhibitor to which the PCP made no response. The recommendation was repeated in 2012 and the PCP responded "great idea," however, the individual remained without treatment and/or justification for the lack of treatment. Individual #186 • This individual was hospitalized with pneumococcal pneumonia and sepsis. On the day of discharge, 2/2/12, the individual was seen by the accepting MD, who documented in the IPN that the discharge diagnosis was UTI. The note was brief and lacked vital signs. The next medical note was dated 2/6/12. It indicated that there was a question about the diagnosis. The monitoring team presumes that data were not sent from the hospital at discharge because the CXR report clearly indicated the presence of a RML pneumonia. The next medical entry was dated 4/9/12 indicating inadequate documentation of follow-up care. Individual #40 • On 3/8/12, nursing noted in the IPN that the individual had no bowel movement for three days and a bisacodyl suppository was given. The individual had a large bowel movement in response to this suppository, but there was no evidence that a physician was ever notified. On 3/14/12, there was another IPN entry that stated no bowl movement for three days, so and another suppository was given. Again, there was no evidence that a physician was ever notified. This type of management of chronic constipation was reactive and likely results in greater long term problems for the individual. Based on the IPN documentation, there was no evidence that any change was	

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		made in the individual's bowel management plan. The monitoring team did not have any additional records for review, but over the span of two to three weeks, the bowel plan did not change, even though multiple suppositories were given. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 79 individuals. The following data regarding AED use were summarized from the list provided: • 14 of 79 (18%) individuals received 0 AEDs • 49 of 79 (62%) individuals received 1 AED • 13 of 79 (16%) individuals received 2 AEDs • 3 of 79 (4%) individuals received 3 AEDs The number of neurology clinic appointments is summarized in the table below. Neurology Clinic Appointments 2011-2012 Dec 9 Jan 10 Feb 8 March 7 April 12 Total 46 The total number of appointments was reasonable given the number of individuals with the diagnosis of seizure disorder who actually received medications. Many of the appointments were utilized by the same individuals. Some individuals may not have had follow-up appointments as required. Individual #129, Individual #288, Individual #277, and Individual #186 did not have clear documentation of follow-up neurology appointments. The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. One individual did not have a diagnosis of seizure disorder and one had the diagnosis of pseudo-seizures. The following is a summary of the review of the remaining eight records: • 4 of 8 (50%) individuals were seen at least twice over the past 12 months • 3 of 8 (38%) individuals had documentation of the seizure description • 4 of 8 (50%) individuals had documentation of current medications for seizures and dosages • 5 of 8 (63%) individuals had documentation of recent blood levels of antiepileptic medications	

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		• 0 of 8 (0%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 5 of 8 (63%) individuals had documentation of recommendations for medications • 1 of 8 (13%) individuals had documentation of recommendations related to monitoring of bone health, etc. The facility reported that three individuals had refractory seizure disorder. Record reviews showed that Individual #203 also had refractory seizure disorder, but was not identified as such by the facility. The monitoring team continues to recommend that individuals with a diagnosis of refractory seizure disorder be referred to a qualified epileptologist for evaluation of more aggressive management. The facility did not have an onsite neurology-psychiatry clinic. The process to capture medical and psychiatric information will need to be evaluated to determine if it is achieving the goal of assisting in improving integration of services. The medical summary was not completed by the treating physician, which in itself presented an opportunity for error. Four of the eight individuals reviewed had active psychiatric issues in addition to seizure disorders. Record reviews indicated problems related to the integration of neurology and psychiatry. The following are a few examples: • Individual #46 was seen by the neurologist who noted the individual had chronic psychiatric illness with agitated behavior. The consultation referral (medical summary) did not mention the history of agitation and behavioral issues. The neurologist noted the use of the drug Keppra and made the recommendation to crossover from Keppra to another AED. • Individual #164 was evaluated and the neurologist noted that multiple behavioral issues erupted with recent trials of AEDs making management of seizure disorder difficult. • Individual #26 was seen and the neurologist noted the SGSSLC physician reported the individual was seizure free, yet other records indicated the individual had seizure activity. If in fact this were the case, the medication would need to be increased. The physician summarizing the case was not the PCP. **Do Not Resuscitate**	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility submitted a list of individuals who had DNR orders in place. The list included 15 individuals with Level III DNRs meaning that no resuscitative measures were to be performed. The dates of implementation ranged from 2002 to 2012. Such long term DNRs were not consistent with a 2011 policy proposed by DADS, which implicitly stated that DNRs were appropriate for individuals with terminal conditions. The policy defined a terminal condition as an incurable condition caused by injury, disease, or illness that, according to reasonable medical judgment, will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Although the monitoring team specifically requested the reason or criteria for every individual with an active DNR, that information was not provided.

The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy.</td><td></td></tr>
<tr><td>L2</td><td>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.</td><td><u>Medical Reviews</u>
External medical reviewers, from sister SSLCs, conducted Round 5 of the external medical reviews in March 2012. Although titled Round 5, this was the third review for the facility. A five percent sample of records (13 records) was examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight 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 to be in place, in addition to receiving a score of 80% on nonessential items.

The facility had problems generating data. Documents for providers were missing, percentages were greater than 100, and the compliance-by-question graphs were both labeled as external. Nonetheless, the overall compliance scores are presented in the table below.

<table>
<tr><td colspan="4">External Medical Reviews 2012
% Compliance</td></tr>
<tr><td></td><td>Date of Review</td><td>Essential</td><td>Nonessential</td></tr>
<tr><td>Round 5</td><td>March</td><td>93</td><td>84</td></tr>
</table>

The lowest rates of compliance were noted with (1) signing and dating the APLs, (2)</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		responding to the recommendations of the pharmacist on the QDRR, (3) documentation of a rationale for not following the recommendation of the pharmacist, (4) IPN documentation of consultations, (5) IPN documentation following hospitalization within 24 hours, and (6) documentation of assessment within 24 hours following ordering of medical treatment. The QA Department developed action plans and the QA nurse completed follow-up however, no data were provided on the status of the corrective action plans. The facility also completed its first round of medical management audits. External and internal audits were completed. The medical director completed the internal audits. Data are presented in the table below.	

Medical Management Audits March 2012 % Compliance					
Diabetes		Osteoporosis		Pneumonia	
Internal	External	Internal	External	Internal	External
107	93	74	74	55	39

The inter-rater reliability showed a lack of consensus in the diabetes and pneumonia audits. The tools and raters should be evaluated to determine the source of the lack of homogeneity. This is particularly important given the overall poor compliance score for the pneumonia audits and the great importance of the management of pneumonia for individuals supported by the facility.

Previous reviews indicated there were issues related to pneumonia, as did this review and as discussed in section L1. The medical director provided some data related to action plans for the audit. The medical audit focused on process indicators and did not assess clinical outcomes. Corrective actions targeted individual problems, however, the very low compliance rate of 39% suggested the existence of a serious issue.

The facility must be cautious about implementing corrective actions that do not address the underlying problems. This is where the appropriate use of performance improvement methodology and root cause analysis demonstrates its greatest value. The facility must ensure that corrective actions have adequately addressed the issues/root causes that resulted in low compliance scores. As an overall approach to addressing deficiencies, the failure to adopt the correct approach in correcting problems will result in a recurrence of similar problems and a need for the very same corrective actions in the future.

<u>Mortality Management at SGSSLC</u>

#	Provision	Assessment of Status	Compliance
		At the time of the review, there were two death reviews that were not yet completed. The facility completed two clinical death reviews on 5/30/12. The medical director reported that the delays were due to pending autopsy reports. Since the last onsite review, there were three deaths. Information for the three deaths is summarized below: • The average age of death was 68 years with an age range of 32 to 93 years. • The causes of death were: (1) cardiac arrest (2) cardiopulmonary failure of unknown origin, and (3) hypertensive heart disease • There were two autopsies performed. • All three individuals died at the facility. • One individual received hospice services. The monitoring team met with the medical director, facility director, and QA nurse to discuss mortality management at SGSSLC. The clinical death reviews generated no recommendations. Issues related to physician documentation and the emergency response system were discussed during this meeting. Since the clinical reviews generated no recommendations, it was apparent that the concerns of the monitoring team were not surfaced by the Clinical Death Review Committee. While the issues may not have influenced the ultimate outcome for the individuals, they involved problems that may affect the care of other individuals and are worthy of further review to determine the potential for corrective measures. The facility had not conducted the Administrative Death Reviews.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a structured medical quality program. A comprehensive set of measures had not been identified. State office developed a set of disease management audits to serve as one component of the medical quality program. Additionally, the recently revised state medical policy included a section on data collection and analysis. SSLCs were required to collect data on key areas such as mortality, aspiration pneumonia, seizure disorders, and infectious diseases, analyze and trend these data, and take appropriate corrective actions. The facility had not outlined a plan or system to implement such a program. At the time of the review, there was little attention given to this area. The medical audits were all process focused and did not assess any clinical outcomes. In response to a request for data on the facility's medical quality program, the medical department submitted "medical quality trending not available." The facility's self-assessment, action plans, and provision action information did not provide any additional information on the development of a medical quality program beyond the disease management audits that were being conducted. In moving forward with this provision, the medical director should review provision L1.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The content of provision L1 demonstrated that the monitoring team assessed structural (staffing and services available), process (documentation and provision of services), and clinical outcomes (diabetes mellitus, pneumonia, and seizure outcomes) to assess the quality of medical care. The facility will need to develop a comprehensive set of indicators that includes, at a minimum, a mix of process and outcome indicators in order to move towards substantial compliance with this provision item. Moreover, the facility will need to demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology should be utilized to ensure remediation is achieved.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	State office issued a series of clinical guidelines and protocols on enteral feeding, aspiration risk reduction, constipation/bowel management, seizure management, urinary tract infections, osteoporosis, diabetes mellitus, and anticoagulation. Many of these were reviewed at SGSSLC during the December 2011 review. The medical department had not done any additional work in this area. No local guidelines had been developed based on the state issued guidelines. Many departments received the protocols in the weeks just prior to the onsite review. The aspiration risk reduction protocols were not shared with the habilitation therapies director or the department. There was no documentary evidence that the medical staff had received appropriate in servicing on the various protocols and guidelines. The documentation for verification of in servicing of the medical staff on the clinical guidelines and protocols was submitted to the monitoring team. The physician signatures were dated 6/12/12. There were very low rates of compliance with several preventive care requirements and cancer screenings. The failure to thoroughly document an adequate explanation for this was an indication that the medical staff was not familiar with some of the specific requirements or opted to disregard them.	Noncompliance

Recommendations:

1. The facility should examine the current staffing and use of physician resources and consider pursing a third or .75FTE PCP as a means of increasing continuity of care. (L1).

2. The duties and responsibilities of the medical compliance nurse should be clearly defined and include tracking and management of medical quality data (L1).

3. The facility director along with the medical director should review the duties and responsibilities of the medical director and redefine the role given the creation of the medical compliance nurse position (L1).

4. The facility should review the current structure of the physicians' workday and consider conducting the daily provider meetings in the mornings (L1).

5. The medical director should facilitate the daily provider meetings (L1).

6. Minutes should be completed for every daily provider meeting. The format should allow for documentation of discussion, action steps, responsible persons, and timelines for completion. Those items should be briefly addressed as appropriate in the subsequent meetings and closure should be documented (L1).

7. As required by the Health Care Guidelines, the SGSSLC medical staff must provide necessary information to the consultants and hospitals to ensure that the best possible decisions can be made on behalf of the individuals. This communication should be documented in the AR of the individuals (L1).

8. The medical director should ensure that all AMAs are consistently done in the same format. A sample should be reviewed periodically to assess timeliness of completion as well as quality of content (L1).

9. Quarterly Medical Summaries should be completed by the primary care physicians in accordance with state issued medical policy (L1).

10. The facility should determine the source of the missing documents such as the APLs, PCFS, and immunization records (L1).

11. The Preventive Care Flow Sheets should sign and initialed when updated by providers (L1).

12. The medical director should ensure that a thorough risk benefit analysis is completed when determining the appropriateness of preventive screenings. Input should be solicited from the entire team, including the individual/legally authorized representative when appropriate (L1).

13. The medical director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).

14. Individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation (L1).

15. For every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g.,

Dermatology Consult, 1/1/12).

16. The template for the disease management component of the quality audits needs to be expanded to capture clinical outcomes in addition to processes (L2).

17. The facility must develop a quality program based on a comprehensive set of process and outcome indicators in addition to the quality audits that are occurring (L3).

18. The facility must demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

19. The medical director must develop local policies and procedures based on the clinical guidelines issued by sate office (L4).

20. The medical director should review the various policies, procedures, and guidelines and ensure that all are consistent with state issued guidelines (L4).

21. All forms, protocols, and guidelines should include an issue or revision date (L4).

22. The medical director should ensure that all disciplines that need the clinical guidelines have access to them (L4).

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 Active Record Order and Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o SGSSLC Nursing Services Policies & Procedures o SGSSLC Self-Assessment, Plan of Improvement, and Nursing Care Action Plan (updated 5/1/12) o Alphabetical list of individuals with current ISP, annual nursing assessment, and quarterly nursing assessment (due) dates o Nursing staffing reports for the last six months o The last six months, list of all individuals admitted to the Infirmary, length of stay, and diagnosis o The last six months, minutes from the following meetings: Infection Control, Environmental/Safety Committee, Specialty Nurses Meeting, Nurse Manager Meeting, Pharmacy and Therapeutics, Medication Variance Committee Meeting, o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curriculum for emergency procedures o The last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Emergency Drill Checklists 1/1/12-4/30/12 o Locations of AEDs, suction machines, oxygen, and emergency medical equipment o All facility policies, procedures, and guidelines that directly describe the mission, vision, operations, etc. of the facility's infirmary o Infection control monitoring tools o Policies/procedures addressing infection control o Infection control letter to staff regarding membership and attendance at meetings o Infection Control Observation Reports 1/1/12 – 6/7/12 o Random Monitoring of Hand Washing Reports 1/1/12 – 6/7/12 o Job descriptions of Acute RN, RN CM Supervisor, and Nurse Recruiter o Consultation Tracking System data for 3/1/12 – 5/30/12 o Hospice Policy o Pain PIT meeting minutes 1/1/12 – 6/5/12 o Enteral PIT meeting minutes 1/1/12 – 6/5/12 o List of employees date and results of most current TB test, date and results of next prior TB test o List of retention strategies to retain current nursing staff at facility

	o Written exam to demonstrate understanding of acute illness/injury policy o Meeting minutes from meeting of CNE with QA to review Prevention and Nursing Care Plan monitoring tools o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals on modified diets/thickened liquids o Documentation of annual consideration of resuming oral intake for individuals receiving enteral nutrition o Last six months peer reviews for Nursing Department o Last six months mortality reviews and QI Death Reviews for Nursing for individuals who died o "Day of the Week" nurses' schedule for 5/1/12 – 6/6/12 o For the last six individuals who transitioned to the community, their completed nursing discharge summary o Employee Education files of six randomly selected nurses o Records of: • Individual #112, Individual #145, Individual #203, Individual #218, Individual #186, Individual #116, Individual #9, Individual #26, Individual #258, Individual #380, Individual #17, Individual #254, Individual #46, Individual #52, Individual #43, Individual #23, Individual #37, Individual #50, Individual #150, Individual #21 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Angela Garner o Nursing Operations Officer, Lisa Busbee o Infection Control Nurse, David Ann Knight o QA Nurse, Lisa Owens o Hospital Liaison, Melanie Nealey o Nurse Educator, Jennie Price o Program Compliance Nurse, Sheila Cunningham o Nurse Recruiter, Patsy Smith o PNMT RN, Maria DeLuna o Acute RN, Katherine Correa o RN CM Supervisor, Regina Haight o Clinic Nurse, Virginia Dooley <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 6/5/12 Medication Variance Committee Meeting

	o 6/5/12 Nurse Manager Meeting o 6/6/12 CNE Meeting o 6/6/12 Enteral PIT Meeting o 6/6/12 ISPAs for Individual #90, Individual #38, and Individual #203. o 6/7/12 Meeting with CNE, NOO, RNCM Supervisor, and Program Compliance Nurse
	Facility Self-Assessment: SGSSLC submitted its self-assessment, which was updated on 5/1/12. Since the prior review, SGSSLC made several revisions to its self-assessment process and separated the report into three separate sections. The self-assessment now stood alone as its own document and described, for each provision item, the (1) lists of discrete activities engaged in over the past six months, (2) results of the activities as measured by scores on monitoring tools, and (3) self-ratings that were based upon the results of the activities. Although the format was a marked improvement in the facility's self-assessment process, the content continued to need work. For example, across all provisions of section M, the results of the self-assessments were based upon very small sample sizes and the results of audits that were usually less than five in number. In addition, across most of the provisions, the facility inexplicably pointed out that several of their "reviews of random audits [which were the bases of their self-assessment] had not been implemented at this time." Thus, it was unclear to the monitoring team how the conclusions reached by the Section Lead for section M could or should be relied upon. During the conduct of the onsite review, the monitoring team reviewed the self-assessment and prior monitoring report(s) with CNE, NOO, and other members of the nursing leadership team, and provided feedback on ways in which the various activities engaged in to conduct the self-assessment could be modified to promote compliance with the provision items. In addition, the following recommendations may be helpful to the facility when assessing, measuring, and rating compliance. • Do not rely solely on the results of the statewide self-monitoring tools as the measure of compliance. The tools may be one of several activities used to self-assess, but will not likely be sufficient to gauge substantial compliance. • Consider what the monitoring team evaluates and the activities they engage in to evaluate compliance. Their activities extend beyond completion of monitoring tools and almost always involve direct observations and assessment of outcomes for individuals served by the facility. • Reliability does not mean validity. These two distinct concepts are both important to measure and incorporate into evaluation and self-assessment activities. • Utilize the expertise of the QA Nurse, who was knowledgeable about how to measure, evaluate, and rate compliance, in planning ongoing self-assessment and monitoring activities. According to the Chief Nurse Executive and Center Lead for section M, at the time of the updated self-assessment, the facility's self-ratings indicated that it continued to need improvement in all six provisions of section M in order to meet a rating of substantial compliance. On the basis of all monitoring activities undertaken by the monitoring team, the monitoring team was in agreement with the facility's self-ratings.

	During the onsite review, the presentation books put together by various members of the nursing department were reviewed. Most, if not all, of the information in these books were already submitted vis a vis the monitoring team's document request and already reviewed by the monitoring team in preparation for the visit. The only exception to this generalization was that the presentation book prepared by the Nurse Educator included several additional examples of steps that she had taken to improve three of the most important areas of nursing education – performing training, evaluating competence, and verifying skills. See section M4 for more information that pertains to these activities.
	Summary of Monitor's Assessment: The review of the facility's document submission and the outcomes of onsite review activities revealed that SGSSLC had accomplished some important activities, such as hired new nurses to serve in key leadership capacities, held several inter-departmental meetings, and conducted a number of re-training and education sessions, but as noted in the facility's self-assessment, they failed to achieve compliance with the provisions of section M. In addition, all provisions of section M were in need of significant improvement in order to meet the requirements of the Settlement Agreement and Health Care Guidelines. During the conduct of the review, the monitoring team met at length with the CNE and NOO to review the expectations of the provisions of section M and the concern over the Nursing Department's lack of progress in most areas. For example, there continued to be problems ensuring the presence of adequate numbers of trained, competent, stable nursing staff members across the campus. There continued to be vacancies, turnover, nurses working overtime and "covering" homes, and evidence of low morale across the department. There also continued to be no effective infection prevention and control program. Thus, there were numerous violations of basic standards of infection control occurring on a regular basis, as well as gross violations of basic health and safety practices. Nursing care was not being documented or delivered in accordance with generally accepted professional standards of care or in accordance with the protocols developed by the state and adopted by the facility. There continued to be lapses in tracking and recording individuals' basic health status information, such as their food/fluid intake, output, bowel movements, weight, and presence of triggers of aspiration. Although the absence of these data had, and continued to, negatively impacted the delivery of individuals' health, medical, and rehabilitation services, to date, corrections had not been consistently developed and/or implemented. Thus, these problems persisted and they continued to jeopardize the health and safety of individuals served by the facility. Although the CNE, NOO, and other members of the facility's nursing leadership and management team were aware of many of these problems, and, as always, they sincerely voiced their commitment to improve the delivery of nursing supports and services, it was plain that they needed the help of the facility's administration and senior management staff members to make progress and achieve compliance with the provisions of section M.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Since the prior review, SGSSLC reported that they retrained nursing staff members on the management of acute illnesses and injuries, created spreadsheets, implemented the use of the Post Hospitalization/ER/LTAC Assessment and Nursing Discharge Summary forms, met with the Habilitation Therapy Department to discuss the integration of post-hospitalization assessments, conducted random audits of hospitalized individuals' records, and provided training and implemented the use of the state's nursing protocols. Of note, although the nurses received 17 laminated nursing protocol cards, it was reported that, as of the review, they had received training on 9 of the 17 protocols. According to the facility's self-assessment, since the prior monitoring review, the results of their self-monitoring of nursing care of individuals with acute illnesses and injuries and/or recently hospitalized or treated at emergency rooms/urgent care facilities revealed scores that fluctuated between 25% and 44% compliance. Thus, as of the review, they reported, "this provision [was] not in substantial compliance [and] assessments [were] not being completed appropriately, and follow-through [was] not evident." The monitoring team agreed with the facility's finding of noncompliance, and based its rating on findings that failed to reveal substantial evidence of the presence and adequacy of assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals health status sufficient to help ensure that the changes were readily identified and addressed. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, all residential areas were visited, daily observations of nursing care were made, 20 nurses were interviewed, and 20 individuals' records were reviewed. Ten of the 20 records reviewed were selected by the facility and presumably representative of the most positive examples of the state of nursing care at the facility. Consistent with the findings and conclusions in the facility's self-assessment, the monitoring review revealed that there continued to be problems ensuring that nurses' adequately identified health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area <u>Staffing, Structure, and Supervision</u> As reported in each prior review, the Nursing Department continued to have almost 20% of its positions vacant. Daily use of overtime and nurses "covering" homes persisted. A review of the Nursing Department's own daily staffing data and schedules revealed that	Noncompliance

#	Provision	Assessment of Status	Compliance
		during the month of May 2012, there was only one day when it appeared as though the daily schedule was not changed to cover unscheduled absences and holes in the schedule. Upon further review of the May 2012 staffing data and daily schedules, it was also revealed that 50% of the time nurses were working overtime, and 20% of the time there was only one nurse on duty to cover the entire campus during the hours of 10 pm to 6 am. Of note, when the monitoring team requested any and all policies/procedures that addressed minimum staffing and use of agency/contract nurses, the Nursing Department replied, "We do not have a policy addressing minimum staffing for nursing. Minimum staff is anything less than one nurse per home." A review of the three different organizational charts of the Nursing Department that were provided to the monitoring team depicted a confusing configuration of lines of authority and supervision in the Nursing Department. For example, one chart indicated that the CNE supervised the Infection Control Nurse, Acute RN, and other nursing leadership, but another chart indicated that the Acute RN, who was not supervised by anyone, supervised the Infection Control Nurse. In addition, none of the organizational charts showed the Nurse Recruiter. Also, a review of the job descriptions of two newly hired nurses – the Acute RN and the Nurse Recruiter – revealed that, despite the significance of these nurses, little to no care was taken in crafting the expectations of their positions in the Nursing Department. Rather, haphazard lists of additional duties were added to the end of the templates of the job descriptions for a Nurse II and Nurse III. To further complicate these matters, it was reported that since the prior review, the three Nurse Managers' supervisory assignments were changed, such that they supervised the delivery of nursing care to a unit of individuals, but also had supervisory authority over all nurses who worked a particular shift of duty. There was no reasonable explanation provided for this perplexing arrangement of supervision. The problems noted above were not just a matter of the difficulty with or the inconvenience of completing paperwork. Rather, they were a graphic depiction of the rampant problems of unclear lines of authority and lack of leadership that beleaguered the Nursing Department. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. However, as noted in the prior reviews, the content as well as signature/credentials appearing in some nurses' notes were not legible. Some nurses' notes failed to have the time of the entry documented on the note, which made it difficult, if not impossible, to know when critically important nursing assessments and interventions were delivered. Some notes were written on the margins of the IPN rather	

#	Provision	Assessment of Status	Compliance
		than a new IPN, and some nurses continued to misunderstand the meaning of "Subjective" data. It appeared as though nurses were confusing "subjective data" with "subject," i.e., the "topic," and documented all sorts of entries under this heading, such as "N/A," "Left palm," "Infirmary discharge," etc. There were also other recordkeeping and documentation problems found across the 20 records selected and submitted by the facility for review that impacted upon the findings in other sections, including M3, M4, and M5. For example: • Six of the 20 individuals failed to have current quarterly nursing assessments. • At least two individuals nursing assessments were signed and dated <u>before</u> the "Date(s) Completed, " which raised question regarding their authenticity. • Of the three sample individuals recently admitted to SGSSLC, not one had an admission assessment that was completed in a timely manner. Individual #37's and Individual #43's comprehensive nursing assessments were not completed until 26 and 30 days, respectively, after the individuals' admission to the facility. At the time of the review, Individual #52, did not have a comprehensive nursing assessment filed in her record. • Three individuals, who suffered multiple chronic health conditions failed to have a health management plan filed in their records. • One of the 20 individuals failed to have a current, annual ISP filed in his record. • The IPNs of several individuals records indicated that their records were missing the results of important lab tests, there were delays in treatment because physicians failed to receive all pages of the individuals' specialty medical consultations, and the physicians' and dietician's notes from a tertiary facility were filed among the SGSSLC IPNs. • Incomplete documentation of nursing interventions and cryptic phrases, such as, "Benadryl appears to be helping," "not as much drainage noted at this time," "feet look pretty good," "no problems," etc., were found across many of the individuals' records. <u>Hospitalization and Hospital Liaison Activities</u> According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make periodic visits to a hospitalized individual to obtain as much up- to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include, but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center."	

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		Three of the 20 individuals selected for in-depth review were hospitalized four times during the period of 1/1/12 – 6/7/12 for treatment of significant changes in their health. In accordance with the state's clear policy directives and the provisions of the Settlement Agreement, all of the individuals who were hospitalized had Hospital Liaison Reports filed in their records. These reports revealed evidence that throughout the individuals' hospitalizations, the nurse Hospital Liaison visited the individuals and kept in regular contact with the individuals' tertiary care providers throughout their hospitalizations. In addition, the nurse Hospital Liaison thoroughly reviewed individuals' hospital records, interviewed tertiary care providers, and reported to interdisciplinary team members the hospitalized individuals' health status, response to treatment, and progress toward discharge. The monitoring team review revealed that individuals who were sent to the hospital, as well as individuals who remained at the facility, benefitted from the oversight and advocacy of the Hospital Liaison. For example, a review of Individual #26's record revealed that throughout her hospitalization for treatment of altered mental status, Lithium toxicity, and aspiration pneumonia, the Hospital Liaison extensively collaborated with the PNMT RN and other clinical professionals. In addition, she participated in helping Individual #26's team learn about her new health risks and helped them in planning for Individual #26's transition from the hospital setting to the facility. As noted during the prior review, the nurse Hospital Liaison continued to carry out her role and responsibilities with strong commitment and dedication to promoting quality care. Since the prior review, the nurse Hospital Liaison became a member of the facility's Human Rights Committee (HRC), was appointed the position of Hospice Liaison, and was soon to become the Ethics Committee chairperson. During the monitoring team's interview with the nurse Hospital Liaison, when she was asked why she assumed these additional roles/responsibilities, she explained that she did so in order "to make a difference" in the lives of the individuals served by the facility. The nurse Hospital Liaison convincingly explained to the monitoring team how this occurred. For example, as a member of the HRC, the nurse Hospital Liaison participated in the review of Individual #254's appeal of her diet restrictions. Although Individual #254 was morbidly obese and her physician reasonably reported that she could not ethically order an increase in Individual #254's caloric intake due to Individual #254's high risks of heart disease, joint problems, and other health problems, the nurse Hospital Liaison, armed with information obtained from her Lippincott manual and other sources, was able to provide credible information to the team and persuade Individual #254's physician and her other team members to offer and exhaust other less restrictive alternatives, which were more amenable to Individual #254 than severe calorie restriction and consistent with addressing her needs for health and safety. The approach of the nurse Hospital Liaison was a model for other nurses to follow - she got involved, informed, and invested	

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		in positive outcomes for individuals. Wound/Skin Integrity According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs...[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns, and formulates recommendations for preventative measures and management." According to the facility's action plan for section M, on 2/14/12, "a dedicated nurse to create a committee and be responsible for skin integrity issues and conduct quarterly meetings" was identified. At the time of the review, however, SGSSLC did not have a nurse dedicated and responsible for skin integrity issues of a separate Skin Integrity Committee. Rather, the oversight of this important aspect of identifying, assessing, notifying physicians, monitoring, intervening, and keeping appropriate records of this important aspect of the delivery of supports and services was folded into the PNMT's weekly reviews of changes in individuals' health status. On a positive note, the PNMT's reviews ensured that individuals with alteration in skin integrity were indeed identified, recommendations were made, actions were taken, and follow-up to resolution was occurred. Also of note, the RN case managers for units 511 and 516W fairly regularly attended the PNMT's weekly reviews. Notwithstanding the PNMT's dutiful oversight of some individuals' altered skin integrity, a review of the documents submitted by the facility and information obtained during the onsite activities revealed several problems, which were shared with the CNE, NOO, Director of Rehabilitation, and PNMT RN during the review. For example, an examination of the PNMT's weekly reviews revealed that during March 2012 and April 2012, at least four individuals suffered skin breakdown to their buttocks (1), hips/coccyx (2), and toe (1). Although there were a number of recommendations made to address the individuals' health risks, which were possibly associated with and/or contributed to the individuals' wounds/pressure sores, there was little evidence to suggest that the Nursing Department effectively responded to and/or implemented the recommendations made by the PNMT in a timely manner or at all. Thus, month after month, the PNMT continued to record problems obtaining individuals' relevant health status information, such as their intake/output, bowel movements, weight, adequacy of enteral nutrition, etc. These failures stymied the efforts of the PNMT and resulted in a number of setbacks to individuals. Thus, the PNMT resorted to developing individual-specific corrective action plans with "due dates" for the Nursing Department to implement basic nursing care duties tantamount to making it certain that individuals'	

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		ate, drank, and eliminated, and responding to untoward events, such as aspiration triggers, seizures, dehydration, and constipation in a timely manner. Also of note, there was no evidence that the skin integrity data, which were captured by the PNMT, were analyzed for patterns and trends, and no recommendations for facility-wide preventative measures and management were formulated. When the monitoring team shared this finding with the Director of Rehabilitation, who oversaw the PNMT, it was evident that immediate follow-up would occur. <u>Infection Control</u> According to SGSSLC's action plan, provision action information, and self-assessment, which were updated on 5/1/12, since the prior review, only two actions were reportedly taken to address the prior review's findings related to this provision - the Infection Control Nurse was in the process of obtaining her certification in infection prevention and control, and the Infection Control Education Manual for new employee orientation was implemented. Notwithstanding these two initiatives, as noted in all prior reports, the review continued to reveal that the Infection Control Nurse and the facility's procedures and protocols for infection prevention and control were not adequately developed, implemented, and supported from both within and outside the Nursing Department. For example, since the prior review, only one Infection Control Committee meeting was held. The 4/27/12 Infection Control Committee meeting provided its members with a snapshot of the infections that were reported during the two-month period of February 2012 – March 2012. No longitudinal, historical, or contextual data were prepared or discussed. Thus, there was no evidence that the Committee reviewed these data for the possible patterns and trends of infections suffered by individuals served by the facility. Although the 4/27/12 Infection Control Committee meeting had no agenda, the meeting minutes referenced several serious health and safety problems at the facility. For example, it was during this meeting that the Infection Control Nurse reported, "a large number of staff have not come in to do the TB skin test or sign up for the chest x-ray." The Infection Control Nurse also reported that facility employees who had a worksite risk of exposure to tuberculosis had not been properly tested for at least the past two to six years, and one employee had not been tested since 1970. Although, the Committee discussed this serious public health and safety risk, aggressive actions were not taken to correct the problem until the monitoring team brought this matter to the attention of state officials during the onsite review.	

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		The minutes also referenced that there was the possibility that, facility-wide, clean linens were contaminated during their transport to the facility by unsanitary laundry trucks that were not properly disinfected. In addition, the minutes noted the PPD conversions of four individuals during the one-month period of 3/8/12- 4/6/12 and the repeated failures of staff members to turn in reports of infections in a timely manner. Despite the serious nature of these problems, the recommendations made by the Committee to address the problems were limited to benign activities such as "making lists," "reminding staff" of their responsibilities, and sending email messages to staff members instructing them to instruct someone else to properly implement infection prevention and control procedure(s). During the monitoring team's interview with the Infection Control Nurse, it was again very clear that she had not been provided with the tools she needed to do her job. When asked to elaborate on the status of her pending certification, as reported in the facility's self-assessment, she reported no progress had been made, and that she had done nothing other than surf the internet for information about infection prevention and control certification/continuing education programs. In addition, since the prior review, the Infection Control Nurse was not afforded any opportunities to obtain formal training in infection prevention and control. And, as noted previously, the Infection Control Nurse continued to try to manage infection data without sufficient training and/or knowledge of the computer software used by the facility. Not to be held back by the lack of support, the Infection Control Nurse continued to try to make progress toward meeting the expectations of the Settlement Agreement and Health Care Guidelines. As a result, since the prior review, the Infection Control Nurse developed a Pandemic Infectious Disease policy, which was well-received by state officials and reportedly "the best [pandemic policy] ever turned in." In addition, the facility's document submission indicated that the Infection Control Nurse continued to train new employees in infection prevention and control, made infection control observations, conducted random monitoring of hand washing, completed monthly infection control monitoring tools, and reviewed staff members' answers to questions #14 and #15 on the mealtime monitoring tools, which unit nurses completed each month on each home. A review of these various observation and monitoring reports revealed the following: • During the period of 1/1/12-6/7/12, approximately 11 unique Infection Control Observation Reports were completed. Due to the number of duplicate handwritten and typed reports submitted by the facility, the monitoring team was only able to approximate the number of actual observations conducted during the six-month period. • A review of the 11 Infection Control Observation Reports revealed that the same	

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		homes/units were repeatedly reviewed month after month and sometimes the same home was reviewed twice during the month, for no apparent reason. • Despite the problems identified during the infection control reviews, the scores on the 11 reports ranged from 85% to 100% compliance with basic standards of infection control and regulatory requirements. For example, one home scored 93% even though there were many problems, such as staff members who were unable to correctly demonstrate proper hand-washing, staff members who failed to wash their hands when they were visibly soiled, staff members who were unable to find personal protective equipment and were not aware of ever having that equipment on the home, hazardous supplies unsecured and accessible to individuals, laundry door propped open and unattended, medication room refrigerator soiled with spills and temperature not checked as required, non-functioning dishwasher, loose screws in furnishings, and multiple, old cigarette butts all over the porch and stains from spills. • During the period of 1/1/12-6/7/12, there were 13 occurrences of random monitoring of hand washing. All 13 staff members reviewed scored 100%. Thus, no problems were identified and no corrective actions were considered or implemented. • Question #14 and #15 on the mealtime monitoring tools asked the reviewer to identify whether or not staff members followed proper hand washing before and during the meal and whether or not staff members encouraged the individual to wash his/her hands before and after the meal. Although hundreds of monitoring tools were completed during the past six months, as of the review, the Infection Control Nurse reported, "There [was] no official analysis of the mealtime monitoring forms for infection control. [The Infection Control Nurse] reviews the forms and trains as needed when they fail." Thus, it remained unclear to the monitoring team, what actions, if any, were taken in response to staff members who reportedly "forgot" to wash their hands when they assisted individuals at mealtime and what actions, if any, were taken to address the scores of reports that indicated that individuals were not encouraged or assisted to wash their hands before and after their meals. <u>Emergency Response</u> Another opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to ensure that they and other staff members were adequately and appropriately trained and competent to respond to actual medical emergencies vis a vis mock medical emergency drills. Since the prior review, the facility reported that they trained all nurses on the emergency "crash" bags stored on the units. During the monitoring team's review of the presence,	

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		availability, and functioning of medical emergency equipment, it was noted that since the prior review, the storage, availability, and accessibility of medical emergency equipment had declined. A review of all living areas revealed that the presence and location of suction machines, oxygen, emergency equipment, backboards, and AEDs was not consistent across units, not regularly checked by nurses as required by state and facility policy, and, sometimes the equipment/supplies were dirty and covered with dust, and/or stored under heaps of old clothing, backpacks, and other assorted discarded supplies and personal belongings. Also during random checks of staff members' compliance with facility policy, many, including unit supervisors and home charge staff members, failed to have their CPR mask, as required. These findings were unexpected given that the 4/9/12 death review of Individual #168 indicated that when the first nurse responded to the scene of the medical emergency, he/she observed staff members on the scene and Individual #168 "lying on the floor, not breathing and with no pulse." Unfortunately, however, the medical emergency equipment was not present at the scene. Thus, the nurse reported that he/she "immediately ran back down[stairs] to get the crash kit bag," and "notified [staff] to get the AED." Although the presence of medical emergency equipment at the scene may not have changed the ultimate outcome of this untoward event, there was precious time lost while the nurse and staff members chased down medical emergency equipment. A review of Emergency Drill Checklists for 1/1/12-4/30/12 revealed that 79 drills were conducted during the four-month period. However, as noted during all prior reviews, although nurses continued to participate in the drills, in accordance with the state's and SGSSLC's policies, other clinical professionals, who were in direct contact with the individuals served by the facility, failed to participate in over 85% of the drills conducted during the four-month period. A second problem identified during the monitoring team's review of the Emergency Drill Checklists and database was that although the database indicated that only two of the 79 drills "failed," the Emergency Drill Checklists clearly indicated that the serious problems that were identified during the conduct of the drill and these problems were not completely addressed by the Drill Instructors. The following examples were illustrative: • During February 2012, at least 25% of the Emergency Drill Checklists indicated that nurses could not be located or were "unable to respond" for various reasons and medical emergency equipment was not brought to the scene. However, all of these drills were "passed." • On 3/22/12, no backboard or emergency "crash" bag was brought to the scene, and the nurse was not called. Nonetheless, the Emergency Drill Checklist indicated that the drill was "passed." • On 4/26/12, the Emergency Drill Checklist indicated, "CPR drill was passed, but	

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		[staff member] could not remember the steps or their order." Of note, the staff member was told that he/she would attend a CPR refresher course that was not scheduled to occur until 5/16/12. A third problem identified during the conduct of the review was that on 10/20/11 SGSSLC "operationalized" the state's 9/7/11 Emergency Response policy and made several changes that appeared to significantly vary from the state's standardized procedures. For example, at SGSSLC, "medications as designated by the physician," were required to be stored in the emergency equipment bags. Thus, the medical emergency equipment bags were stored in the locked medication rooms. At SGSSLC, nurses, rather than direct care staff members were required to carry almost all of the medical emergency equipment to the scene. This requirement seemed almost impossible for many nurses to implement and appeared to require nurses to make two trips, or find another staff member to help them carry the equipment, to the scene. Also, at SGSSLC, staff members who failed a drill were not be allowed to work unsupervised with individuals "until they complete and pass the CPR refresher course." This requirement was much stricter than the state's policy, which only required that staff members pass a "drill" before working unsupervised with individuals. During the monitoring team's meeting with the CNE, NOO, and other members of the nursing leadership team, it was evident that they had not considered or evaluated the impact of the above referenced changes on nurses, other facility staff members, and/or the individuals. Infirmary Another way for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to provide health care to individuals who were residing in the facility's infirmary. The SGSSLC infirmary had five beds. During the four-month period of 1/1/12-4/30/12, the facility reported that there were only nine admissions to the infirmary with an average length of stay of 6.4 days. At the time of the review, there were no individuals residing in the infirmary. Notwithstanding the apparently low utilization of the facility's infirmary, since the prior review, an Acute RN was added to the nursing leadership team. According to the job description for the Acute RN, in general, it was her responsibility to perform complex nursing work. The Acute RN was supposed to work under the immediate supervision of the Nurse Manager, monitor the health status of all individuals served/assigned to the RN Case Manager, monitor the clinical record of the individuals on the assigned case load, monitoring physicians' orders and MARs to ascertain that medications/treatments were administered as ordered, supervise the work of others,	

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		work closely with other disciplines and members of the individuals' interdisciplinary teams, and participate in training and continuing education activities and staff meetings. During the monitoring team's interview with the Acute RN, it was evident that many of the "essential job functions" referenced in her job description were not actual expectations for her position, as she understood it. For example, the Nurse Manager did not supervise the Acute RN, rather, she was supervised by the CNE. The Acute RN supervised no one, she did not have a caseload per se, and she was not responsible to monitor the health status of individuals assigned to any one particular RN case manager. The Acute RN was also not responsible to monitor physicians' orders and MARs once an individual was discharged from the five-bed infirmary. It was not surprising to find discrepancies between what was described in the Acute RN's job description and duty list and what she understood or surmised about her position because the only facility policies/procedures and/or guidelines, which she reportedly read, that described the mission, vision, purpose, scope, operations, and management of the facility's infirmary were three 2001 policies. A review of the 20 sample individuals revealed that, over the past six months, five of the 20 individuals were transferred to/from the emergency room, discharged from the hospital, and/or residents of the infirmary. Overall, a review of their records failed to reveal that the Acute RN responsible for their care ensured that their needs were met. For example, there were incomplete Post-Hospital/ER/LTAC nursing assessments, no evidence that daily, acute assessments were performed by the Acute RN, infirmary discharge notes that were written by the nurse Hospital Liaison instead of the Acute RN, and no evidence of follow-up by the Acute RN "on the individuals' fifth business day post infirmary discharge," as required. <u>Other Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the state's Nursing Services Policy stipulated that nursing staff members must document all health care issues and must have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Across the 20 individuals reviewed, there was evidence that their physicians usually responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen by their doctor. However, as noted in	

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		prior reviews, it was the direct care staff members who continued to be the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy reliance upon the direct care staff members to readily identify problems, and on the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician. A review of 20 sample individuals' records showed that the facility failed to ensure that its nurses consistently identified, implemented, and documented their interventions to address individuals' health care problems and changes in health status, and/or conducted at least daily follow-up until resolution of the significant changes in individuals' health status occurred. The following examples represented the seriousness of this problem at SGSSLC. • Individual #26 was a 65-year-old woman who suffered a 10-day ordeal of decline related to lithium toxicity. During the period of 4/19/12 to 4/28/12, each and every day, Individual #26 endured one sign/symptom after another of lithium toxicity and steadily declined from a woman who initially complained of not feeling well and being more tired than usual to a woman who was barely able to speak, lethargic, disoriented, drooling, unable to walk or feed herself, refusing to eat/drink, seizing, and twitching. Although Individual #26's nurses regularly documented and described the textbook signs/symptoms of lithium toxicity in their notes, they failed to take all necessary and appropriate actions in response to their findings. On 4/28/12, Individual #26 was transferred to the hospital where she was treated for lithium toxicity, metabolic encephalopathy, malnutrition, and aspiration pneumonia. • Individual #112 was a 25-year-old man who was diagnosed with a neurodegenerative disorder called Huntington's disease. Over the past several months, Individual #112 suffered a number of significant changes in his health status that failed to result in timely and consistent nursing assessments and interventions. For example, there was no evidence of follow-up to possible injuries he suffered after numerous falls, no evidence of follow-up assessments after changes in his psychotropic medications, no evidence of follow-up to his complaints of coughing and signs of congestion, and delayed assessments and lack of urgency in his nurses' response to his decline. • On 5/21/12, less than 24-hours after Individual #258 was hit on the head with a telephone, her direct care staff member reported that she did not want to get out of bed, and it was taking her longer than usual to complete her daily routine. Although Individual #258's nurse noted that she was drowsy and at risk for dehydration and increased weight loss and planned to monitor her and notify her psychiatrist of the significant changes in her condition, there was no evidence of follow-up.	

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		• Individual #46 was a 52-year-old woman who was diagnosed with a seizure disorder. Individual #46 was undergoing changes in her seizure medications and suffered a break-through seizure. Although Individual #46's nurse noted that she was "slow in coming to her usual mental status," her nurse failed to conduct a complete assessment, as called for by the facility's seizure protocol. In addition, there was no evidence of any follow-up nursing assessments until several days later, when Individual #46's direct care staff member reported that she was "not arousable."	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In accordance with the provisions of the Settlement Agreement, the DADS Nursing Services Policy and Procedures affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized Comprehensive Nursing Assessment, the Acute Care Nursing Assessment, and the Post-Hospital/ER/LTAC Assessment forms in use at SGSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. In addition, a review of the state's guidelines for completing the quarterly/annual comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus, making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other. According to the facility's self-assessment, their reviews of their monitoring data revealed a downward trend, from 75% in January 2012 to 62% in March 2012, in compliance scores pertaining to nursing assessments. They also reported that their data showed that assessments were not being completed in a timely manner, and not all elements were being included. As noted in section M1, 10 of the 20 sample individuals' records reviewed were selected by the facility and presumably representative of the most positive examples of nursing care at the facility. Although it was not anticipated, a review of the 20 records revealed that six of the 20 records failed to have current quarterly nursing assessments, at least two individuals nursing assessments were signed and dated before the "Date(s) Completed, " which raised question regarding their authenticity, and none of the three sample individuals who were recently admitted to SGSSLC had an admission nursing assessment that was completed in a timely manner. Of the remaining 11 individuals' nursing assessments that were current, all but one, Individual #218's, assessment failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and	Noncompliance

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		their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, as noted in all prior reviews, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. As a result of this serious problem, the individuals' 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. As a result, a rating of noncompliance was given to this provision item. As noted in all previous reports, at SGSSLC, IPNs were episode-driven and almost always written in response to narrow, specific, and significant changes in individuals' health status. Thus, the annual and quarterly nursing assessments continued to play an important part in the delivery of nursing supports and services because they continued to be the only processes whereby individuals' nurses' collected, analyzed, and recorded their evaluations of individuals' health status and their responses to treatment interventions from "head to toe." At SGSSLC, the only significant exception to this rule was that head to toe assessments were usually requested by facility administrators when investigating or conducting follow-up to allegations of abuse/neglect. Also at SGSSLC, in addition to the annual and quarterly comprehensive nursing assessments, nurses were required to complete Acute Assessments and Post Hospitalization/ER/LTAC Nursing Assessments of individuals who acutely ill and/or discharged from the emergency room, hospital, and/or LTAC. Of the 20 records reviewed, 25% were records of individuals who were transferred to the emergency room and/or hospitalized during the period of 1/1/12 – 6/7/12. None of these individuals' assessments were complete. Some were missing pages, and a number had one or more important sections that were incomplete or left blank. Other examples are given below: <u>Regarding specific individuals</u> • Individual #254's most salient health problem was her morbid obesity. Her nursing assessment noted that was "not losing [weight] as she should be." However, there were no analyses of her "noncompliance" and no review of the weight loss strategies that were tried/failed. Also, monitoring of her meals provided little to no pertinent information, they stated, "No deficits." • Individual #43 was a 19-year-old man recently admitted to the facility. Thus, his comprehensive nursing assessment was an especially critical source of health information, but it failed to provide an evaluation of his medications, there was no date of his nurse's meal monitoring, there was no evaluation of his seven-pound weight loss in one month, there were reportedly no results of the EEG he underwent, and nothing about the status of his HPV series and meningococcal	

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		vaccination. • Individual #186 was hospitalized with pneumonia, bacteremia, and urinary tract infection. At the time of the review, her annual medical examination was over a year old, and the health information in her ISP was not current. Thus, the health information recorded in Individual #186's quarterly and annual nursing assessments were heavily relied upon by the members of her IDT. In addition, the presence of misinformation called into question the validity of the assessment and reliability of the quarterly and annual review processes. <u>Regarding numerous individuals</u> • SGSSLC reported that they relied upon a "Consultation Tracking System" for all clinical professionals to view provider orders for consultations, reasons for the consultations, whether or not the consultation appointment was kept, and dates tracking orders, rounds, appointments, etc. A review of these data for the three-month period of 3/1/12-5/30/12 revealed serious problems. The single largest problem was missing data and blank entries for almost all fields in the database. It was apparent that all aspects of the system needed to be thoroughly reviewed and revised if SGSSLC expected it to be an effective tool for its clinical professionals. • Individuals' weekly Aspiration Trigger Assessment reports and health status tracking logs were not consistently completed or reviewed by nurses as part of the assessment process. • As noted in all prior reviews, the impact of many of the individuals' chronic conditions were either not adequately portrayed by the individuals' nursing assessments and/or not even referenced in the individuals' nursing diagnoses. • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status. This was especially noted when individuals suffered unplanned, significant weight loss, but remained within the desired weight range calculated by their dietician. • For reasons that were not explained or understood by the monitoring team, meal monitoring was not conducted as part of the individual's annual/quarterly comprehensive nursing assessment when the individual received enteral nutrition/fluids. • Lists of nursing problems/diagnoses were incomplete and usually copied verbatim from prior assessments regardless of any changes that had occurred. • There were several individuals where particular assessment activities, such as meal monitoring, obtaining weight, etc., were copied over from one review period to the next. This called into question the validity and reliability of the assessment process, especially since nurses signed and dated the assessments attesting to the fact that they had indeed performed/completed all aspects of the	

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		assessment and provided the results of their assessments to the individuals' QDDPs and other IDT members.	
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.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of interventions. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals served by the facility. The guidelines also indicated that RN case mangers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Officer on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. According to the facility's self-report for section M3, since the prior review, corrective action plans for this provision were developed, nurses were re-trained on specific aspects of nursing care, and monitoring of HMPs and ACPs was increased. The monitoring team was struck by the findings from the facility's reviews of their overall compliance in developing, implementing, and evaluating nursing care plans. It was reported that the overall compliance rating steadily and significantly declined from 93% in January 2012 to 13% in April 2012. Of note, the facility reported that it formed a Care Plan Committee that was assigned the task of reviewing all HMPs and ACPs that were created to ensure that all elements outlines in the Health Care Guidelines and the nursing care plan-monitoring tools were addressed. Currently, the monitoring review of 20 individuals' records revealed that three of the 20 individuals' records failed to have at least one HMP. Consistent with the facility's findings, all 17 individuals who had at least one HMP failed to have specific, individualized nursing interventions developed to address all of their health care needs, including their needs associated with their health risks. As a result, a rating of	Noncompliance

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		noncompliance was given to this provision item. Some general comments regarding the 17 sample individuals' care plans are below. Of note, all of the findings were consistent with the findings from the prior reviews. • Generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, many of which were not, continued to be the pattern of health care planning at SGSSLC. o A number of the interventions put forward in the stock care plans were not consistent with the state's health and nursing care protocols. • Almost identical HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. • ACPs were not consistently developed in response to emergent health problems and/or resolved in a timely manner. • Not one of the 20 individuals records contained plans that addressed all of the current health needs of the individuals at all times. • Almost all HMPs and ACPs signature sheets had one or fewer signatures. • Goals and outcomes were not specific, measurable, attainable, relevant, and person-centered. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • On 3/20/12, Individual #145 was a 46-year-old man who was readmitted to SGSSLC from the hospital where he was treated for failure to thrive. Since Individual #145's admission, his health greatly improved with the care he received over the past several months. Although Individual #145 continued to require vigilant care and treatment to help ensure his continued improvement and prevent decline, a review of his HMPs revealed that they were in dire need of review/revision. For example, his HMP for pain referenced interventions such as lubricating his skin with "Crisco," his HMP for alteration in skin integrity referenced "vulvovaginitis," which clearly did not apply, his HMP for choking and aspiration referenced a different individual's name, and other plans referred to him as a "her." • Since the prior review, Individual #23 was diagnosed with multiple sclerosis (MS), a disease that was highly variable from individual to individuals and from time to time in the same individual's life. Nonetheless, Individual #23's two and a half page multiple sclerosis HMP failed to reference many of the effective strategies that were available to modify the disease course, treatment, and exacerbations and manage her symptoms, improve her function and safety, provide her with emotional support, and enhance the quality of her young life. • Individual #52 was a 36-year-old woman who was admitted to SGSSLC on	

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		4/26/12 from Big Spring State Hospital. Since her admission, Individual #52 suffered a human bite that broke her skin, hyponatremia, allergic rhinitis, and multiple changes in her psychotropic medications and chemical restraints. Notwithstanding her multiple behavioral challenges and health needs, at the time of the review, there were no nursing assessments, nurses' notes, or HMPs filed in her record. • Individual #203 was a 56-year-old woman who had many health needs and risks. She received all of her nutrition and fluids via PEG tube and required vey close monitoring of her fluid intake to prevent fluid overload. Strikingly, Individual #203's HMPs had not been individualized to reflect these conditions. Thus, her HMPs continued to reference interventions that were contraindicated and, if implemented, could cause her serious harm. For example, Individual #203's HMPs referenced interventions such as forcing oral fluids, eating three meals a days, and increased fluid intake up to 2,000 ml per day.	
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.	Of the six provisions of section M, M4 has the broadest scope. This provision item clearly ties assessment and reporting protocols to outcomes, and it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item demands that each component of the nursing process is in place and put into practice, such that the health needs of the individuals served by the facility are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. The facility's self-assessment indicated that, since the prior monitoring review, the Nurse Educator applied for continuing education units for specific training programs offered to facility nurses, and the CNE and NOO developed spreadsheets for tracking the results of monitoring tools and audits and were working on developing a protocol to address the problem of nurses who failed to attend and complete annual, ongoing, refresher, etc. training, as required. The CNE reported, however, that based upon the findings from the facility's self-assessments, "this provision [was] not in substantial compliance because not all training has been completed and compliance in following policies and procedures continues to be an issue." The monitoring team was in agreement with the self-rating of noncompliance due to the findings of numerous problems in the implementation of the nursing assessment and reporting protocols specifically developed by the state, and some developed by the facility, to improve nursing practice and ensure consistent application of the nursing process from assessment, to diagnosis, to plan development, to implementation of interventions, and to evaluation of outcomes.	Noncompliance

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		The CNE and NOO continued to work together to manage the Nursing Department. They also continued to struggle over how to best utilize and deploy their nursing staff and meet the provisions of section M. In defense of the CNE and NOO, much of their day was spent trying to solve the problems of the day, which were usually related to staffing, or the lack thereof. Their efforts to lead and manage the department were beset by continuous high turnover and vacant positions in the Nursing Department. In the words of the NOO, they were "forever trying to get caught up." During the monitoring team's informal interviews with nurses, they continued to report low morale, differing opinions on the presence and effectiveness of nurses in leadership positions, lack of effective systems of communication, and other work force issues, which were previously noted and reported by the monitoring team. These problems continued to present serious and persistent barriers to improving nursing care and achieving substantial compliance with the provisions of section M. Since the prior review, a full-time Nurse Recruiter was added to the Nursing Department. The Nurse Recruiter was not new to the facility or the state system. Thus, she was fully aware of the challenges that faced SGSSLC's recruitment and retention program. Notwithstanding the challenges she faced, the Nurse Recruited reported that the loved her job. During the interview with the monitoring team, the Nurse Recruiter reported that since February 2012, she participated in 10 visits to schools of nursing and colleges, she was invited to attend the Texas Workforce Job Fair, and she was asked to speak to former military personnel at the Goodfellow AFB about the jobs at SGSSLC. Notwithstanding these positive findings, the Nurse Recruiter had not reviewed and analyzed staffing data for trends and patterns of absenteeism, vacancy, etc. that affected the functioning and morale of the department. In addition, she reported that she had not worked at all with the local contract nursing agencies to establish some, albeit, limited, collegial relationships and rapport. Also, when the monitoring team asked the Nurse Recruited to describe details of the facility's self-assessment's report of "retention strategies to retain current nursing staff at the facility," the only planned activities by the facility to retain current nursing staff that the Nurse Recruiter was aware of were that several meals during Nurses' Week were provided free of charge on all shifts, occasionally RNs brought lunch into the facility for the LVNs, and, within the week prior to the review, one of the Nurse Managers began asking nurses to nominate someone for "Nurse of the Month." When the monitoring team asked the Nurse Recruiter for more details about the "Nurse of the Month" activity, she referred the monitoring team to the Nurse Manager.	

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		It was clear that there was much work to be done in this area in order to build a successful recruitment and retention program. Although it was reported by the Nursing Department that they started having monthly bake sales to raise money for gifts/prizes for nurses, it was not clear how this activity was related to improving recruitment and retention and what other steps, if any, were planned and/or underway to do so. Since the prior review, the Nurse Educator was integral to the department's endeavor to ensure that the state's and the facility's nursing policies, procedures, and protocols were properly implemented. For example, the Nurse Educator had conducted a number of training and re-training classes that covered various nursing activities, such as assessments, care plans, medication administration, and the state-issued nursing protocols. In addition, the Nurse Educator was already prepared for the state's training on documentation and physical assessment, which was scheduled to occur on 8/14/12. All RNs were given their textbooks and workbooks, and all RNs received a course "primer" that was developed by the Nurse Educator to "welcome" the RNs to the class. The Nurse Educator also developed a system to track nurses who both attended and failed to attend requisite training sessions. During the review, the Nurse Educator demonstrated the effectiveness of her tracking system and reported that, since its inception, not one nurse required more than two notices of delinquency to their supervisor to ensure his/her compliance with training requirements. Notwithstanding this positive finding, a review of the competency/skill and on-the-job training records for eight of the most recently hired nurses' and five agency nurses' revealed problems documenting and maintaining accurate and complete evidence that nurses actually received the orientation and training that was reported to the monitoring team, and that the nurses were truly evaluated and deemed competent to carry out their duties prior to their assignments to individuals, units and/or the infirmary. For example, two of the eight records requested were unable to be located. Five of the six records reviewed had blank entries for the assessment and verification of their competence/skills by the nurses' Nurse Managers, and two of the six nurses' records failed to have verification of their skills/competence in a number of areas. These problems were significant because they were indicative of gaps and lapses in three of the most important areas of nursing education – performing training, evaluating competence, and verifying skills. During observations on the units, few nurses were observed to have the state's protocols on laminated cards on their person and/or in their workstations. Although SGSSLC reported that they had implemented at least nine of the state's nursing protocols, at the time of the review, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the protocols were consistently and/or correctly used to	

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		guide and direct nursing interventions during episodes of acute changes in health, ensure that adequate and appropriate nursing assessments and monitoring of health status changes were completely carried out, and trigger the parameters and time frames for the reporting of signs and symptoms of significant changes in health to the individuals' physician and/or other clinical professionals, as indicated. Thus, supporting documentation failed to corroborate the facility's report that they had actually implemented the nursing protocols. For multiple individuals, their records revealed the following: • Individuals who suffered episodes human bite wounds that broke their skin failed to have evidence of implementation of the protocol developed to address their acute injures. Thus, there were lapses in reviews of vaccination immunization histories and at least one individual who suffered complications that included infection and delayed healing of her wound. • Individuals who suffered frequent episodes of nausea, vomiting, and diarrhea failed to have evidence of implementation of the protocols developed to address these problems. Thus, individuals suffered complications, such as dehydration and fluid/electrolyte imbalance. • Several individuals who suffered head injuries were not assessed or monitored, in accordance with the head injury protocol. This was especially significant for individuals who suffered repeated head injuries and were not closely and completely assessed and monitored, as indicated by the protocol. • The enteral feedings of individuals who suffered episodes of wheezing, gurgling, and change in breath sounds were not stopped immediately and their physicians were not notified, in accordance with the enteral feeding protocol. • Individuals who ingested batteries and other inedible objects failed to have evidence of implementation of the protocol developed to address their pica. As a result of failure to monitor the individuals' stool, there were individuals for whom passage of the objects was not confirmed. Although it was apparent to the monitoring team that adherence to the protocols was a work in progress, it was not apparent what actions the Nursing Department planned to take, apart from increasing the number of monitoring tools, to help ensure that their nurses would consistently implement the nursing protocols. Since the prior review, the Quality Assurance Nurse played a much smaller and less visible role in the Nursing Department's oversight, monitoring, and improvement of nursing care. Of note, there was only one action step in the Nursing Department's action plan and self-assessment that referenced the participation of the QA Nurse, who reportedly met with the CNE in February 2012, to "review the prevention and nursing	

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		care plan monitoring tools to ensure program effectiveness." The nonattendance of the QA Nurse at various nursing committee meetings and PITs and the absence of her sharp insight, good judgment, and wise guidance were significant and notable losses to the Nursing Department. It was also troubling for the monitoring team to read the three QA Nurses' Death Reviews for Nursing and find that many of the same problems and recommendations noted in prior death reviews were also noted in the current death reviews. For example, the three most recent QA Death Reviews for Nursing continued to note problems in completing adequate documentation, conducting nursing assessments, developing health management and acute care plans, reviewing health risks, and implementing interventions to address individuals' health problems. Since the prior review, the Program Compliance Nurse joined the nursing leadership team, but, as of the review, she had resigned, and her last day of work occurred during the onsite review. Unfortunately, the Program Compliance Nurse was reported by the facility to be the "responsible person" for several steps in the facility's action plans to achieve compliance with the provisions of section M. The Program Compliance Nurse candidly reported that when she started her job she did not have a tracking system to record and analyze the results of the monitoring/audit tools. However, over the past six months, the Program Compliance Nurse developed a tracking system, entered all of the monitoring/audit into the system, and had it ready for her replacement to analyze and share with the Nursing Department.	
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.	At the time of the monitoring review, SGSSLC had completed the first year of its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the ISP process. According to the facility's action plan, since the prior monitoring review, nurses were re-trained on how to complete the Aspiration Trigger Datasheet and the role of the RN case manager in the state's health risk assessment ad planning processes. According to the self-assessment, this provision was "not in substantial compliance because the tools have not been created at this time, therefore the goals for the provision have not met the measure of success." One of the most obvious ways that the Nursing Department would improve its performance and compliance with the risk assessment and planning processes would be through improving its nurses' assessment and documentation of individuals' indicators of risk and their attendance and participation in the IDT and ISP processes. During the conduct of the review, the monitoring team attended three IDT meetings, which were	Noncompliance

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		held on behalf of Individual #90, Individual #38, and Individual #203. The QDDP who chaired the meetings was covering for the individuals' assigned QDDP. Nonetheless, the covering QDDP was well prepared and organized, and she paid scrupulous attention to detail. The meeting discussions were focused on the assessment of the individuals' risks and the development of risk action plans. For the most part, the QDDP kept the discussion of the individuals' health and health risks on track. All attendees participated in the discussion, and although the meetings were focused on health, the individuals' Home Manager and Psychologist ensured that the discussion of the individuals' health and health risks was relevant to other aspects of their lives. The conduct of the PNMT RN, who participated in the meetings, was exemplary. She was exceedingly knowledgeable and informed about all aspects – health related and non-health related – of the individuals' lives. The RN case manager who participated in the meetings was also very well prepared and knowledgeable of the individuals' health needs and risks. The RN case manager and the PNMT RN worked well together and effectively ensured that the assigned risk levels were accurate and the risk action plans were developed in accordance with the individuals' needs and risks. All 20 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and over half of the 20 individuals reviewed were referred to as having one or more "high" health risks. All of the 20 sample individuals whose records were reviewed were also reviewed by their IDTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. As noted in the prior report and consistent with the facility's self-assessment, there continued to be problems with health risk ratings that 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: • Since June 2011, Individual #258 suffered many falls. Nonetheless, her risk of falls was not revised until after she fell and suffered a serious head injury. Of note, as of the monitoring review, there were still no planned interventions to address Individual #258's high risk of falls. • Individual #9 had frequent and well-documented episodes of self-injurious behavior that resulted in wounds to her arms and around her eye. Notwithstanding the serious nature of her injuries and high health risks related to alteration in skin integrity and infection, as of the monitoring review, the risk levels assigned to these areas were "low. • Individual #112 was a 25-year-old man who was diagnosed with a	

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		neurodegenerative disease called Huntington's disease. Over the past six months, Individual #112's health status significantly declined. Notwithstanding the many significant changes in Individual #112's health status and functioning, there was no evidence that his 12/1/11 risk action plan had been reviewed or revised.	
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.	Since the prior review, the facility's action plan indicated that several steps toward compliance with this provision item were "completed," several steps were "in process," and some steps were "not started." For example, over the past six months, the Nurse Educator conducted training sessions on the state's new medication variance and medication excess/shortage forms that were received by the facility. The Nurse Educator also held special, one-on-one training sessions in medication administration practices for nurses who were identified by their supervisors as needing additional training due to practice deficiencies and medication errors. In addition, the Nursing Department developed a spreadsheet to help them track and analyze variances in medications and identify areas in need of improvement and/or development of corrective action plans. During the monitoring review, the monitoring team attended the Medication Variance Performance Enhancement Team's meeting. According to the Chairperson, the team was no longer meeting once a week and was currently considered a "PET," rather than a "PIT" because apparently the facility's Quality Improvement Council determined that all system-wide problems were resolve and "just monitoring of the solutions" was needed. Indeed, counts of medications were occurring three times a day, as scheduled, and no medications were being returned to or requested from the pharmacy without proper documentation of reconciliation and/or explanation for the over/short medication(s). Also, although there were medication errors reported during the month under review (April 2012), it was reported that most errors were identified during the nurses' daily counting/reconciliation of medications. Also, most errors were due to problems that occurred during administration and documentation, and no errors adversely affected the individuals. Notwithstanding the Quality Improvement Council's optimistic view and the facility's actions and plans to implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care, as indicated in more detail below, much work still needed to be done to ensure that the nursing practices associated with medication administration and accountability were carried out in accordance with generally accepted professional standards of practice and the Health Care Guidelines. Thus, consistent with the facility's self-assessment, this	Noncompliance

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		provision item was rated as being in noncompliance. Observations of medication administration, oral and enteral, were conducted on selected units. During four of the five observations, there were numerous violations of accepted professional standards of nursing practice and egregious violations of basic infection control practices and procedures. For example, during one or more of the four medication observations, nurses failed to use the individuals' MARs during medication administration, properly sign and verify that medications were administered as ordered, provide individuals with privacy and dignity, sanitize and/or wash their hands between their contacts with individuals and/or soiled materials, and ensure that all crushed, dissolved, and otherwise altered medications were completely given and not left in discarded medication and paper drinking cups and/or adhering to enteral feeding equipment. In addition, the bins of individuals' enteral feeding equipment, which were soiled and stained from prior use, were lined with wet washcloths. The combination of moisture from the washcloths and spilt nutritional supplements provided a perfect environment for bacterial growth. Also, as noted during the prior review, liquid- and pill-form medications were pre-poured together into unlabeled medication cups, set on a shelf in the medication room, and administered by the nurse well over an hour later. Since the prior review, there was no evidence of follow-up by the nurses with the pharmacist to ascertain that there were no problems with pre-pouring and mixing 10 or more crushed medications along with Mylanta, guaifenesin, and liquid multivitamin altogether in a plastic cup and allowing the mixture to sit for over an hour before administration. A number of the 20 individuals reviewed had a SAM (self-administration of medication) assessment and designation filed in their record. During the observations of medication administration, the nurses uniformly treated individuals with respect and dignity during medication administration, but, with the exception of one observation, observations failed to reveal that reasonable attempts were made to implement the individuals' SAM program. The review of 20 individuals' current MARs for the period of 5/1/12-5/31/12 revealed no improvement in performance from the prior review. Over 75% of the 20 individuals reviewed had omissions and/or discrepancies in their MARs. These omissions and discrepancies included missing entries for psychotropic, anticonvulsant, diabetic, gastrointestinal, bowel, antibiotic medication(s), vitamins/supplements, and/or oral,	

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		wound, and/or skin treatments during the one-month period.	

Recommendations:

1. Assistance from the facility's senior management to guide, direct, and support the CNE's development of a strategic plan to effectively utilize the nurses in leadership and management positions to achieve substantial compliance with the provisions of section M (M1-M6).

2. Bring administrative and clinical supports to bear on the facility's infection control and management processes and fully develop a functioning program of infection prevention and control (M1, M4, M5, M6).

3. Ensure the presence, availability, and accessibility of clean and sanitary emergency medical equipment, which are regularly checked and in working order, as required by the state and facility's policies (M1).

4. Effectively address and completely resolve as soon as possible the problems that persist in ensuring that individuals receive their enteral nutrition and fluids, as ordered (M1, M6).

5. Consider clarifying expectations for nurses in leadership and management positions to lead by example and become regularly involved in the daily delivery of nursing care on the homes (M1-M6).

6. Review and appropriately revise the job descriptions of the Acute RN and Nurse Recruiter to ensure that the descriptions accurately match the expectations for these positions (M1- M4).

7. Consider developing staffing policies/procedures that ensure that adequate numbers of nurses present and available across all shifts, in accordance with relevant clinical factors and the presence, severity, and complexity of individuals' current health and medical needs across the entire campus (M1-M6).

8. Develop ways to help all nurses understand how they should be using the standardized nursing protocols during their daily routines. (M1–M6).

9. Analyze the efficacy and outcomes associated with the facility's operations of a five-bed infirmary and consider developing policies/procedures that define its mission and scope and guide and direct its operations and management (M1).

10. Continue to work on ensuring that nurses consistently document health care problems and changes in health status, adequately intervene, notify the physician(s) in a timely manner, and appropriately record follow-up to problems once identified (M1, M4).

11. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and risks (M1, M2, M5).

12. The facility should consider re-evaluating the current healthcare planning approach including the overreliance on standardized, stock care plans versus the development and implementation of person-centered health care plans, interventions, and goals (M3).

13. The Nursing Department should seize all opportunities to reestablish consistent communication and collaboration with the QA Department and especially the QA Nurse (M4).

14. Consider developing additional strategies to improve the collaboration and cooperation between the Nursing and Habilitation Departments, and especially with the PNMT RN, to improve the coordination of individuals' health care (M1-M6).

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:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 4/19/12 o SGSSLC Self-Assessment for Section N o SGSSLC Action Plan Provision N o SGSSLC Provision Action Information o SGSSLC Organizational Charts o SGSSLC Pharmacists Prospective Review Of Medication Orders, 11/17/11 o SGSSLC "PRN" Medication Pharmacy Review, 11/17/11 o SGSSLC Medication Variances, 11/3/11 o SGSSLC Quarterly Drug Regimen Review, 11/17/11 o SGSSLC Chemical Restraint Pharmacy Review Date o DISCUS - Monitoring of Medication Side Effects and Tardive Dyskinesia, 9/22/11 o MOSES – Monitoring of Side Effects 4/26/11 o SGSSLC Suspected Adverse Drug Reactions 1/27/11, Rev 11/17/11 o SGSSLC Pharmacy and Therapeutics Committee Corrective Action Process o SGSSLC Drug Utilization Evaluation 11/17/11 o SGSSLC Lab Matrix, 9/15/11 o Physician Orders, December 2011 – May 2012, Days 1-7 o Pharmacy and Therapeutics Committee Meeting Minutes, 3/21/12 o PET Medication Error/Medication Variance Review Committee Meeting Notes, 12/1/11, 2/16/12, 3/8/12, 4/26/12 o Polypharmacy Committee Meeting Minutes, 2/16/12, 3/8/12, 4/19/12, 5/10/12 o Review of Physicians' Orders and Clinical Interventions, 1/12- 4/12 o Adverse Drug Reactions Reports 11/11 – 4/12 o Drug Utilization Calendar, 11/17/11 o Drug Utilization Evaluations • Quetiapine o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #10, Individual #314, Individual #97, Individual #32, Individual #385, Individual #245, Individual #340, Individual #132, Individual #247, Individual #369, Individual #38, Individual #309, Individual #304, Individual #9, Individual #76, Individual #186, Individual #377, Individual #163, Individual #231, Individual #168, Individual #277, Individual #203, Individual #93, Individual #188, Individual #277, Individual #163, Individual #203, Individual #188, Individual #168, Individual #186, Individual #76,

	Individual #93, Individual #377, Individual #231 o MOSES evaluations for the following individuals: • Individual #206, Individual #150, Individual #371, Individual #55, Individual #9, Individual #29, Individual #383, Individual #349, Individual #367, Individual #169, Individual #57, Individual #218, Individual #48, Individual #144, Individual #175, Individual #283, Individual #215, Individual #253, Individual #210, Individual #277, Individual #163, Individual #203, Individual #188, Individual #168 Individual #186, Individual #76, Individual #93, Individual #377, Individual #231 o DISCUS evaluations for the following individuals: • Individual #206, Individual #150, Individual #371, Individual #55, Individual #9, Individual #29, Individual #383, Individual #349, Individual #367, Individual #169, Individual #57, Individual #218, Individual #48, Individual #144, Individual #175, Individual #283, Individual #215, Individual #253, Individual #210, Individual #277, Individual #163, Individual #203, Individual #188, Individual #168 Individual #186, Individual #76, Individual #93, Individual #377, Individual #231 <u>Interviews and Meetings Held</u>: o Philip Roland, PharmD, MHA, Clinical Pharmacist o Donald Conoly, RPh, Pharmacy Director o Charles Njemanze, Facility Director o Ronnie Marecek, RPh, Staff Pharmacist o Rebecca McKown, MD, Medical Director o Joel Bessman, MD, Primary Care Physician o William Bazzell, MD, Psychiatrist o Lisa Owens, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Medication Variance Committee Meeting o Psychotropic Polypharmacy Meeting o Daily Clinical Services Meeting o Pharmacy Department
	Facility Self-Assessment: SGSSLC completed three documents as part of its self-assessment process. The first document was the one historically known as the self–assessment. In addition to the self-assessment, the facility completed an action plan and the provision action information (PAI) document. The PAI detailed all of the actions taken towards substantial compliance with the Settlement Agreement while the action plan listed those items that needed to be completed. During the week of the onsite review, the monitoring team had the opportunity to discuss the self-assessment process with staff. The facility did not conduct a through self-rating. That is, for some

	provision items, it elected not to rate certain elements. This resulted in erroneous self-ratings. Looking at Provision N3, there were five distinct components. The self-assessment did not address the monitoring of metabolic and endocrine risk associated with the use of antipsychotic medications. In the case of provision item N2, the facility rated itself in substantial compliance based on the fact that lab monitoring was completed on 100% of all QDRRs. Inherent in this provision item is the requirement to conduct QDRRs in a timely manner, but that was not addressed in the self-assessment. To take this process forward, the monitoring team recommends that the pharmacy director and clinical pharmacist review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities The facility rated itself in substantial compliance with provision items N2, N3, and N8. For provision items N1, N4, N5, N6, and N7, the facility rated itself in noncompliance. The monitoring team found noncompliance with all eight provision items.
	Summary of Monitor's Assessment: Significant progress was not seen in this area. Throughout the week of the review, the monitoring team was informed of the many barriers encountered in achieving progress. It appeared that the medical staff did not complete reviews of QDRRs in a timely manner, and did not always complete the MOSES and DISCUS evaluations. There was a failure to conduct regular Pharmacy and Therapeutics Committee meetings, which was important because this committee was charged with the oversight of many processes such as DUEs, ADRs, and even medication variances. While there were failures on the part of the facility's medical leadership, it was also clear that the clinical and administrative leaders of the pharmacy department did not carry out the duties and responsibilities of their positions in a manner that would result in successful advancement towards achieving compliance with the Settlement Agreement. For almost every provision item, there was at least, some degree of failure on the part of the facility staff to execute or comply with the requirements set forth in the Settlement Agreement resulting in noncompliance in all eight provision items. The pharmacy staff did not adequately document the communications between pharmacists and prescribers and had not started the process of lab reviews prior to dispensing medications. QDRRs were not present in several records and were not available for some individuals when requested by the monitoring team. The reason for this was not clear. A review of the most recent QDRR schedule indicated that the reviews may not have been completed in a timely manner. Facility leadership will need to further review this pattern. This was very unfortunate, because to the credit of the clinical pharmacist, the quality of the actual QDRR evaluations was the best seen since the compliance reviews began.

	The facility was also beginning to show a disturbing increase in the number of individuals with diabetes and metabolic syndrome and, surprisingly, the medical and quality departments had taken no action to further investigate a trend of more than a 50% increase in the number of individuals with the diagnosis of diabetes. The MOSES and DISCUS evaluations were not completed in accordance with state policy as the psychiatrists continued to complete both. The facility met some requirements with regards to ADRs and DUEs, but overall it failed to meet the requirements set forth in the Health Care Guidelines. Finally, improvement was seen in some aspects of the medication variance system. The facility attempted to capture variances in all steps of the medication use system. Oddly, the pharmacy department failed to report numerous prescribing errors that were clearly visible in orders reviewed by the monitoring team. Nonetheless, the facility fell short by failing to report all medication errors particularly those that related to physician prescribing errors.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The pharmacy director and clinical pharmacist reported that prospective reviews were completed for all new orders through the WORx software program. The program checked the standard parameters, including therapeutic duplication, drug interactions, and allergies. The policy Prospective Review of Medication Orders was approved on 11/17/11. It was reported during the December 2011 review, that full implementation of the policy occurred in December 2011. The goal of the prospective review was to assure the appropriateness, safety, and effectiveness of the medications used. The policy outlined the steps used to achieve this goal: 1. The pharmacist or technician entered information into the WORx software. Medication was dispensed only after the order was entered. 2. The pharmacist reviewed all orders entered by the technician. 3. The pharmacist, in conjunction with WORx, reviewed the orders for allergies, indications, contraindications, etc. 4. Any questions regarding the orders were resolved with the prescriber and a written notation of these discussions and resolution was made in the Pharmacist Review of Physician Orders and Clinical Interventions Worksheet. 5. The pharmacist contacted the prescriber for Level I and Level II drug interactions. The prescriber was provided a written monograph for Level III interactions. The monitoring team requested copies of all clinical interventions documented since the last onsite review and data were provided for February 2012 through April 2012. The clinical pharmacist reported that data collection did not start until February 2012.	Noncompliance

		Additional data were provided when the clinical pharmacist was reminded of the implementation date. The data were reviewed and discussed with the clinical pharmacist and pharmacy director. Overall, a relatively small number of interventions were documented. There were nine in January, 15 in February, three in March, and 12 in April. Most of the issues involved a lack of medication indications. The pharmacy director and clinical pharmacist did not believe that pharmacy staff had daily contact with the medical staff relative to clarification of orders. The pharmacy director dispensed medications and stated that he documented all communication with providers. Nonetheless, the clinical pharmacist noted in the self-assessment that the facility was not in substantial compliance because "we have identified five documented clinical interventions/clarifications per day as a reasonable expectation and there were 28 for the quarter January through March 2012." The monitoring team discussed order review practices with the staff pharmacist. He indicated that he contacted the medical staff once or twice a day and acknowledged that he did not document those discussions in the clinical interventions log. Copies of orders received in the pharmacy for the first seven days of the months of December 2011 through May 2012 were reviewed. There were many orders that had clarification notes made by pharmacy staff and these were not recorded in the log provided to the monitoring team. It was, therefore, obvious that the staff did not comply with the requirement to resolve questions "with the prescriber" and provide a "written notation of these discussions and resolution in the Pharmacist Review of Physician Orders and Clinical Interventions Worksheet." The following are a few examples that were not documented in the log as required: • Individual #346, 12/13/11: The wrong dose of medication was prescribed. The pharmacy documented that the dose was changed by the prescriber. • Individual #186, 12/4/11: The pharmacy documented, "Per MD dx is UTI." • Individual #241, 5/25/12: The order stated start .5 mg, but did not give a drug name. The pharmacy clarified with the prescriber. • Individual #90, 3/7/12: The pharmacy clarified the diagnosis for a medication order written. • Individual #278, 3/9/12: The pharmacy noted "New order written. Dose changed to 500 mg." • Individual #44, 3/8/12: The pharmacy clarified the diagnosis with the physician for an antibiotic order. • Individual #146, 3/8/12: The pharmacy contacted the physician to change an antibiotic order due to an allergy. Bactrim was prescribed. The physician order sheet indicated sulfa allergy. • Individual #363, 3/5/12: There was no diagnosis for medication. The pharmacy clarified the order. • Individual #148, 2/24/12: Per MD, medication is for 1st 10 days of each month. • Individual #197, 2/2/12: The pharmacy documented "Disregard allergy and fill."	

		Finally, this provision item required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The clinical pharmacist reported that some work was started in this area with the development of a list of drugs that would require monitoring at the point of dispensing. Those efforts were suspended due to ongoing work in state office related to the intelligent alerts pilot. Two sister SSLCs were chosen to pilot the use of this drug alert module which ensured that labs associated with drug use were appropriately monitored. Seven drugs were targeted for this new process. When new orders for these drugs were entered, a series of alerts related to laboratory monitoring appeared. The drugs were chosen based on the importance of laboratory monitoring due to risk, therapeutic index, etc. It appeared to be a potentially viable solution to meeting the needs of the facility. Efforts related to this were ongoing in state office and appeared to be progressing. The monitoring team recommends that the clinical pharmacist continue to work with the pharmacy services coordinator in moving forward with this provision item.	
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.	The Drug Regimen Review policy was approved on 11/17/11. It provided the framework for evaluating an individual's medication regimen retrospectively. According to policy, QDRRs were completed every 90 days and included a pharmacy review of allergies, contraindications, dose, route, duplication of therapy, interactions, and proper utilization. Following completion by the pharmacist, the Quarterly Drug Regimen Review, which included the worksheets, was forwarded to the primary providers and psychiatrists for review. The total allocated turn around time from pharmacy review to physician review was 14 days. A total of 25 QDRRs were reviewed. The QDRRs submitted to the monitoring team did not include the drug profiles. It lists the drug name, dose, route, frequency, indication, and start and stop dates. The profiles were requested during the review and were provided, however, the profiles provided listed the drugs that were administered as of 3/1/12. Therefore, the monitoring team utilized drug profiles that may have differed from the actual profiles of the individuals at the time the QDRRs were completed. The QDRRs covered the required areas. Generally, the reviews were substantially improved over those seen during the last review. This applied to content and presentation. The first page noted comments that included weights, lab values, EKGs, vision exams, etc. The second page listed recommendations and provider responses. This was followed by the worksheets. The documents were typed, neat, and did not contain the artifacts seen during the past two reviews. The recommendations generated, for the most	Noncompliance

		part, were reasonable and clinically relevant. The following are examples of the types of recommendations that were offered by the clinical pharmacist: • Obtain EKG due to diagnosis of hypertension. Schedule MOSES and DISCUS. • Complete MOSES and DISCUS due to lack of conclusion. • Consider drug reductions. • Consider MRI or neurology consult due to elevated prolactin levels. • Consider repeat DEXA scan and or use of Alendronate. • Consider eye evaluation due to quetiapine use. Notwithstanding improvement in the content of the assessments, the monitoring team identified a series of problems with the current QDRR system as well as some opportunities for improvement in the content of the actual reports. The systems issues identified included: • Current QDRRs were not found in all records included in the record sample. In fact, for the following seven individuals, the date provided was the most recent QDRR included in the record: Individual #186, 1/23/12; Individual #277, 2/3/12; Individual #188, 10/14/11; Individual #203, 1/18/12; Individual #163, 8/3/11; Individual #76, 9/26/11, Individual #168, 10/12/11 • QDRRs were requested from the pharmacy department, but were not available for two individuals upon request. Drug profiles, without QDRRs, were provided for Individual #331 and Individual #362. " No QDRR" was written on the profiles. • The QDDRs present in the records did not include drug profiles. The medical director reported that this presented a problem with physician review of the evaluations and was a problem that started at the end of 2011. The monitoring team noted the absence of the drug profiles in the records and discussed this requirement with the clinical pharmacist. It appeared that this problem coincided with the change in personnel. • There were lengthy delays between pharmacy review and the physician reviews. In fact, during the first three months of the year, the response time by the medical staff was documented as 55 days in January, 27 days in February, and 34 days in March. The medical staff had been counseled regarding this matter and timelines were being revaluated with the next set of QDRRs. The monitoring team noted similar findings with more pronounced delays noted in the sample. • The facility was not using the scheduling system required by state office. The state format required that each individual have had a schedule in place by January 2012. The format was requested several times by the monitoring team. The final request two weeks after the review produced a schedule that did not meet the requirement. Facility management will need to determine if the absence of QDDRs in the records is attributed, in part, to scheduling issues. • During interviews, the clinical pharmacist reported that the lab matrix was used as the guidelines for monitoring when completing the QDRRs. The QDRR policy	

		cited the use of the Medication Audit Criteria and Guidelines for monitoring the use of psychotropics. That attachment was not provided. • The facility should review the lab matrix to ensure that requirements are consistent with all other policies procedures and guidelines. If the facility adopts a guide for every six month eye exams, that should be included in the lab matrix. The monitoring team also believes that the value of the reviews could be improved by addressing issues related to content: • Monitoring for diabetes mellitus was inconsistent and not comprehensive. Some elements were present for some individuals, but not present for other individuals. All elements contained in the lab matrix were never included for all individuals. • Monitoring of hypertension was inconsistent. Individuals on antihypertensive medication did not always have blood pressure and heart rates listed. • The appropriateness of the frequency of laboratory monitoring could not be determined because single lab values were presented on the worksheet. • Monitoring of renal function for lithium use was done with serum creatinine only, which is not always adequate particularly in elderly individuals. • The comments section referred the reader to the worksheets where the various labs were found under different sections. Even so, lab values were usually documented by exception, with only abnormal values presented. In some cases, this was quite confusing. The monitoring team encourages the use of exact lab values and not documentation by exception. • The comments presented weights and lipids as miscellaneous items when in fact these were often linked to the monitoring of metabolic syndrome. It was difficult to understand why this was done and in almost every instance, there was no discussion by the clinical pharmacist of this. In fact, the monitoring team needed to review the drug profile to ensure with certainty that the individual received new generation antipsychotics. The comments section could have easily made a statement such as " monitoring for olanzapine/metabolic syndrome use: lipids results…HbA1c…BMP… EKG… etc." The pharmacist did not utilize all of the data to provide an overall risk assessment related to development of metabolic syndrome. Given the results of the facility's quetiapine DUE (discussed in section N7), as well as the increasing number of individuals with the diagnosis of diabetes mellitus (discussed in section N3 and section L), it might be necessary to better organize this section of the QDRR as a reminder to the medical staff of the importance of monitoring for metabolic syndrome. The following examples illustrate the issues discussed above: • Individual #10, 3/20/12: The pharmacist noted "RBC indices explained by folate and B12 levels." RBC 3.08L, MCV 102.7H, Folate 18.72H, B12 1441H. The comment is not clear. There was no documentation of an Hb or Hct. This	

		individual also had an elevated glucose of 125, but there was no HbA1c and no recommendation made to have one. This was significant because this individual received a new generation antipsychotic medication. The individual had NA checked for motoring of blood pressure and heart, but received two medications for control of hypertension. • Individual #314, 12/18/11: This individual had abnormal indices related to the CBC documented, but the Hb and Hct were not documented. There was no documentation of diabetes monitoring such as microalbumin or albumin/creatinine ratio and HbA1c for this individual with obesity and hyperlipidemia. The CMP was reported as WNL and no specific creatinine was provided.	
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 five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications were documented in the QDRRs. For each use, there was a comment related to the indication. The clinical pharmacist completed a paired t- test, which showed a reduction in the use of restraints, which was reported as statistically significant. The monitoring team would like to highlight that statistical significance does not always equate with clinical significance. Therefore, while proper data analysis is appreciated, interpretation must always be judicious. The facility had recently approved a policy on the review of chemical restraints. The pharmacist stated that this was essentially no longer relevant since the state had issued a new policy related to chemical restraint use. Comments were also found on the use of benzodiazepines, but these were usually limited to stating that the drug was used along with and the indication for use of the agent. The P&T minutes contained vey little information on benzodiazepine use. The use of PRN meds is discussed further in section J. <u>Polypharmacy</u> Polypharmacy was commented on in the QDRRs, however, these comments were very limited. The clinical pharmacist was noted to make suggestions regarding decreasing drug dosages and this was good to see. A polypharmacy committee met on a monthly basis. At each meeting, three or four individuals were discussed. Overall, the facility had problems managing data related to polypharmacy. During meetings with the pharmacy director and clinical pharmacist, they were unable to assimilate a list of meds related to polypharmacy simply stating that it was housed elsewhere. Polypharmacy is discussed further in section J.	Noncompliance

		Anticholinergic Monitoring Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk was stratified as low, medium, or high and there was documentation of how the risk was currently addressed. Generally, there were no recommendations made on how to further minimize the burden, but overall, attention was given to this issue. Monitoring Metabolic and Endocrine Risk The facility monitored individuals for the metabolic risk through the QDRRs which were completed quarterly. For the most part, it appeared that individuals had monitoring of glucose and lipids although the compliance with frequency could not be determined. The monitoring team noted that the facility's list of individuals, with the diagnosis of diabetes increased from 36 to 64 since the December 2011 review. The medical director attributed this to improved accuracy of databases. The most recent QDRRs/med profiles of those individuals were reviewed. Of the 64 individuals, 43 or 67% received at least one new generation antipsychotic medication. Most individuals appeared to have basic lab monitoring. The facility's DUE on quetiapine indicated that there were some issues related to appropriate monitoring. This is discussed further in section N7. As a general observation, the monitoring team noted in the QDRRs, for individuals who received new generation antipsychotics, there was no clear demonstration of association of drug use with monitoring of labs, weights, and eye exams when appropriate. The various monitoring parameters were scattered on various pages of the report. Labs, such as glucoses, were found in work sheets. Weights and lipids were labeled as miscellaneous items under comments. The information was rarely, if ever, pulled together to formulate a conclusion or synopsis regarding the actual risk for development of metabolic syndrome. Given the 56% increase in the number of individuals with the diagnosis of diabetes, the monitoring team recommends that the facility further review this area to ensure that drug use and monitoring for all individuals currently diagnosed with diabetes/metabolic syndrome and those at risk are appropriate. If current data were accurate, the facility's diabetes prevalence would be triple that of the general population and further scrutiny would be warranted.	
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	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. For the prospective reviews, the pharmacy department documented relatively few interactions between pharmacists and prescribers and had little evidence that changes accepted were actually completed. A sample of QDRRs submitted by the facility, in addition to QDRRs included in the record	Noncompliance

	individual's medical record a clinical justification why the recommendation is not followed.	sample were evaluated. There were 27 recommendations. Twenty-one of the recommendations were medical recommendations with some psychiatry overlap. • 8 of 21 (38%) recommendations were accepted by the PCP • 2 of 21 (10%) recommendations were rejected by the PCP • 8 of 21 (38%) recommendations were responded to with "rounds or discussion" • 3 of 21 (14%) recommendations had no response For the same sample of QDRRs, there were 11 recommendations regarding the use of psychotropic agents: • 5 of 13 (38%) recommendations were accepted by the psychiatrist • 2 of 13 (15%) recommendations were rejected by the psychiatrist • 4 of 13 (31%) recommendations were responded to with "rounds or discussion" • 2 of 13 (15%) recommendations had no response Determination of physician follow through of recommendations was difficult due to the overall limited number of QDRRs available in the records. Seven of the records reviewed did not have current QDRRs. The clinical pharmacist stated that he did not follow-up on the recommendations until the next QDRR was done. It will be important for the department to keep some data on this as the department stabilizes.	
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.	A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample was reviewed. The findings are summarized below: Thirty-three MOSES evaluations were reviewed for timeliness and completion: • 30 of 33 (91%) were signed and dated by the prescriber o 3 of 3 (100%) unsigned evaluations were found in the record samples • 25 of 33 (76%) documented no action necessary • 2 of 33 (6%) documented actions taken, such as drug changes and monitoring • 6 of 33 (18%) documented no prescriber review (blank) o 4 of 6 (67%) blank evaluations were found in the record sample o 2 of 6 (33%) blank evaluations were found in the facility's submission Thirty–three DISCUS evaluations were reviewed for timelines and completion: • 31 of 33 (94%) were signed and dated by the prescriber o 2 of 2 (100%) unsigned evaluations were found in the record samples • 22 of 33 (67%) indicated no TD • 5 of 33 (15%) indicated TD present • 6 of 33 (18%) documented no prescriber conclusion (blank) o 4 of 6 (67%) blank evaluations were found in the record sample o 2 of 6 (33%) blank evaluations were found in the facility's submission	Noncompliance

		The sample of documents submitted by the facility indicated that the medical staff reviewed the evaluations promptly, but the QDRRs often noted that the evaluations were not done or lacked a conclusion. Some documents that were included in the record sample showed delays of four to six weeks from the date of completion of the assessment to the date of physician review. This appeared to be more problematic in the first half of 2012, but in several instances, the medical staff did not date their signatures, so it could not be determined if the problem had actually improved. The MOSES evaluations for Individual #186, Individual #163, and Individual #203 were all reviewed by the physicians more than four weeks after completion. Per the state issued policy, Medical Care effective 4/19/12, the MOSES evaluation required the signature of the nurse, attending physician, and psychiatrist (if the drug was used for psychiatric purposes). The DISCUS evaluation required the signature of the nurse and psychiatrist only unless the drug monitored was considered a non-psychiatric drug. The P&T March 2012 minutes indicated the PCPs would complete the MOSES evaluations, but all documents reviewed were completed by the psychiatrists at SGSSLC. Reviews of documents, such as Annual Medical Assessments, neurology clinic notes, and integrated progress notes indicated that primary providers and neurology consultants were not utilizing information captured in these side effect rating tools when making treatment decisions. By having the psychiatrists complete both evaluations, the facility was not following state issued medical policy, which it was mandated to do. The facility must demonstrate that the evaluations are completed in a timely manner, are adequately completed, and are utilized in clinical practice. Providing adequate training to healthcare practitioners on the value, use, and requirements for completion of these tools may be helpful in achieving these goals.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The ADR policy was revised in November 2011 to include a probability scale, a severity rating scale, and critical indicators for determining the need for an intense case review. The risk probability number was included as a means of proactively identifying potential problematic ADRs for intense review. Forty-seven ADRs were reported from December 2011 to April 2012. The clinical pharmacist detected all ADRs during completion of the QDRRs. Moreover, there was no evidence that the PCP, medical director or the Pharmacy and Therapeutics Committee adequately reviewed these ADRs as required by facility policy. The ADR reporting form required the signature of the clinical pharmacist, but did not require the signature of the chair of the P&T Committee. The daily clinical meeting minutes did not record discussion of ADRs. The P&T Committee meetings were conducted in September 2011 and March 2012. The notes from the March 2012 meeting documented that the clinical pharmacist put together a quick report. There was no documentation of discussion of any particular cases, even those that were serious and resulted in hospitalization. There was no	Noncompliance

		documentation of data analysis or trending. For example, the monitoring team noted that lithium was implicated in four ADRs, some of which were serious. The P&T minutes simply stated, "as of now, our reporting is inadequate." All ADRs should have been reviewed by the medical staff, but two in particular, required a more detailed review. • Individual #76 was hospitalized with lithium toxicity and renal failure. This individual had chronic kidney disease, but continued to receive treatment with lithium. That case should have been reviewed to ensure that treatment and monitoring was consistent with current standards of care. Notes from the consulting nephrologist indicated that there was acute lithium toxicity superimposed upon chronic lithium toxicity and chronic kidney disease. • Individual #325 experienced hypoglycemia. The clinical pharmacist noted that the risk threshold was met and the case required further review. The ADR was reported on 4/18/12. The ADR log entry stated the case was referred for review at the next P&T meeting, which was scheduled for June. The facility must promptly review ADRs that meet the threshold for case analysis. As part of a risk management strategy, it is not appropriate to delay a case review for a period of two months to determine if further action is warranted. The facility policy should clarify timelines for review. A fully implemented ADR reporting and monitoring system mandates that all healthcare professionals and others with extensive contact with the individuals have the ability to recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. The clinical pharmacist reported that nursing staff had been trained. The medical staff, direct care professionals, and other staff with significant exposure to individuals did not receive training. The monitoring team highly recommends that the clinical pharmacist review the content of the training. The purpose of the training should be to educate staff on the facility's ADR system as well as the recognition and detection of adverse drug reactions. Based on the lack of reporting, the current training had not been effective. Training will need to be appropriate for the various staff targeted. The clinical pharmacist described the facility's ADR system as a "first class system." In essence, the facility developed an adequate policy that captured much of the appropriate terminology used in current literature. It was clear that the clinical pharmacist had knowledge of what needed to occur. Equally as clear was that the facility failed to move from the realm of theory into the realm of implementation by executing what was written in policy. At this point, the facility must move past procedure development and discussion and simply comply with policy and procedure. As noted above, many of the steps outlined in the ADR policy simply did not occur as outlined.	

<table>
<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>The DUE policy was approved in November 2011. The procedure captured the essential requirements of the Health Care Guidelines.

The clinical pharmacist completed a DUE on quetiapine in February 2012. The following information is a synopsis taken from the facility's DUE report. The objective of the DUE was to evaluate the proper use of quetiapine based on FDA and clinical indications, evaluate whether the appropriate monitoring was conducted, assess possible adverse reactions, events, or suspected side effects, and provide recommendations related to appropriate use, monitoring, and expected clinical outcomes. The report discussed the development of criteria for a lithium DUE, probably in error. Thirty-nine individuals received quetiapine. Individuals were included for review if there had been a QDRR conducted during the last quarter of 2011 using the new QDRR. A total of 17 individuals met this criterion for review.

The DUE was not presented in the Pharmacy and Therapeutics Committee meeting. The results provided in the DUE report are summarized in the table below:

<table>
<tr><th>Criteria</th><th>Compliance (%)</th></tr>
<tr><td>Indication</td><td>100</td></tr>
<tr><td>Dose (within the recommended daily dose)</td><td>41.2</td></tr>
<tr><td>MOSES</td><td>64</td></tr>
<tr><td>DISCUS</td><td>59</td></tr>
<tr><td>Wt/BMI</td><td>100</td></tr>
<tr><td>HbA1c</td><td>29</td></tr>
<tr><td>Eye exams (per manufacturer recommendations every six months)</td><td>0</td></tr>
</table>

Other findings reported in the DUE:
• 9 of 17 (53%) individuals had a low fasting blood sugar
• 2 of 17 (12%) individuals had a high fasting blood sugar (182 and 246)
• 2 of 17 (12%) individuals had neither a fasting blood sugar nor a HbA1c
• 3 of 17 (18%) individuals had a BMI > 30
• 6 of 17 (35%) individuals had elevated prolactin levels
• 4 of 17 (24%) individuals did not have an annual EKG
• 1 of 17 (6%) individuals did not have a lipid panel

Overall, the DUE was well written, provided good background information and good recommendations. The Pharmacy and Therapeutics Committee minutes, dated 3/21/12, lacked discussion related to the DUE. Rather, it stated that the DUE would be discussed at the "Thursday meeting," however, the monitoring team could not find documentary evidence of such a discussion. The facility's DUE policy required oversight of this process by the P&T Committee, including analysis and trending of data. In fact, the DUE policy adopted in November 2011 disbanded the DUE Committee shifting all oversight of this</td>
<td>Noncompliance</td>
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		important process to the P&T Committee. Notwithstanding performance of a very good DUE, the facility did not comply with it's own well crafted policy resulting in identification by the monitoring team of the following problems: • DUEs were not performed on a quarterly basis in accordance with the published schedule. During the December 2011 review, it was noted that DUEs were not completed for several months due to the lack of a clinical pharmacist. The locum tenens pharmacist completed an audit on the use of Keppra. A DUE report was not provided. During the December 2011 review, the monitoring team clearly indicated that the Keppra audit did not fulfill the requirements of a DUE because it lacked the essential components. This was also documented in the subsequent report. Thus, the facility had completed only one DUE since the last review. • There was no documentation that the Pharmacy and Therapeutics Committee approved the DUE calendar dated 11/17/11. • As required by policy, the DUE was not presented to the P&T Committee and there was no analysis of data by the committee. Furthermore, there was no plan of correction generated for several significant deficiencies identified in the DUE. The failure to address deficiencies was cited in previous reviews. The clinical pharmacist noted this and added a specific provision to the November 2011 policy regarding correction actions. This provision required the Pharmacy and Therapeutics Committee to develop and implement an action plan including timelines for revaluation. This was discussed during the December 2011 review and the monitoring team expected improvement in this area. An additional policy P&T Corrective Action Plan Process was developed (date unknown) that specifically addressed the need for corrective actions. While recommendations were made in response to deficiencies found in the quetiapine DUE, no clear plan of correction was outlined. • There was no documentation in the Pharmacy and Therapeutics Committee minutes of any follow-up of deficiencies noted in previous DUEs, such as those noted in the May 2011 review. Medication room audits completed in 2011 showed egregious deficits. Many rooms were cited for the lack of cleanliness, conversion tables, and poison control information. There were problems with medication refrigerator temperature logs and numerous other issues. During the December 2011 visit, the monitoring team was simply told the issues were corrected. With all of these problems identified in the past, quality metrics maintained by the pharmacy showed that no medication room audits were conducted. This would make identification of problems difficult, if not impossible. Again, the facility developed an adequate procedure for completion of DUEs, conducted a adequate DUE, but failed to execute most other aspects of the DUE system in accordance with the requirements set forth in the Health Care Guidelines. The Health Care Guidelines assigned several important roles to the Pharmacy and Therapeutics Committee. A fundamental requirement for any functional committee is to have regularly scheduled	

<table>
<tr><td></td><td></td><td>meetings. As discussed, this did not occur at SGSSLC. The importance of this requirement was discussed during the onsite review with the facility director and the medical director.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The facility continued to make some progress in this area. The reconciliation process remained in place. It started in the pharmacy, with the weekly medication exchange count. During that time, the pharmacist, and nurse counted all medications. Once the medications were placed in the homes, nurses conducted medication counts with every shift change. This process virtually eliminated the problem of medications being returned to the pharmacy with no explanation. The facility, however, did not have a process in place to reconcile all liquid and non-pill medications.

The medication data for 2011- 2012 provided to the monitoring team are summarized in the table below.

<table>
<tr><td colspan="7">Medication Variance Data 2011 - 2012</td></tr>
<tr><td>Error Type</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td></tr>
<tr><td>Omission</td><td>14</td><td>6</td><td>20</td><td>4</td><td>4</td><td>6</td></tr>
<tr><td>Wrong Time</td><td>0</td><td>1</td><td>2</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Wrong Patient</td><td>1</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Extra Dose</td><td>4</td><td>1</td><td>0</td><td>1</td><td>1</td><td>2</td></tr>
<tr><td>Dose Form</td><td>5</td><td>7</td><td>5</td><td>1</td><td>1</td><td>3</td></tr>
<tr><td>Wrong Technique</td><td>2</td><td>0</td><td>0</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Wrong Prep</td><td>2</td><td>0</td><td>2</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Wrong Route</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Prescribing</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Administration</td><td>--</td><td>13.5</td><td>28</td><td>4</td><td>3</td><td>5 5/6</td></tr>
<tr><td>Monitoring</td><td>--</td><td>0</td><td>1</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Dispensing</td><td>--</td><td>1.5</td><td>.5</td><td>2</td><td>3</td><td>2</td></tr>
<tr><td>Documentation</td><td>--</td><td>0</td><td>.5</td><td>2</td><td>2</td><td>3 5/6</td></tr>
<tr><td>Transcribing</td><td>--</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1 1/3</td></tr>
<tr><td>Total</td><td>28</td><td>16</td><td>30</td><td>8</td><td>8</td><td>13</td></tr>
</table>

During the December 2011 review, the monitoring team recommended tracking all variances that occurred within the medication use system as required by policy. The monitoring team noted during the December 2011 review that prescribing errors that were intercepted in the pharmacy were not reported. The pharmacy director explained that he captured these as “prospective review data.”

Through the review of physician orders, it was observed that there were prescribing variances that were neither captured during prospective reviews nor reported as medication variances. These involved the wrong doses of medications, the wrong forms of medications, and medications that were prescribed when allergies were clearly indicated on the physician order forms. The occurrences were not infrequent. Examples are found in section N1 and additional examples are provide below:</td><td>Noncompliance</td></tr>
</table>

		• Individual #146, 3/8/12: The pharmacy contacted the physician to change an antibiotic order due to an allergy. Bactrim prescribed. Order sheet indicated sulfa allergy. • Individual #148, 1/5/12: Ampicillin was prescribed with a documented penicillin allergy. • Individual #248, 1/31/12: HCTZ was prescribed with a clearly documented HCTZ allergy. The examples presented in this report were found in a very small sample of orders, but indicated a failure on the part of the pharmacy to report very important potential medication variances or Category A variances. Reporting such errors is very important for the purposes of risk management. These ever important "near misses" provided opportunities for education and improvement. Thus, these data should be reported, analyzed, and trended. Moreover, it should be used to implement appropriate corrective actions, training, and educational activities targeted at improving performance. Per SSLC Medication Variance Guidelines dated 1/24/12, "Category A medication variances must be documented and counted with the total medication variances, whether they are 'potential errors' in the pharmacy, with medical or with nursing." The facility did not comply with state issued policy regarding the reporting of medication variances. This provision remains in noncompliance.	

Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The pharmacist must document communication with prescribers as required by facility policy. The outcomes of the interventions should be documented.
    b. There should be clear documentation of the prescriber who is contacted and the time of contact.
    c. The pharmacy director will also need to have a process for tracking prescriber responses and making referrals to the medical director when appropriate. This would involve having some ability to track the acceptance of recommendations.
    d. The facility should work with state office to expand the drug list used as part of the intelligent alerts.
    e. The facility will need to determine how it will provide documentation that drug monitoring occurs.
    f. The pharmacy director and clinical pharmacist should ensure that the prospective reviews are appropriately connected with other pharmacy monitoring systems such as the ADR monitoring and reporting system such that a CI that identifies an ADR appropriately triggers the ADR system.

2. The facility must clarify the standard that will be used for laboratory monitoring (N2).

3. The facility should develop an operational procedure specific to completion of QDRRs that outlines the process, duties, and responsibilities for pharmacists and the medical staff. This procedure should also include the exact criteria that will be used in the QDRR. Timelines for document completion should also be provided (N2).

4. The facility must complete QDRRS every 90 days for every individual in accordance with state scheduling directives (N2).

5. The facility director should designate staff outside of the medical and pharmacy departments to investigate the many problems associated with the QDRRs such as missing QDRRs (N2).

6. The facility must consider review of diabetes data and take corrective action as warranted (N3).

7. The clinical pharmacist should follow up on the most critical recommendations before the next quarterly QDRR.

8. The facility must ensure that employees have adequate training on completion of the MOSES and DISCUS evaluations. Documentation of training and attendance should be maintained (N5).

9. The medical director must ensure that the MOSES and DISCUS evaluations are completed in accordance with state medical policy. The PCP must complete the MOSES evaluations. The evaluations should be provided to the neurologist for review (N5).

10. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
    a. The ADR policy should specify how the reporting form is completed.
    b. ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form.
    c. The facility must ensure that all medical providers, pharmacists, nurses, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained
    d. The facility should review ADRs in accordance with facility policy and procedure (N6).

11. The results of the MOSES and DISCUS evaluations should be provided to the neurology consultants. The primary care physicians should also review the data and consider documenting scores and findings in annual and quarterly assessments (N5).

12. The facility must conduct DUEs in accordance with facility policy and procedure. A new DUE must be completed each quarter (N7).

13. The clinical leaders of the facility, medical, nursing and pharmacy, must ensure that staff are reporting all medication variances, actual and potential, in accordance with state policy (N8).

14. The pharmacy director should ensure that appropriate reconciliation of all liquid medications is being completed and documentation is being maintained in a format that can be retrieved and reviewed (N8).

15. The pharmacy director should ensure that the clinical pharmacist is using the standard state quarter system (N1-N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SGSSLC client list o Admissions list o PNMT Staff list o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section)-Physical Nutritional Management o SGSSLC Policy Competency Training and Monitoring of Physical Management Plans (12/15/11) o SSLC Policy 012.2 Physical Nutritional Management (4/23/12) Draft o PNM spreadsheets submitted and summary reports o PNMT Assessment template o PNMT Weekly Summaries o PNMT Recommendations and Corrective Action Plans o Individuals with PNM Needs o PNM Monitoring tool templates o Mealtime Drill list o Program Effectiveness Tracking log o PNMP Competencies o Completed PNMP Monitoring Forms submitted o PNMP Effectiveness Monitoring forms submitted o Individual Specific Monitoring Guidelines o PNMP monitoring tool spreadsheets o NEO curriculum materials related to PNM, tests and checklists o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Chronic Respiratory Infections o Individuals with Fecal Impaction o Individuals with MBSS in the last year o Poor Oral Hygiene o Pneumonias in the Past Year o Aspiration Pneumonia

	o Individuals with Choking Incidents and related documentation o Individuals with MBS during the last year o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o Schedule of monitoring for PNMPs per risk levels o PNM Maintenance Log o Handouts from ISP meeting for Individual #18 o PNMT Assessments, Risk Assessments, Action Plans and ISPs: • Individual #59, Individual #203, Individual #188, Individual #146, Individual #90, Individual #76, Individual #128, Individual #344, Individual #288, Individual #66, and Individual #18 o APEN Evaluations: • Individual #66, Individual #278, Individual #203, Individual #109, Individual #146, Individual #90, o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (<u>not submitted</u>), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 o PNMP section in Individual Notebooks for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188,

	Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 <u>Interviews and Meetings Held</u>: o Maria DeLuna, RN o Judy Perkins, PT o Dena Johnston, OTR o Erin Bristo, MS, CCC/SLP o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o PNMT meeting o Mealtime PET meeting o ISP for Individual #188
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, data presented to illustrate elements assessed and an analysis of the findings, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. The activities for self-assessment listed for each provision were as follows: • O1: Tracking of PNMT attendance, Tracking of referrals and discharges, Analysis of referral source: PNMT (review of weekly indicators/PNMT post-hospitalization assessment) vs. IDT, Analysis of PNMT referral reasons, Analysis of PNMP plan integration into the ISP, and an O1

	analysis. • O2: At risk identification for choking and aspiration and have supports in place through PNMP and/or skill acquisition program related to risk, Risk vs. occurrence for choking and aspiration, % of those with occurrences for choking and aspiration in which the IDT met to discuss risk and action plans (ISPAs), Comprehensive PNMT assessment audit results, and an O2 analysis. • O3: PNMP essential elements compliance, Tracking of ISP attendance by professional discipline, Analyze ISP audit results regarding PNMP integration into the ISP- Section F audit, Analyze PNMP monitoring results for staff compliance for mealtime and positioning (oral care, bed, medication administration), and an O3 analysis. • O4: IDT mealtime monitoring analysis, PNMP monitoring for mealtime and positioning staff compliance, and an O4 analysis. • O5: Monthly competency/compliance-based training conducted (individual, NEO, PNM refresher), Staff training – Section O audit tool, PNMP monitoring for mealtime and positioning staff compliance, and an O5 analysis. • O6: PNMP monitoring for mealtime and positioning staff compliance, Review of identified plans of correction based on issues identified with the Universal Monitoring Tool, Tracking of results of follow-up training, mentoring, and rechecks for compliance for failed PNM compliance monitoring, and an O6 analysis. • O7: Completion of program effectiveness monitoring, Effectiveness of programs, Resolution of identified problems, and Review of correct implementation of Risk and actin plan review for those individuals who had occurrence of choking and aspiration. • O8: Section O8 audit results –Integration into the ISP, and Identification of a plan to return to oral intake when appropriate – integration into ISPA. While these were generally appropriate self-assessment activities, they were not the only ones that would be necessary to demonstrate substantial compliance in some cases and were complex elements to track effectively in others. The elements for this provision should be reviewed to simplify and clarify the relationship to the Settlement Agreement. The director, Dena Johnston, is commended for her approach to this process. She appeared to understand what was needed and presented meaningful data in a useful manner that was clear and precise using graphs with careful comparative analysis of these findings each month. However, as was reported in many cases, the sample size was too small to be a reasonable representation of status or progress for a particular element. The facility self-rated itself as in noncompliance for O1 through O8. While actions taken were definite steps in the direction of substantial compliance for this provision, the monitoring team concurred with the findings of noncompliance for these elements.

	Summary of Monitor's Assessment: There was a fully-constituted PNMT, including a full time nurse. While the team met weekly, attendance was less than adequate by all team members (dietitian and physician). A meeting observed during this review showed improvement since the last review. A referral to the PNMT (self-referral of from the IDT) indicated that there was an urgent need for specialized supports and services and, as such, the assessment process should be completed in a timely manner. These assessments should be completed in a month or less, and actions to address identified needs should be implemented throughout the assessment process. The assessments reviewed stated the reason for referral, but did not identify the date of referral, nor was this identified in the weekly summary documentation by the PNMT. Currently the facility tracked referrals versus discharges, and the referral source (all have been from the PNMT weekly reviews) to address compliance with this provision. The timeliness of the provision of assessment and the implementation of necessary supports, however, is a key element to the effective provision of services by the PNMT and should be tracked and analyzed. Since these data were not documented in the weekly meeting summaries or the assessments reviewed, this could not be assessed by the monitoring team. Some PNMT members attended ISPAs to review hospitalizations, other changes in status, and to present assessment findings. The PNMT should examine PNM issues from a system perspective in conjunction with other groups or teams in the facility to ensure there is effective trend analysis of identified issues. Key clinical indicators and health risk status should drive identification of the need for PNMT supports and services. Individuals presenting with these were reviewed and, in some cases, an assessment was completed. The documentation of routine reviews conducted by the PNMT did not consistently close the loop on identified concerns or the effectiveness of strategies implemented. An outline of criteria for referral should be developed in an attempt to address the absence of referrals. During the PNMT meeting attended by the monitoring team, members of the IDT attended for the individuals they served. However, it was noted that the setup of the room and the format of the meeting made it appear to be more of an inquisition by the PNMT rather than a collaborative review of status. This was discussed with the team at that time. Additionally, there was little participation by team members other than the nurse. This should be addressed as well as each team member should play an integral part in assessment, review, and follow-up of individual cases. These concerns were discussed extensively with the PNMT members. Continued experience with the PNMT process will likely result in further refinement. Mealtimes were observed in a number of homes. Overall, there appeared to be improvements related to the environments and implementation of the dining plans, though there were issues noted, many of which should have been identified through monitoring by PNMPCs and professional staff. Staff continued to require coaching and supports for consistency with techniques and there were some food texture issues noted. Positioning was also improved. Overall, staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. • Some staff, however, were better able to answer questions about implementation of the plans, and

	this was an improvement over previous reviews. • A small number were exceptional in their knowledge of the individuals they supported. Monitoring frequency was clearly outlined, though was not individualized by the IDT. Findings were consistently reviewed and analyzed to drive staff training and supports. The majority (100%) of the PNMP monitoring sheets submitted reported compliance (80% or greater) with implementation of the PNMP. This information should be analyzed to determine which areas scored the highest/lowest, to ensure that there is consistency with regard to frequency and activity, and to determine which items consistently scored lower across homes and facility-wide. The analysis of all monitoring results reported concerns for excessively high scores which did not correlate well with general observations by report. This issue should be addressed via training and inter-rater reliability checks for monitors.

#	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, 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	Core PNMT Membership: The current core team members of the PNMT were Maria DeLuna, RN, Judy Perkins, PT, Dena Johnston, OTR, Erin Bristo, MS, CCC/SLP, and Sally Nolen, LD, MBA. There was no physician core team member, but medical membership included Joel Bessman, MD and Kimberly Johnson, MD. Alternates were assigned for the SLP, PT and OTR positions. Each of the core team members was a full-time state employee. Only the nurse served full-time on the PNMT; each of the others had additional responsibilities. Additional participants on the team included PNMPCs, nurse case managers, QDDPs, direct support professionals, home managers, and other IST members of the individuals reviewed. The PNMT did not function independently of the IDT. An initial meeting was held with the IDT to identify risks with rationales and action plans. The PNMT functioned to support the IDT with action plans the responsibility of both the IDT and the PNMT. The PNMT Action Plan was integrated with the risk action plan. All of this was good to see. Continuing Education Continuing education was documented for each of the core members of the team in the last year and included the alternates as well. Each team member had participated in a webinar, Introduction to PNMT in August 2011 and attended PNMT training in August 2011. Additional continuing education was documented related to the following and attended by one or more team members: • Enteral Feeding Safety (4/16/12) • Enteral Feeding Tubes: A Guide for Nurses (4/23/12) • Gus Eckhardt Trauma Symposium (4/21/12) • Assessment of Technologies (8/9/11) • Introduction to GI/Dysphagia (8/10/11)	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Annual Habilitation Therapies Conference (10/13-10/14/11) • Role of the Dietitian PNMT (9/28/11) • Dementia Outside the Box Seminar (5/17/11) This level of continuing education was adequate. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Consideration of continued PNM-related continuing education opportunities for all team members, in addition to the state-sponsored conferences/webinars should be a priority. <u>Qualifications of Core Team Members</u> No resumes were submitted, so it was not possible to verify experience and qualifications other than licensure for team members, each of which was verified online. Each of the team members had been assigned to the team during previous reviews and experience with individuals with developmental disabilities had been noted at that time, though the extent of experience for Ms. Bristo was not known at this time. <u>PNMT Meeting Frequency and Membership Attendance</u> PNMT Weekly Summaries were submitted for 19 meetings held from 12/7/11 through 4/13/12. Meetings were held weekly, though weekly summaries were not submitted for meetings held after 4/13/12. Attendance during that period was: • RN: 90% • PT: 95% with alternate • OT: 90% with alternate • SLP: 100% • LD: 65% • PNMPC: 5% • MD: 50% • FNP: 35% • QDDP: 75% • RN Case Manager: 75% • Home Manager: 75% • Psychologist: 15% On average, attendance by the core team members was acceptable with the exception of the dietitian. There had been a significant lag in the availability of the dietitian and there was a newly hired contract dietitian completing NEO training at the time of this review. She attended the PNMT meeting on 6/6/12, her first. Alternates did not consistently attend meetings in the absence of the core team members for SLP, OT, or PT. Attendance by the physician was inconsistent. Attendance by the IDT members was generally consistent since 1/4/12. It is critical that all core team members participate in each	

#	Provision	Assessment of Status	Compliance
		meeting because this is key to the provision of appropriate and adequate services. Facility Documentation IPNs for the 20 individuals included in the sample of individuals selected by the monitoring team were not submitted. This negatively impacted the ability of the monitor to adequately review the facility's status with some aspects of provision O.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	PNMT Referral Process Since 12/7/11, the PNMT had reviewed 18 individuals who were identified as active cases. Four of these had received a PNMT assessment (Individual #203, Individual #59, Individual #146, and Individual #188) in the last two months. Others had received assessments prior to that time. For the 11 of those included in the sample selected by the monitoring team, 10 assessments were contained in their individual records. There was no evidence of a PNMT assessment for Individual #384 in his individual record. A referral to the PNMT (self-referral, or from the IDT) meant that there was an urgent need for specialized supports and services and, as such, the assessment process should be completed in a timely manner, that is, in a month or less. Further, actions to address identified needs should be implemented during the assessment process. This information is a key element to the effective provision of services by the PNMT and should be tracked and analyzed. Since these data were not documented in the weekly summaries or in the assessments, this could not be assessed by the monitoring team. Concerns for the timeliness of PNMT assessment included: • Individual #128 (11/16/11): Though there was evidence of involvement by the PNMT after prior health change episodes in November 2010 and August 2011, an actual assessment was not completed until 11/16/11 after hospitalization for aspiration pneumonia, acute hypoxia, and gastrostomy tube placement. • Individual #76 (12/14/11): There was a diagnosis of bacterial pneumonia on 9/26/11, though after a choking incident on 5/6/11 concerns were noted, with recommendations for a dysphagiagram, which was not completed until 12/1/11. Diet changes had resulted in significant behavioral challenges. He was again hospitalized on two occasions for fecal impaction, chronic renal failure, and bowel obstruction. He presented as a very complex case and extensive participation by the PNMT in the development and implementation of his treatment plan was indicated.	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMT Assessment and Review There were at least 22 individuals reviewed by the PNMT since 12/14/11 who were provided assessments. Ten were available for review by the monitoring team. Six had been completed since the previous onsite review. These were generally of a similar format, though the more current assessments were more thorough in content. These included an extensive review of individual risk levels at the time of the assessment and a rationale. It was not clear if these were the rationales reported by the IDT or only as reported by the PNMT. It was not clear if the information reported was based on actual observation by the PNMT members. Most of the documentation appeared to be from extensive record review. While health and medical history were necessary to gain perspective on the individual's current status, it was critical that hands-on assessment of current status be documented. Other aspects of the written report did not reflect use of the data presented. Further the documentation of routine reviews conducted by the PNMT did not close the loop on identified concerns or the effectiveness of strategies implemented. For example, in the case of Individual #203: • The PT/OT portion of the PNMT assessment report (2/3/12) used the exact same wording as her OT/PT Evaluation Update dated 8/10/10, nearly two years earlier. • The analysis of findings tended to present further objective data and/or to summarize previously reported objective data rather than a clinical analysis of all the data reported to determine the specific issues requiring supports. • The PNMT weekly summaries did not document completion of each of the recommendations included in the assessment. No integrated progress notes were submitted though requested. • There was no reference to the Head of Bed evaluation (HOBE) recommended on 2/3/12 in the weekly summary notes, until 3/16/12, over one month later. • The action plan did not include actual recommendations. The action steps instead were general care strategies. • Specific status reports on recommendations and measurable outcomes were not consistent in the documentation by the PNMT. During the PNMT meeting attended by the monitoring team, members of the IDT attended the meeting for individuals they served. However, the setup of the room and the format of the meeting made it appear to be more of an inquisition by the PNMT rather than a collaborative review of status. This was discussed with the team at that time. Additionally, there was little participation by team members other than the nurse. This should be addressed as well as each team member should play an integral part in assessment, review and follow-up of individual cases.	

#	Provision	Assessment of Status	Compliance
		Risk Assessment Health risks and the rationale were included in the PNMT assessments, but it was not clearly documented that the PNMT reviewed all risk levels to determine if they were consistent with their evaluation findings, or whether any changes to these risk levels were indicated. It was reported that this process was conducted with the IDTs, in most cases. In the case of the risk rating tools, an original tool was completed that was supposed to be reviewed on a quarterly basis, post-hospitalization, or if there was any change in status (noted for Individual #203). Risk assessment ratings for the individuals selected in the sample by the monitoring team were requested. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, there was no rationale provided for a particular rating and ratings were often inconsistent with clinical indicators. Some examples included: • Individual #17 was identified at medium risk for skin integrity, but was reported to have a Stage II pressure ulcer, lower extremity edema, and poor nutrition. • Individual #384 was identified at medium risk for cardiac disease yet was listed with mitral valve prolapse, took medication for hypertension, and smoked. • Individual #7 was at a medium risk for fractures because she had not had any in the last three years. However, she had osteoporosis and was at high risk for falls. • Individual #238 was identified at low risk for diabetes because he did not have diabetes. There was no report of family history, and he was overweight, hypertensive, and had hypertriglyceridemia. The action plans associated with the risk rating tools generally listed only routine care and protocols for the risk concerns identified rather than unique and/or appropriately more aggressive interventions to address the identified risks. Referrals to the PNMT were not made appropriately by the IDT. As all PNMT members, except the RN, were also IDT members for the individuals served at SGSSLC, a number of referrals to the PNMT could be generated by them as IDT members during participation ISP and ISPA meetings.	
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	PNMP Format and Content It was reported that at least 200 individuals living at SGSSLC had identified PNM needs and were provided PNMPs. Comments below relate only to the 20 PNMPs submitted for the individuals in the sample as selected by the monitoring team and for whom individual records were submitted. Improvements in the format and content were noted. Improvement in the implementation of the plans was observed. • PNMPs for 20 of 20 individuals in the sample (100%) were current within the last 12 months. In four cases (Individual #238, Individual #384, Individual #104, and Individual #7), however, the PNMP in the individual record and the one in the	Noncompliance

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	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.	Individual Notebook were not the same. • PNMPs for 18 of 20 individuals in the sample (90%) were of the same format and consistent with the most current state-established format that included risk levels, triggers and outcomes. • PNMPs for 18 of 20 individuals in the sample (90%) included a list of risk areas, but did not specify the actual risk level as high, medium, or low. Each of those listing the risk areas also provided a brief rationale. • In 9 of 20 PNMPs (45%), photographs of positioning and/or adaptive equipment were included. The photographs were generally large and easy to see, particularly the color versions. A few had been distorted when added to the plans (Individual #90 and Individual #66), but in general were an improvement over previous reviews. It appeared that some individuals without pictures should have had them (e.g., Individual #146, Individual #17, Individual #18, Individual #7.) • In 20 of 20 PNMPs (100%), positioning was addressed. • In 9 of 9 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though generally minimal. • In 20 of 20 PNMPs (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 20 of 20 PNMPs (100%), the PNMP had a distinct heading for bathing instructions. • In 0 of 20 (0%) of the PNMPs, toileting instructions were provided. • In 15 of 20 (75%) of the PNMPs, handling precautions or handling instructions were provided for individuals who were described as requiring assistance with mobility or repositioning or the individual was listed as independent. • In 20 of 20 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • There were 7 of 20 individuals (35%) who had feeding tubes. There were no specific instructions for nothing by mouth. • In 19 of 20 PNMPs (95%), dining position for meals or enteral nutrition was provided via photographs. These were provided in the Dining Plans for most individuals rather than the PNMPs. Positioning plans were included for six individuals who were seated in wheelchairs and received enteral nutrition (Individual #128, Individual #98, Individual #26, Individual #66, Individual #203, and Individual #90). No pictures for the dining position were provided for Individual #295. Individual #203 was enterally nourished yet she also had a Dining Plan for oral intake in her record dated 1/12/10. • 10 of 13 individuals who ate orally (77%) had Dining Plans current within the last 12 months contained in the individual record or book.	

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		• In 13 of 13 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 13 of 13 PNMPs for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 13 of the 13 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section. • In 19 of 20 PNMPs (95%), a heading for medication administration was included in the plan. • In 18 of 20 PNMPs (90%), a heading for oral hygiene was included in the plan. • 18 of 20 PNMPs (90%) included information related to communication. This was absent for Individual #288. In the case of Individual #238, the PNMP stated only that he could communicate his wants and needs, but it did not indicate how he did so. Specifics regarding expressive communication or strategies that staff could use were limited. Others did not include AAC used by the individual for communication. There were 19 ISPs submitted for the 20 individuals included in the sample selected by the monitoring team. Only 15 of those were current within the last 12 months. ISP meeting attendance by the following team members was as follows for the current ISPs included in the sample for whom signature sheets were present in the individual record (also see section F above): • Medical: 13% • Psychiatry: 13% • Nursing: 100% • LD: 13% • Physical Therapy: 47% • Communication: 13% • Occupational Therapy: 20% • PNMPC: 0% • Psychology: 893% It would not be possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs could not be reviewed and revised in a comprehensive manner by the IDTs. The Physical Nutritional Management Plan was referenced in 10 of the 14 current ISPs. The sections varied as well as the content. Actual review of the PNMP by the IDT was not	

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		evident. In some cases, specific strategies were included. In others, it was mentioned only that the individual had a PNMP. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's ISP as a result. The QDDPs continued to require greater guidance as to consistent strategies to incorporate PNMP information into the IDT discussion and the ISP document and action steps.	
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.	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input would be limited. There was limited evidence of ISPAs for required changes in the PNMPs. Unfortunately, these documents were not readily available to all staff, rather only the annual ISP document was included in the individual notebooks, thereby, creating a potential gap in information for direct support staff. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve IDT involvement in the development of the plans. Dining Plans were available in the dining areas. 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. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. 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 NEO and in individual-specific training provided by the therapists and PNMPCs. <u>Observations</u> There was clear improvement related to mealtimes in the homes observed by the monitoring team. Observations are presented below: • Individual #165: Staff placed his plate of food in front of him and instructed him to wait. His Dining Plan indicated that he should take one small sip at a time, but he was permitted to drink quickly without intervention. His plan indicated that he should receive hand over hand prompts, but these were not provided by staff. • Individual #150: He was assisted by staff to eat, but his Dining Plans stated that he should be prompted to slow down and take small bites. It was of concern that this had not been noticed during monitoring by the PNMPCs. • Individual #389: His Dining Plan instructed that staff may need to place their hand on his to slow him down. Staff only provided verbal prompts and did not appear to be aware of the need for physical prompts.	Noncompliance

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		• Individual #379: His plan referenced a SAP for safe eating, but no training strategies were available during the meal. • Individual #294: Staff moved his plate away to stop fast eating behavior and staff were standing rather than being seated to provided assistance. The majority of staff struggled to verbalize the rationale for the strategies and to answer questions related to individual health risks, though those staff who did answer the questions did so confidently and accurately. In one case, a PNMPC was observed conducting a skills drill with a staff person who did an excellent job assisting the individual, but she struggled with the questions related to why the program was in place. The PNMPC offered leading questions to assist the staff and, as such, the interview was not adequate to assess knowledge and competence. It had been recently determined that the previous questions asked of staff were rote and practiced and did not reflect assimilated knowledge related to their role in the provision of PNM supports and services. The questions were changed, yet the PNMPCs will require significant training to make this change effective. <u>Choking/Aspiration Events</u> One individual had a choking event since the last onsite review that required the Heimlich (Individual #104, 12/20/11). There was no evidence of review by the PNMT on 12/21/11 during the PNMT meeting. Instead his case was discussed on 12/28/11 and he listed as an active case for assessment. It was noted that this had been the third incident since April 2011. There was no evidence that he had been assessed by the PNMT following this or any other incidents. It would be expected that the PNMT would review <u>any</u> choking event and conduct an assessment for an individual, particularly with repeated incidents. Additional documentation also indicated that there were at least 18 events involving excessive coughing, near choking, or swallow with struggle events reported since 11/4/11. There was an entry stating that the Heimlich was used for Individual #34 on 4/28/12, but no supporting documentation was submitted.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed	<u>New Employee Orientation</u> There were approximately 24 hours allotted to PNM related training topics (listed as mobility, lifting, and diet management) and taught by Habilitation Therapy staff. Training materials were submitted for the PNM training for NEO. This training was divided into four sections, including Physical, Nutritional, Management, and Plan. In addition, there was a section for dysphagia. The content of this course was not modified since the previous review. Copies of the PowerPoint slides were submitted and this	Noncompliance

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	competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	appeared to be comprehensive with functional information provided to staff: Skills Drills for Positioning, Off Home supports, Mealtime, AAC, and Lifting and Transfers (Stand Pivot, Sara Lift and Mechanical). Foundational training included the following: • Risk guidelines • Aspiration pneumonia • PNMP philosophy, content and policies • Techniques and equipment • Lifting and transfers • Positioning • Dining/eating/oral intake • Communication • Monitoring procedures The slides in all portions of PNM-related NEO were well-supported with pictures designed to enhance direct support staff learning. Training records documenting successful completion of all foundational training and competencies was maintained by the Competency Training and Development department at SGSSLC. It could not be determined from the materials submitted, however, if there were sufficient opportunities for active participation and practice of the skills necessary for appropriate implementation of PNMPs. Shadowing was assigned after completion of the NEO classes and staff received home-specific/individual specific training (up to four hours per employee) conducted by the PNMPCs with up to 15 days to complete this in the following homes: 509B, 508A, 510A, 512A, 511A East and 511A West and 516East and West. These homes were residences for individuals with more complex PNM needs. For other homes, the PNMPCs reviewed the PNMPs, but did not provide increased training beyond that provided in NEO. Each employee was provided a "toolkit" that consisted of cards outlining key information for each area for which training was provided. Each employee was also expected to sign an acknowledgement that they had been trained to implement the PNMP as written 24 hours a day, seven days a week. Check-offs were completed in each area (Skills Drills for Positioning, Off Home supports, Mealtime, AAC, Lifting and Transfers), permitting up to 30 days to establish this. This was repeated until the staff achieved competency or an action plan was developed by the Home Manager to address training issues. No staff was permitted to assist individuals alone until competency was demonstrated. A Home Reference Guide had been developed and distributed for new employees. Compliance monitoring then continued and in the case that a DSP had two noncompliant skill drills in one six month period, he or she would be	

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		referred back to the Competency Training and Development department to re-establish competency through additional lectures, practice, and check-offs. Annual retraining included lifting and transfers only. An iLearn class related to aspiration was also provided annually to staff. <u>Individual-Specific PNMP Training</u> Individual-specific inservice training for PNMPCs and the direct support professionals was provided by the professional staff upon the introduction of a new PNMP or if there were major changes made to the plan (non-foundational as taught in NEO). If further staff training was required, the therapists established competency of the PNMPC, home supervisors, and/or nurse case manager, who then in turn completed cascade training for the additional staff. There was a plan to add train-the trainer content to NEO for staff hired as home managers and also for existing home managers. This had been a focus of training for PNMPCs as well. Skills drills were attached to the inservice training sheet to document return demonstration of the necessary skills. Ongoing compliance monitoring was tracked by individual name rather than staff name so it was not known if all staff were drilled or with what frequency. It was policy that staff were not to work with an individual at high risk until they had been trained and checked off. Per the monitoring results, it was common for staff to report that they had not been trained to implement an individual's PNMP. Pulled staff were required to review all aspects of the PNMP and sign the PNMP Supports Review Validation form. Pulled staff were required to obtain needed training and clarification from supervisors and/or Therapy Services as necessary. It was of concern that training for pulled staff relied on them merely reading the plans and being expected to ask questions. It was not clear if these staff could be assigned to an individual with high risk health concerns.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Monitoring Staff Competency and Compliance</u> Monitoring of staff competency and compliance was documented on a Universal Compliance Monitoring form. Frequency of this monitoring, conducted largely by the PNMPCs, was reported to be based on risk levels established by the IDT. The Risk Action Plans, however, were not well developed by the IDTs and did not generally address the frequency of monitoring. The Habilitation Therapies assessments did not individualize recommendations for monitoring that differed significantly from that scheduled. Data were entered into a spreadsheet maintained by Habilitation Therapies. Individuals at high risk in an area were monitored by the PNMPCs at a prescribed frequency. Risk areas and specific supports drove the occurrence of monitoring.	Noncompliance

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		Additional risk areas were to be added in the near future for individual-specific monitoring and included: • Respiratory compromise • Gastrointestinal concerns • Challenging behavior • Osteoporosis • Fractures Specific and related skills drills were scheduled for completion either monthly or quarterly dependent on the level of risk by the PNMPCs. Individualization of this schedule was not noted in the assessments or IDT Action Plans as yet. There was a database related to monitoring and findings, with consistent review and analysis. Many of these were identified as essential elements used for the self-assessment related to Section s O, P, and R as well as to drive corrective actions and training needs. Monitoring findings based on the completed forms submitted for March 2012 (62) were as follows: • 100% (51) • 90% (6) • 80% (5) The majority (100%) of the PNMP monitoring sheets submitted reported compliance (80% or greater) with implementation of the PNMP. This information should be analyzed to determine which areas scored the highest/lowest, to ensure that there is consistency with regard to frequency and activity, and to determine which items consistently scored lower across homes and facility-wide. The analysis of all monitoring results reported concerns for excessively high scores which did not correlate well with general observations by report. This issue should be addressed via training and inter-rater reliability checks for monitors.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Individual-Specific Monitoring:</u> The current monitoring system for implementation compliance and staff competency was to be based on individual risk levels. Individuals at high risk were to be monitored monthly to ensure that staff were in compliance with PNMP implementation. Individuals with medium risks were monitored quarterly. Member of the IDT also conducted scheduled compliance monitoring for mealtimes. This type of monitoring focused on staff performance, but was tracked per individual rather than by staff. This was different than monitoring that focused on the individual's health status and the impact of supports and services on health, function and risk levels. There was a need for greater focus on	Noncompliance

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		individual status monitoring and review of triggers, in addition to compliance monitoring. The potential links between the two should be identified via routine trend analysis. The Mealtime PET met routinely to review the findings and trends related to mealtime monitoring. The original Performance Improvement Team had been converted to a Performance Evaluation Team. Data obtained from this team's actions were reported to the QI Council. A meeting was observed by the monitoring team and excellent discussion was noted by some team members, though not all appeared to participate or contribute. They were attempting to review the frequency of monitoring to ensure that it was meaningful and useful. PNMPs were revised as needed throughout the ISP year. Review of the plans occurred during annual assessments and routine quarterly reviews by the clinicians. Changes were not consistently documented via an ISPA or even in the IPNs. The ISP process continued to undergo changes and it is hoped that this will be addressed via implementation of those modifications. The monitoring team looks forward to seeing improvements with this. <u>Effectiveness Monitoring:</u> As described above, effectiveness monitoring of the PNMPs was conducted at least quarterly in the PNM Clinic as well as using the Universal PNMP Monitoring Form. These forms were not a part of the individual record, so this information remained separate. Consideration for how this could be addressed was indicated. Equipment and supports were reviewed for implementation, but often stopped short of actually assessing or analyzing the impact on function, health, or risk levels. In most cases, the effectiveness of interventions and supports were not specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. Findings and recommendations were tracked and the therapist was to meet with the IDT as indicated by the monitoring results. <u>Validation of Monitoring by PNMPCs:</u> Inter-rater reliability observations of the PNMPCs for skills drills were accomplished by the supervisor within three months of initial hire. This was repeated at least annually or as indicated by performance. Annual review was not likely sufficient for paraprofessional staff and should be ongoing. Also, there were a number of issues noted by the monitoring team that should have been identified by PNMPCs during their monitoring, such as errors or omissions in the Dining Plans and/or PNMPs. Routine validation should be conducted by professional staff with the PNMPCs at regular intervals to ensure consistency and continued competence/compliance.	

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		Trend Analysis: Information gathered from the various types of monitoring was entered into a database with monthly analysis and reporting by the Director of Habilitation Therapies. Trends or concerns identified were addressed via corrective action plans within the department and collaboratively with other departments if determined to be more systemic in nature.	
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.	Individuals Who Received Enteral Nutrition There were nine individuals listed who received enteral nutrition. None were listed as having received new tube placements since the previous onsite review and only two had been placed in the last year. Only one individual who received enteral nutrition was also listed with poor oral hygiene (Individual #90). The list submitted that identified individuals with pneumonia in the last 12 months included 21 incidences for 19 individuals since 4/18/11. Individual #278 and Individual #78 were each listed with two incidences. Those listed with aspiration pneumonia included Individual #128, Individual #146, and Individual #59. Of these individuals, each had received an assessment completed by the PNMT. There were 17 cases of bacterial pneumonia that should not necessarily be ruled out as aspiration as at least three were enterally nourished. Three others were listed at high risk for aspiration, bowel obstruction, and/or gastrointestinal concerns. At least 10 others were identified as at medium risk for these same issues that could result in aspiration. APEN Assessments A sample of APEN assessments was requested for at least 10 individuals for whom these were completed since the previous review. Only seven were submitted. Each of these assessments had been completed in early 2011 and the assessment for Individual #146 was undated. Per the policy, each individual who received enteral nutrition and each individual who was diagnosed with aspiration pneumonia should receive one of these assessments completed by the IDT on an annual basis. Six of these individuals received enteral nutrition. Only Individual #146 was listed with aspiration pneumonia. Both Individual #128 and Individual #59 were diagnosed with aspiration pneumonia and Individual #128 also had a gastrostomy tube. Each of these individuals should have received a current APEN assessment in 2012. Measurable outcomes were outlined in only three of the assessments and, in some cases, an Action Plan was attached or integrated into the report. There was no analysis of all clinical findings. The initial rationale for enteral eating was identified early in the report, but there was no evidence that all clinical information was reviewed to determine if enteral nutrition continued to be appropriate and medically necessary at the time of the assessment.	Noncompliance

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		PNMPs All individuals who received enteral nutrition in the selected sample had been provided a PNMP that included the same elements as described above.	

Recommendations:

1. Ensure that there is appropriate and timely follow-up for all identified issues for individuals reviewed by the PNMT. Ensure that documentation reflects this (O2).

2. Access the existing data system for risk, and occurrence of key clinical indicators and/or diagnoses to drive better identification of a need for PNMT review. This should effectively impact the referrals from the IDT as well as for self-referral (O2).

3. Consider establishing guidelines for the IDTs regarding referral to the PNMT with training for teams (O2)

4. Consider reorganizing the PNMT meeting format to better facilitate IDT participation as well as participation by all PNMT members (O2).

5. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2 and O7).

6. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O3-O6).

7. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. Frequency of monitoring should be addressed in the action plans (O2, O6, O7).

8. Inter-rater reliability checks for PNMPs and other IDT members who conduct monitoring may need to occur more frequently (O7).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SGSSLC client list o Admissions list o Budgeted, Filled, and Unfilled Positions list, Section I o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o SGSSLC Policy Competency Training and Monitoring of Physical Management Plans (12/15/11) o SSLC Policy 012.2 Physical Nutritional Management (4/23/12) Draft o OT/PT spreadsheets submitted o Individuals receiving direct OT/PT o OT/PT Comprehensive Assessment template and guidelines o OT/PT Assessment of Current Status template (Draft 3/15/12) o OT/PT Assessment Tracking Log (5/8/12) o OT/PT spreadsheets submitted and summary reports o Individuals with PNM Needs o PNM Monitoring tool templates o Mealtime Drill list o Program Effectiveness Tracking log o PNMP Competencies o Completed PNMP Monitoring Forms submitted o PNMP Effectiveness Monitoring forms submitted o Individual Specific Monitoring Guidelines o PNMP monitoring tool spreadsheets o NEO curriculum materials related to PNM, tests and checklists o List of PNMP monitoring completed in the last quarter o List of hospitalizations/ER visits/Infirmary Admissions o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Chronic Respiratory Infections o Individuals with Fecal Impaction o Individuals with MBSS in the last year o Poor Oral Hygiene

	o Pneumonias in the Past Year o Aspiration Pneumonia o Individuals with Choking Incidents and related documentation o Individuals with MBS during the last year o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthotic Devices o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o PNM Maintenance Log o Handouts from ISP meeting for Individual #188 o OT/PT Assessments: • Individual #24, Individual #280, Individual #37, Individual #362, and Individual #8 o OT/PT Assessments and ISPs: o Individual #7, Individual #18, Individual #90, Individual #66, Individual #384, Individual #44, Individual #318, Individual #153, Individual #346, Individual #109, and Individual #127, Individual #273, Individual #345, Individual #201, and Individual #369 o PT/PT Assessments, ISPs, ISPAs, SAPs, plans and other documentation for the following: o Individual #26, Individual #78, Individual #318 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (not submitted), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, and Nutrition tab, for the following: o Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26

	o PNMP section in Individual Notebooks for the following: o Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: o Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR o Judy Perkins, PT o Cindy Bolen, PT o Charis Worden, OTR o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs o Wheelchair clinic o ISP for Individual #188
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, data presented to illustrate elements assessed, and an analysis of the findings, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. The activities for self-assessment listed for each provision were as follows: • P1: New admission assessments; Assigned monthly Comprehensive Assessments, new admission assessments, and assessment updates; OT/PT assessment compliance scores; Comprehensive

	Assessment progression; and a P1 analysis. • P2: PNMP essential element compliance; OT/PT plan integration and review; and a P2 analysis. • P3: Completed monitoring of assigned staff compliance skill drills; Staff compliance in implementation of PNM interventions/supports; and a P3 analysis. • P4: Completion of program effectiveness monitoring; Effectiveness of programs; Resolution of identified problems; and a P4 analysis. The director, Dena Johnston, is commended for her approach to this process. She appeared to understand what was needed and presented meaningful data in a useful manner that was clear and precise, using graphs with careful comparative analysis of these findings each month. That information was used to guide actions for subsequent months. Even so, while these were appropriate self-assessment activities, they were not the only activities that would be necessary to self-assess substantial compliance in some cases. The monitoring team discussed approaches to self-assessment with Ms. Johnston and it is hoped that this provided a clear direction for the future. This report should also provide some insight into additional measures for self-assessment of compliance with this provision. The facility self-rated itself as in substantial compliance for P1 and non-compliant with P2 through P4. The monitoring team concurred with these findings. Below, details regarding the self-assessment for P1 are provided because they demonstrate a good self-assessment process (measures and outcomes). • All individuals newly admitted must receive a Comprehensive Assessment or a Rehabilitation screen for services completed with documentation five days prior to the ISP. o 100% of new admission assessments were completed within the required timeframe from November 2011 through April 2012. • All assigned monthly Comprehensive Assessments must be completed 10 days prior to the ISP. o 100% of all assigned assessments were completed for April 2012, but 50% of these were not completed 10 days prior to the ISP. Staffing was cited as the overriding barrier to achieving this outcome. • Total assessment completion percentage. If an assessment was not completed prior to the ISP, it was expected that it would be completed prior to the next reporting period. o 100% of all delinquent assessments for January, February and March were completed. This was a result of targeted corrective actions developed based on analysis of elemental data. • Tracking of delinquent assessments must show that past due reports were being completed and not more than two months delinquent. o Overall assessment compliance scores since October 2011 were: 57%, 71%, 84%, 81%, 87%, 91%, and 81%, demonstrating a steady increase until April 2012. The decrease in the April scores were attributed to the use of a newly revised audit tool with additional required elements related to risk. • OT/PT Assessment compliance scores were expected to be 80% or greater.

	o While overall compliance scores remained above 80%, some very key elements scored quite low. Because the audit tool elements were not weighted and all were of equal value, it was possible to score very low on some very essential elements, yet still achieve an overall compliance score of over 80%. This was addressed, however, as every element was analyzed individually and those that were low were targeted for special review and training with the clinicians. • Comprehensive Assessment progression with the Master Plan was expected monthly. Any percentage of increase was acceptable. These findings were reported by the director on a monthly basis. Corrective strategies were in place to consistently address issues, though staffing continued to be the primary barrier. Based on this audit system, the facility's own compliance findings validated by the monitoring team, and review of the other assessments completed by the therapists, the monitoring team found this provision to be in substantial compliance. While actions taken were definite steps in the direction of substantial compliance for P2 through P4, the monitoring team concurred with the self-ratings of noncompliance.
	Summary of Monitor's Assessment: Progress continued to be made and substantial compliance was achieved in provision P1. The level of staffing for OT and PT clinicians remained consistent at the time of this review, though low for the number of individuals with identified needs. 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 (e.g., wheelchairs), and to review other supports and services. Assessments were reviewed and consistency for content was improved since the last review. Audits were completed by the department director for assessments completed by clinicians to establish competency for each. The reviewed assessment was to be corrected by the therapist prior to submitting to the IDT. Initially every assessment was audited until the therapist achieved 80% compliance, then one assessment was audited monthly. The clinician was expected to maintain the 80% compliance level. If compliance dropped below 80%, the process was initiated again until 80% was re-established. The findings for five audits were submitted for review completed in February 2012 and March 2012. The monitoring team concurred with the findings for these audits and the compliance scores ranged from 75% to 94%, averaging 84% and reflected a significant and consistent improvement in the quality of the assessments completed by the clinicians. There continued to be a very small number of individuals participating in direct PT and OT. Documentation was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process. The department continued to need to move forward to the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also

	address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine. The director tracked specific elements related to section P and reported on each of these elements on a monthly basis. Corrective strategies were in place to consistently address issues though staffing continued to be reported as the primary barrier.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	SGSSLC made continued progress and achieved substantial compliance with this provision. The facility and staff will need to continue to address the items detailed in this report in order to maintain this rating, however, their hard work was evident to the monitoring team during this review. <u>Current Staffing</u> Dena Johnston, OTR, continued to serve as the Habilitation Therapies Department Director. OT/PT staffing was consistent with that during the previous review. Physical therapists included Judy Perkins, PT, and Cindy Bolen, PT. The OT was Charis Worden, OTR. Each was a full time state employee. There were no therapy assistants employed at the time of this review. There were two vacant positions for occupational therapists and one for a therapy assistant, though any of these positions could be filled by either discipline. Each of these staff held licenses to practice in the State of Texas and were verified as current by the monitoring team. There were no therapy technician positions. There were seven PNMPCs with one supervisor, with all positions filled at the time of this review. The census at SGSSLC was 233 individuals. The two PTs shared caseload responsibilities and Judy Perkins, PT, participated on the PNMT. Ms. Worden was the only OT providing services, though it was reported that the director assisted when possible. Ms. Johnston also served on the PNMT. The data reported in the documentation submitted was inaccurate, reporting that there were two OTs and one PT, with one unfilled position for each. As such, the ratios reported were also incorrect. The actual ratio was 1:116.5 for PT and 1:233 for OT based on the actual census. There were 201 individuals with identified PNM needs and the ratio on that basis was 1:201 for OT and 1:100.5 for PT, also too high for the provision of effective supports and services. <u>Continuing Education</u> All of the clinicians reported participation in continuing education during the last year. Topic areas included: • State-sponsored Webinars related to PNMT, Assessment of Technologies, Dysphagia, and Role of the Dietitian in PNMT (August and September 2011) • DADS Annual Habilitation Therapies Conference (October 2011)	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Restraint Alternatives and Fall Prevention (July 2011) • Dementia (May 2011) • Functional Strength Training for the Aging Spine (August 2011) • Medication Management of the Older Adult, Dementia and Stress Reduction (June 2011) • Food Addictions, Overeating and Mood Swings (January 2012) Only one of these occurred in the last six months. Even so, the facility is to be commended for its support of annual educational opportunities for clinicians beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year. <u>New Admissions</u> Eight individuals were admitted to the facility since the last onsite review. Samples of new admission assessments (no more than five) were submitted as requested (Individual #37, Individual #8, Individual #362, Individual #24, and Individual #280). Each of the assessments for individuals newly admitted was completed within 30 days of admission. Individual #43 and Individual #52 were listed as admitted, though per the OT/PT Assessment Tracking Log there was no evidence that assessments were completed for either of them. <u>OT/PT Assessments</u> Per the "Assessment Protocol for Competency for Development/Documentation Skills," dated 4/10/12, assessments were to be completed up to 60 days prior to the ISP, though a minimum deadline was not established. Therapists were to use the established format and written assessments were to be completed within 10 days of conducting the assessment. Rehabilitation Therapies Comprehensive Evaluation and OT/PT Evaluation Update formats were submitted, as well as the Occupational Therapy/Physical Therapy Comprehensive Evaluation (draft dated 2/27/12) and Occupational Therapy/Physical Therapy Assessment of Current Status (draft dated 3/15/12) formats. The latter two formats were assessments proposed by the state for use by facilities and replacing the former two versions. These included instructional guidelines for completion with written cues for the clinicians to guide content for consistency. The instructions with the Comprehensive Evaluation template indicated that it should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. Assessment findings were to reflect how conditions and clinical data affect the individual's function and guide provision of supports. Historical data and information gleaned from record review were to be pertinent to the assessment and provide an analysis of relevance	

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		to clinical findings and recommendations. Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. Recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the monitoring team because <u>all</u> aspects of supports and services should be included in the ISP. The comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content areas of each of these were extensive and comprehensive in nature. The minimal standards established by the monitoring team included the following: • Signed and dated by the clinician upon completion of the written report • Dated as completed 10 days prior to the annual ISP • Diagnoses and relevance to functional status • Individual preferences, strengths, interests, likes, and dislikes • Medical history and relevance to functional status • Health status over the last year • Medications and potential side effects relevant to functional status • Documentation of how the individual's risk levels impact their performance of functional skills • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) • Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Discussion of the expansion of the individual's current abilities • Discussion of the individual's potential to develop new functional skills • Comparative analysis of health and impact on functional status over the last year • Comparative analysis of current functional motor and activities of daily living skills with previous assessments • Identify need for direct or indirect OT and/or PT services • Reassessment schedule	

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		• Monitoring schedule • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs • Factors for community placement • Recommendations for services and supports in the community • Manner in which strategies, interventions, and programs should be utilized throughout the day. While most of the elements listed above were addressed by the new proposed assessment formats, the clinicians should consider each of these as specific content in the proposed headings to ensure assessments were comprehensive as required by the Settlement Agreement. Additional prompts or cues in the form of guiding questions may be helpful to ensure that key elements are addressed in each assessment. The five most current assessments for each clinician (15), five new admission assessments (5), and the OT/PT assessments for the 20 individuals in the sample selected by the monitoring team were requested for review. ISPs were also requested and submitted. Though 49 assessments were submitted, six were duplicated in multiple requests and 14 others were not current within the last 12 months. There were 30 unique assessments submitted, and included 24 Rehabilitation Therapy Comprehensive Evaluations, one Rehabilitation Therapy Assessment, and five updates. ISPs were submitted for 11 of those. All were expired at the time of the onsite review and six of those would have been expired also at the time of the monitoring team's original request for documents. An update was for individuals who had been provided supports and services during the last year. It should review and update a previous comprehensive assessment in order to identify the individual's current year status, identify changes since the previous comprehensive assessment or update, and modify or continue supports and services. Without an adequate comprehensive or baseline assessment, the update was unacceptable. Five of the six updates reviewed referenced the previous comprehensive assessment. Two individuals appeared to have been provided an update prior to the one submitted for this review (Individual #288 and Individual #295), though three of the others appeared to require ongoing PNM supports and services (Individual #26, Individual #76, and Individual #17) and likely should have received an update. Individual #188 did not appear to require PNM services beyond addressing her choking risk. However, in December 2011, she had a major psychiatric episode, with a significant change in her functional status which should have warranted a comprehensive assessment or, minimally, an update. The total number of assessments reviewed was 30. Comments are below:	

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		• 80% (24/30) were identified as comprehensive assessments. The evaluations varied in format and content, though those since October 2011 were generally of the current assessment template. The assessment for Individual #344, dated 9/1/11, did not include a discussion of his risk levels. • 17% (4/30) were identified as updates. The updates were generally consistent in format and content with the exception of that provided for Individual #188, dated 6/8/11, which did not include a discussion of her risk levels. • One assessment was identified as a Rehabilitation Assessment for Individual #344 dated 9/1/11. This was of a similar format to the Comprehensive Assessments, but did not include a discussion of his risk levels. • 80% (4/5) evaluation updates identified the date of the previous assessment(s). • 100% (30/30) were signed copies of the original, though only five had dated signatures. The date of the assessment was consistently identified in the heading, but it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP. • 77% (23/30) of the assessments were dated as completed prior to the annual ISP meeting, though four were completed less than one week prior to the ISP (Individual #369, Individual #201, Individual #188, and Individual #318). Assessments for Individual #344, Individual #295, Individual #26, Individual #210, Individual #18, Individual #44, and Individual #90 were completed <u>after</u> their ISPs. Three were completed more than 60 days prior to the annual ISP, and would require an ISPA to integrate the findings and recommendations into the ISP and an update at the time of the new annual ISP. • 93% (28/30) included a section that reported only some health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports, but inconsistently for recommendations related to changes in the existing risk levels. • 97% (29/30) included an analysis section, most of which provided a sufficient rationale for the interventions and supports recommended. • 97% (29/30) included a monitoring schedule. In some cases the frequency of PNMP monitoring was not identified. The level of health risk was generally used to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP. • 97% (29/30) included a re-assessment schedule. • 93% (28/30) included factors to consider for placement in a community setting. The content for this element varied across assessments. • For the ISPs: o 73% (19/26) of the ISPs submitted were current within the last 12 months. ISPs were not requested for the new admission assessments. o 12% (3/26) of the current ISPs with signature pages submitted were	

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		attended by OT only. No PTs attended these meetings. o 42% (11/26) of the current ISPs with signature pages submitted were attended by PT only. No OTs attended these meetings. Audits were completed by the department director for assessments completed by clinicians to establish competency for each. The assessment reviewed was to be corrected by the therapist prior to submitting to the IDT. Initially, every assessment was audited until the therapist achieved 80% compliance, then one assessment was audited monthly. The clinician was expected to maintain the 80% compliance level. If compliance dropped below 80%, the process was initiated again until 80% was re-established. The findings for five audits were submitted for reviews completed in February 2012 and March 2012. The monitoring team concurred with the findings for these audits and the compliance scores ranged from 75% to 94%, averaging 84%. It was noted that those that fell below 80% were edited to address the elements with a negative finding on the audit tool. These scores reflected a significant and consistent improvement in the quality of the assessments completed by the clinicians. By report, as of March 2012, two of the three therapists had achieved compliance and, thus, would require only one assessment audit per month unless issues were noted. Overall issues identified by the audit process were targeted for staff training each month and the audit tool was revised on 4/1/12 to better reflect content areas related to risk. The system in place would be likely to provide an effective method to ensure continued compliance for the therapists as evidenced by the steady rise in compliance scores over a six month period from October 2011 to March 2012. This system was dependent on the abilities of the director to conduct these audits in a competent manner and to provide adequate oversight and direction to the clinicians for corrective actions. The actions taken by the director to self-monitor and implement supports as per P1 were as follows: • All individuals newly admitted must receive a Comprehensive Assessment or a Rehabilitation screen for services completed with documentation five days prior to the ISP. o 100% of new admission assessments were completed within the required timeframe from November 2011 through April 2012. • All assigned monthly Comprehensive Assessments must be completed 10 days prior to the ISP. o 100% of all assigned assessments were completed for April 2012, but 50% of these were not completed 10 days prior to the ISP. Staffing was cited as the overriding barrier to achieving this outcome. • Total assessment completion percentage. If an assessment was not completed prior to the ISP, it was expected that it would be completed prior to the next	

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		reporting period. o 100% of all delinquent assessments for January, February and March were completed. This was a result of targeted corrective actions developed based on analysis of elemental data. • Tracking of delinquent assessments must show that past due reports were being completed and not more than two months delinquent. o Overall assessment compliance scores since October 2011 were: 57%, 71%, 84%, 81%, 87%, 91%, and 81%, demonstrating a steady increase until April 2012. The decrease in the April scores were attributed to the use of a newly revised audit tool with additional required elements related to risk. • OT/PT Assessment compliance scores were expected to be 80% or greater. o While overall compliance scores remained above 80%, some very key elements scored quite low. Because the audit tool elements were not weighted and all were of equal value, it was possible to score very low on some very essential elements, yet still achieve an overall compliance score of over 80%. This was addressed, however, as every element was analyzed individually and those that were low were targeted for special review and training with the clinicians. • Comprehensive Assessment progression with the Master Plan was expected monthly. Any percentage of increase was acceptable. These findings were reported by the director on a monthly basis. Corrective strategies were in place to consistently address issues, though staffing continued to be the primary barrier. Based on this audit system, the facility's own compliance findings validated by the monitoring team, and review of the other assessments completed by the therapists, the monitoring team found this provision to be in substantial compliance.	
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	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in section O above. Direct PT services were provided for only three individuals and no one was provided direct OT. The focus of these interventions was lower extremity coordination, strengthening and gait training. Documentation including assessments, ISPs, ISPAs, skill acquisition plans, and progress notes were requested for these individuals. • The ISP for Individual #318, dated 2/8/12, stated that he was provided PT three times a week to address his balance and coordination with exercise secondary to a history of falls. There were no measurable outcomes identified for PT intervention except a goal to average no more than two falls a month and no falls that resulted in serious injury through a safe walking program, use of AFO, bed cane, shower chair and walking cane. There was no PT intervention plan for	Noncompliance

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	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.	balance and coordination and no documentation in the IPNs. • The ISP for Individual #78, dated 5/31/11 (expired at the time of this review), indicated that he would participate in a walking program with OT/PT, though no measurable objectives were outlined. There were only four progress note entries between 12/2/12 and 5/30/12. There was no evidence of a PT intervention plan. A current PT assessment was not submitted. • The ISP for Individual #26, dated 1/20/12, stated that she participated in PT intervention three times a week for lower extremity strengthening and coordination. There was no intervention plan. There was an action step that she would participate in a program to ride a recumbent bicycle as a new home program, but no measurable objective was identified. There were only six progress notes written by the PT from 12/5/11 to 1/23/12. The ISP had indicated that there would be staff training to transition this to a program provided by direct support professionals and that training would be provided by PT. There was no mention of this in the discharge note and there was no evidence of training submitted with the documentation. Baselines were not established in the assessments. Establishing baseline is a very basic and key standard of practice for both OT and PT. Further, there was insufficient justification documented in the assessment to initiate or terminate therapy. Measureable goals for direct OT or PT were not included in the ISP or addendum. Change in status was not consistently addressed via an assessment and ISPA. For example, Individual #444's program indicated that she was to be seen twice weekly for a walking program that had been reinstated as of 12/22/11 per an ISPA. However, between 12/22/11 and 2/28/12, she was seen only seven times. Rationale for failure to provide this intervention at the prescribed frequency was not documented. OTs and PTs did not consistently complete a post-hospitalization assessment for individuals upon return to SGSSLC or for other changes in status. Though for individuals followed by the PNMT, the PNMT nurse completed a post-hospitalization assessment, as described in section O above. Occasional issue-specific assessments, such as wheelchairs and positioning were noted as documented in the integrated progress notes or via a consult. The therapists appeared to more consistently address referrals from physicians, though these assessments were not comprehensive findings and recommendations were often not integrated into the ISP or via an ISPA. Elements of the self-assessment for this part of the provision included PNMP essential element compliance, OT/PT plan integration and review, and a P2 analysis.	

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		The data reported that there had been improvement in compliance with the components of the PNMP from November 2011 to March 2012, though was variable and averaged below the established standard of 80%. Additionally, there had been 0% compliance with integration of OT/PT plans, including the PNMP into the ISP. Though this did not appear to be tracked, OT/PT interventions for direct therapy were also not well integrated into the ISP and measurable objectives and appropriate documentation were lacking.	
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.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in section O above. No evidence of competency-based training for the implementation of OT- or PT-designed programs by therapy technicians or by direct support staff was submitted to the monitoring team. Elements of the self-assessment for this part of the provision included completed monitoring of assigned staff compliance skill drills, staff compliance in implementation of PNM interventions/supports, and a P3 analysis. The data presented indicated that staff compliance drills were not completed as scheduled due to a reduction in staffing. Staff compliance was scored as extremely high, likely a false representation of actual implementation. The inter-rater system to validate the performance of the PNMPs and other IDT staff conducting monitoring did not begin until March 2012. While inter-rater compliance was reported as 100%, only one PNMPC had been monitored in March 2012 and three in April 2012. The focus for these had been for mealtimes only, rather than all aspects of PNM monitoring required. By report, there had not been a focus on the quality and consistency of staff training provided in NEO and related to the findings of the PNMPCs and others during PNMP monitoring.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the	<u>Monitoring</u> A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at SGSSLC and addressed in section O above. Recommended frequency of monitoring was included in the OT/PT assessments, though findings of the monitoring conducted were not reported at this time. As indicated in the analysis of the self-assessment, this was recognized as lacking and a plan to improve this was intended. Program effectiveness was generally conducted via quarterly PNM reviews by the therapists	Noncompliance

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	condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The documentation of OT/PT interventions was via SAPs, or for intervention plans via documentation of progress. Although a few progress notes were in the records submitted, these were not consistent across the records reviewed. There were no measurable objectives established for interventions and the documentation related to these interventions was inadequate in providing sufficient data and comparative analysis of progress. There was also inconsistent justification to continue or discontinue the interventions. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the routine monitoring done by the PNMPCs as well as during quarterly reviews by licensed clinicians, as described above in section O. There were routine maintenance checks documented to assess the working condition and cleanliness of the wheelchairs, PNMP monitoring conducted by PNMPCs checked all equipment for working order, but cleanliness was not included as an element reviewed. It appeared that responses to requests for repairs were completed in a timely manner, often on the same day or within 24 hours. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff. Elements of the self-assessment for this part of the provision included completion of program effectiveness monitoring, effectiveness of programs, resolution of identified problems, and a P4 analysis. By report, all issues identified via monitoring were resolved, though it was not yet clearly validated if the monitoring conducted was adequate, consistent and reliable. Also, program effectiveness reported tended to be somewhat rote in nature rather than data-driven. The changes to the assessment process should result in improved identification of indicators that should be tracked to determine this.	

Recommendations:

1. There was a continued need to develop programs to address increasing or expanding functional skills. 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. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).

2. Consider including oral hygiene status in OT/PT assessments. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

3. Results and findings from PNM monitoring during the last year should consistently be reviewed and summarized (P1).

4. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measureable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

5. Implementation of coaching and skills drills with staff was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues (P3).

6. Conduct routine validation of monitoring and training completed by the PNMPCs and IDT members (P4).

7. Effectiveness monitoring findings should be integrated into the individual's personal record through IPNs and reported in the annual assessments (P4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SGSSLC Policy: Dental Services, 9/15/11 o SGSSLC Policy: Missed Dental Appointments, 9/15/11 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 Policy: 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 Organizational Charts o SGSSLC Self -Assessment Section Q o SGSSLC Action Plan Section Q o SGSSLC Provision Action Plan o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals with Medical/Dental Desensitization Plans o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Quarterly Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Documentation of strategies for dental refusals the following individuals: • Individual #331, Individual #129, Individual #153 o Emergency Treatment Documentation for the Following Individuals: • Individual #40, Individual #327 o IPN Documentation for the Following Individuals: • Individual #160, Individual #218, Individual #312, Individual #97, Individual #380 o Complete Dental Records for the Prior Three Years: • Individual #295, Individual #104, Individual #60, Individual #53, Individual #56, Individual #196 Interviews and Meetings Held: o Thomas F. Anderson, DDS, Dental Director o Belinda Lendermon, RDH o Rebecca McKown, MD, Medical Director

	o Lisa Owen, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Dental Department o Informal observations of oral hygiene in homes o QIC Meeting o Clinical IDT Meeting o Daily Medical Provider Meetings
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. For the self-assessment, the facility described for both provision items, a series of activities engaged in to conduct the self -assessment, the results of the self-assessment, and a self-rating. This was a great improvement in the assessment process. During the week of the onsite review, the monitoring team met with the entire dental clinic staff to discuss the self-assessment process. The self-assessment was reviewed quite thoroughly with the staff. They did a good job with this. In fact, they reviewed the monitoring team's report and, for every section of the report, assessed themselves. The assessment included data for annual dental exams, initial exams, oral hygiene ratings, provision of services, and the various metrics cited in the report. This was a very good start for a self-assessment. To take this process forward, the monitoring team recommends that the dental director continue this type of self-assessment, but expand upon it by adding additional metrics that are specific to clinical outcomes in dentistry. The facility rated itself in substantial compliance for both provisions, although it was missing data to substantiate such self -ratings. The monitoring team disagreed with the facility's self-rating and found the facility to be in noncompliance with both provisions.
	Summary of Monitor's Assessment: The dental clinic continued to undergo staffing changes. The long-term dental assistant retired after more than 30 years of employment at the facility. The full time dental hygienist hired in 2009 who resigned in June 2011, returned in February 2012. The part time hygienist continued to work at the facility. This was a positive step for the facility because the full time hygienist at SGSSLC was largely responsible for administering programmatic services at the facility. A great deal of regression was noted during the December 2011 visit, so the hygienist returned to a program that lost significant ground since her departure in terms of the suction toothbrushing and desensitization programs, and data collection. Assessment of some provisions was difficult due to gaps in data, but based on records reviewed, it

	appeared that individuals appeared to get the basic dental treatment they needed. Oral hygiene ratings improved, but the monitoring team had concerns about the data used to derive the overall scores. The suction toothbrushing program improved and this was certainly good to see, particularly because it demonstrated good integration of clinical services. Annual assessments, for the most part, were completed in a timely manner, but the monitoring team found some discrepancies in data. There was a small improvement in the rate of failed appointments, but overall the monitoring team was disappointed with the facility's approach to this problem. In spite of the much touted discussion of strategies and interventions that the monitoring heard during the week of the review, it appeared that, just as in the previous visit, the efforts were cyclical and kicked in just prior to the visit. The dental PAI, dated just one month prior to the review, even included a statement, regarding the facility's deficiencies in this area. Finally, the facility must address issues related to data management. Some of the problems encountered may have been related to the multiple changes in clinic personnel as well as attempts to move to a new dental database. Nonetheless, these problems must be noted because they impacted both the findings and outcome of this review. The clinic attempted to present a great deal of data, but there were problems with this. First, not of all the data were continuous. For several data sets, there were no data reported for three or four months. The facility must provide continuous data based on the cutoff point of the previous visit. Since the facility did not report past September 2011 for several areas for the December 2011 review, it was necessary to provide the data starting with October 2011 for this review. This was discussed with the SAC during the onsite review. Second, the dental clinic presented data in multiple formats. That is, the same type of data was presented in different formats each month, which made month to month comparisons very difficult. Finally, the various documents were inconsistent and contained many inaccuracies. Several of these were discovered during the review, pointed out, and corrected. Other inaccurate data elements were detected following the review and will be pointed out in this report.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with all members of the clinic staff. The monitoring team also attended several meetings in which the dental director and dental hygienist were active participants. <u>Staffing</u> The dental department staff was comprised of the dental director, full-time dental hygienist, part time dental hygienist, 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 two fully equipped operatories.	Noncompliance

#	Provision	Assessment of Status	Compliance
	persons with developmental disabilities shall satisfy these standards.	Provision of Services Dental clinic was conducted five days a week and provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The total number of clinic visits and key category visits are summarized below. The dental database had not been implemented.	

Clinic Appointments 2011 -2012					
	Dec	Jan	Feb	Mar	Apr
Preventive Care	88	56	62	62	46
Restorative	6	10	4	14	0
Emergency Care	0	1	0	1	0
Extractions	1	1	4	1	--
Total Clinic Appointments	220	199	210	239	83

Emergency Care

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 could be referred to the local emergency department, if necessary. The dental documentation for two individuals was reviewed. It appeared that, for the records reviewed, individuals received appropriate emergency dental treatment and follow-up care.

- Individual #40 was seen on 1/13/12 with complaints of pain. The individual required extraction of a broken tooth. The records documented follow-up a week later at which time the individual had removal of a bone spicule. Simple analgesia was provided for pain management.

Oral Surgery

There were no referrals to the oral surgeon. The sample of records reviewed did not indicate any outstanding needs for referral. This will continue to be monitored during subsequent reviews.

Oral Hygiene

The facility tracked oral hygiene ratings quarterly. There was no summary of the longitudinal data provided. Data were provided in a series of spreadsheets and graphs and in many instances, labels and identifying data were missing or not readable. The following data were provided:

- December – 2011 – February 2012
  - Good: 77%
  - Fair: 17%
  - Poor: 3%
  - NA: 3%

#	Provision	Assessment of Status	Compliance
		It should be noted that the facility included edentulous individuals in its overall hygiene ratings. This practice had previously been discussed with the dental services coordinator who indicated that edentulous individuals should not have been included. An email from the dental hygienist was sent to the QDDPs on 3/7/12 requesting that plans be developed for those with poor hygiene ratings. Seven individuals had poor oral hygiene ratings. The following responses with referral dates and follow-up dates were provided by the IDTs: • Individual #237, 4/12/12, 5/8/12: SAP developed by team; not yet implemented. • Individual #216, 5/9/12: Does not have SAP. • Individual #90, 5/10/12: Had SAP, but was discontinued. • Individual #363, Had a recent SAP. No recommendations. Continue to watch for improvement of oral hygiene. There was no information provided for the other three individuals. Fortunately, the facility reported very few individuals with poor oral hygiene. Based on the responses above, the IDTs did not appear to implement timely or effective plans in response to these ratings. The monitoring team is also concerned by a lack of response from the dental clinic to the dearth of appropriate responses from the IDTs. In those cases where the teams did not provide an adequate plan, clinic staff should have taken some action. It would have been appropriate to inquire if assistance was needed in the development of a plan. Several individuals received treatment with suction toothbrushing. Since the full time hygienist had resumed employment, that program appeared to regain strength. A Performance Improvement Team was formed, staff were trained, and individuals were receiving treatment. There was documentation of oversight from all disciplines involved. Record reviews also showed that oral hygiene instructions were provided to individuals and staff at the time of treatment. Moreover, there was evidence that aspiration precautions were utilized when required. <u>Staff Training</u> All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>Policies and Procedures
The facility maintained a local dental services policy that was implemented in September 2011. There were no outstanding issues related to dental policies.

Annual Assessments
In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months along with the date of previous annual assessment was requested. Assessments completed by the end of the anniversary month were considered to be in compliance. Data for six months were not available. The available data were used to calculate compliance rates that are summarized below.

<table>
<tr><th colspan="5">Annual Assessments 2012</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th></tr>
<tr><td>No. Exams</td><td>44</td><td>27</td><td>25</td><td>2</td></tr>
<tr><td>Compliant Exams</td><td>40</td><td>25</td><td>19</td><td>2</td></tr>
<tr><td>% Compliance</td><td>91</td><td>93</td><td>76</td><td>100</td></tr>
</table>

During the December 2011 review, the facility submitted data through the month of September 2011. For this review, data started with January 2012. Thus, the facility reported no data for the months of October, November, and December 2011, yet rated itself in substantial compliance. The completion of annual assessments was a core component in the provision of adequate dental services. It was a basic responsibility of the facility to maintain data related to dental services.

The monitoring team found numerous inconsistences in annual assessment data because the data differed among the various documents. The listing of annual assessments included many individuals who were not listed in the clinic tracking data. Thus, it appeared from one document that 29 exams were completed. After all of the extraneous data such as exams done in October 2011 and May 2012 were removed, it appeared that 44 annual exams were done using the AA tracking document.

Initial Exams
The facility submitted data for nine individuals admitted since the last onsite review. Seven of the nine individuals completed initial dental evaluations. Two individuals evaluations were pending, but were not overdue at the time of document submission.

Dental Records
Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental treatment record. IPN entries were written in SOAP format and were generally</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		dated timed and signed. Copies of the complete dental record for the prior three years for six individuals seen in the dental clinic were reviewed. The following is a summary of those records: • 6 of 6 (100%) records included current annual examinations • 6 of 6 (100%) records included periodontal charts • 6 of 6 (100%) records included Annual Dental Summaries • 6 of 6 (100%) records included treatment plan records Generally, the dental clinic records appeared to be complete. This will need to be assessed at the next review. The initial document request did not include the correct set of documents. A follow-up request was made, and the documents were provided electronically. As a general observation, the monitoring team found much of the documentation in the dental records difficult to read and legibility was difficult in some cases. This concern was expressed in prior reviews. Interpretation due to poor legibility may prove challenging to members of the IDTs. With regards to the various dental assessments, there did not appear to be a plan in place to assess the quality of the assessments. This is discussed further in section H. The current ISP dental summaries will need to be expanded and become more robust. The summary was developed as a tool to share information with the IDTs. It offers an opportunity to provide a concise summary for review and should include information, such as a risk assessment, treatment provided, oral hygiene ratings, self-care assessments, present conditions, needs, behavioral assessment, and recommendations. <u>Failed Appointments</u> The facility reported data on no shows, excused appointments, and refusals. Failed appointments were determined by adding no shows, missed appointments, and refusals. Excused/missed appointments were appointments not kept, but were not the fault of the individual. This included appointments missed due to lack of staff, off campus appointments, etc. Refused appointments were appointments where the individuals refused to receive treatment in clinic.	

Failed Appointments 2011 - 2012					
	Dec	Jan	Feb	Mar	Apr
No Show	17	23	19/20	32	7
Excused/Missed	25	11	11	13	6
Refused	18	20	13	12	2
Total Failed	60	54	43	57	15
Total Visits	220	199	210	239	83
% Failed	27	27	20	24	18

#	Provision	Assessment of Status	Compliance
		The facility did not provide data on failed appointments for the months of October 2011 and November 2011. It appeared that the number of failed appointments was at least beginning to trend downward with the average failure rate of 24%. <u>Dental Restraints</u> The facility did not utilize any pretreatment sedation, conscious sedation, or mechanical restraints. There were no TIVA cases. <u>Strategies to Overcome Barriers to Dental Treatment</u> Over 20% of all dental appointments failed. During the conduct of the review, the monitoring team interviewed staff, attended various meetings, and heard staff discuss the interventions and strategies that were used to overcome barriers to dental treatment. The importance of "informal desensitization" was emphasized. Through various document reviews, the monitoring team identified numerous individuals who repeatedly missed and/or refused dental treatment. The dental clinic staff sent multiple emails to the QDDPs requesting strategies to address the refusals and no shows. Emails stated "we need this for the monitors." The monitoring team was provided a spreadsheet submitted by the psychology department. It listed individuals referred to psychology for assessment following multiple refusals. The spreadsheet included recommendations, such as strategies or formal desensitization. The dental department submission indicated no dental desensitization plans were implemented since the last onsite review. The monitoring team was troubled by what appeared to be the very same pattern seen during the December 2011 review. That is, strategies appeared to be created only at the insistence of the dental clinic staff, and movement was noted in preparation for the review. The documentation clearly showed that teams addressed refusals weeks to months after the actual event occurred, apparently in response to requests from the dental clinic. The monitoring team assumes that if the teams had other written plans they would have submitted those plans as well. The various action plans submitted affirmed that the facility had significant problems in this area. The provision action information document stated, "5/1/12, meeting with psychology regarding systematic desensitization programs and the lack of implementation and communication between dental and psychology." In response to the multiple requests from the dental clinic for strategies, the IDTs and QDDPs provided some responses. The following are a few examples: • Individual #349 refused treatment on 1/18/12. The IDT's plan was dated 3/7/12 and was created only after clinic staff repeatedly insisted that strategies be developed. • Individual #129 had six refusals in 2012. The psychology desensitization	

#	Provision	Assessment of Status	Compliance
		spreadsheet, dated 10/18/11 stated, "Send individual to dental with preferred staff member." There were no further spreadsheet entries or updates and no further plans. An email, dated 3/6/12, sent to the dental clinic in response to numerous requests, stated the IDT "was working on this." • Individual #153 had multiple refusals and missed appointments in February 2012, March 2012, and April 2012. The monitoring team could not identify strategies in place for this individual. The psychology spreadsheet did not indicate that a referral had been made. The monitoring team would like to make it clear that if refusals are re-classified to be excused appointments, these practices should be terminated immediately because such data manipulation is not an acceptable practice. The monitoring team suggests that when barriers to the provision of dental treatment are identified, consideration should be given to the many ways to overcome the barriers. A full spectrum of treatments and strategies, ranging from activities and interventions to full desensitization efforts should be considered. This is an ongoing process that must occur on a daily basis and not weeks prior to monitoring reviews.	

Recommendations:

1. The facility should proceed with implementing the dental database to ensure that data collection can proceed as accurately as possible (Q1).
2. The clinic should maintain a listing of all individuals who are edentulous. Oral hygiene rating for edentulous individuals should be presented separately (Q1).
3. The facility must ensure that those with poor oral hygiene had adequate plans in place to assist in improvement of oral health. Individuals who demonstrate deterioration in hygiene status should also have development of a plan (Q1).
4. Greater effort is needed in the areas of desensitization. There should be evidence that discussions occur yearlong and not just one to two months prior to an onsite review. Ongoing discussions may result in increased development of plans (Q1).
5. Progress notes related to dental treatment performed by practitioners should be dictated so that IDTs 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 (Q2).
6. The facility needs to organize a multidisciplinary workgroup to explore how to best serve the needs of the individuals who must overcome barriers to treatment. This should be approached with some sense of urgency (Q2).
7. The facility must review the multiple issues related to data. Appointments should not be reclassified. Refusals should be counted as refusals (Q2).

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 Admissions list o Budgeted, Filled, and Unfilled Positions list, Section I o Speech Staff list o SLP Continuing Education documentation o SGCCLC Policy Communication Services (5.2.13) o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Speech Language Communication Assessment template and guidelines o AAC-related spreadsheets and summary reports o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o List of individuals with AAC o List of individuals receiving direct speech services o Communication Services Tracking Log o Assessment Tracking Log o Rehabilitation Tracking audits submitted o Compliance Monitoring template o Effectiveness Monitoring template o PNMP Monitoring sheets submitted o NEO training materials o NEO Tool Kit o Communication Assessments and ISPs for the following: • Individual #189, Individual #143, Individual #208, Individual #345, Individual #268, Individual #144 o Communication Assessments for individuals recently admitted to SGSSLC: o ISPs, ISPAs, SAPs, plans, IPNs related to communication and AAC for the following: • Individual #201, Individual #185, Individual #27, Individual #183, Individual #211, Individual #130, Individual #126, Individual #217, Individual #26, Individual #318, Individual #78, Individual #295, and Individual #339 o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries,

	Integrated Progress notes (not submitted), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 o PNMP section in Individual Notebooks for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #76, Individual #128, Individual #146, Individual #104, Individual #188, Individual #66, Individual #18, Individual #7, Individual #295, Individual #203, Individual #344, Individual #98, Individual #210, Individual #318, Individual #384, Individual #90, Individual #238, Individual #17, Individual #288, and Individual #26 Interviews and Meetings Held: o Dena Johnston, OTR Habilitation Therapies Director o Erin Bristo, MS, CCC/SLP o Susan Holler, MS, CCC/SLP o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas, dining rooms, day programs ISP for Individual #188
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. The Presentation Book provided information related to actions taken, data presented to illustrate elements assessed and an analysis of the findings, accomplishments, and work products. The facility was to describe, for each provision item, the activities engaged in to conduct the self-

	assessment of that provision item, and the results and findings from those self-assessment activities and a self-rating of substantial compliance or noncompliance with a rationale. This was significant improvement in the overall self-assessment process. The activities for self-assessment listed for each provision were as follows: • R1: Speech therapy service hours and an R1 analysis. • R2: New admission assessments, Assigned monthly comprehensive assessments, Speech assessment compliance scores, Comprehensive assessment progression – Speech Master Plan, and an R2 analysis. • R3: Integration of communication interventions into the ISP and the development of AAC systems, Staff compliance in implementation of AAC, and an R3 analysis. • R4: Completion of program effectiveness monitoring, Effectiveness of programs, Resolution of identified problems, and an R4 analysis. The director, Dena Johnston, is commended for her approach to this process. She appeared to understand what was needed and presented meaningful data in a useful manner that was clear and precise, using graphs with careful comparative analysis of these findings each month. That information was used to guide actions for subsequent months. Even so, while these were appropriate self-assessment activities, they were not the only activities that would be necessary to self-assess substantial compliance in some cases. The monitoring team discussed approaches to self-assessment with the Ms. Johnston and it is hoped that this provided a clear direction for the future. This report should also provide some insight into additional measures for self-assessment of compliance with this provision. The facility self-rated itself as noncompliant with all four items of R (R1 through R4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: Staffing levels were slightly decreased at the time of this review, though significant efforts had been made toward hiring additional qualified speech staff. The existing clinicians appeared to be strong in their knowledge, skills, and enthusiasm for developing effective, functional, and meaningful communication supports for individuals. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals living at SGSSLC. Though caseload allocation divided these responsibilities, two of the three clinicians were generally able to focus on communication issues. The current ratio for caseloads continued to be high. The Master Plan was submitted, though it was called the Communication Services Tracking Log (undated). The total number of individuals included in the log was 236. Individuals were categorized into five priority levels based on their needs as well as those newly admitted to SGSSLC. The Tracking Log was intended to outline the priorities for completion of communication assessments.

	SGSSLC was conducting (initiated 4/1/12) audits of the assessments previously completed for individuals who were considered to be Priority 1 and, if compliance with those assessments was less than 80%, the assessment would be redone. As per recommendations by the monitoring team, this would be necessary also for those individuals at Priority 2. Audit scores were reported to be below the 80% compliance benchmark established. All other assessments were reportedly proceeding as per the Tracking Log, though by admission, the existing staff were not able to meet the established deadlines. Completion of all the assessments would take years at the current rate and staffing level. Clearly additional strategies were needed to address these issues. The clinicians reported difficulties with implementation of AAC related to inconsistent use throughout the day. Communication Plans were provided for staff reference. A number of systems were recommended in the communication assessments, but without ongoing and consistent support provided by speech clinicians. This should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing 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 these programs for individuals and groups. On the other hand, there were success stories, such as Individual #183. He had been unable to go to work for the last year due to challenging behaviors. The SLP in conjunction with other team members developed an AAC system that consisted of a schedule to guide the length of time he stayed on task at work, as well as a token system to provide reinforcement at intervals until his payday. This had been effective and resulted in his transition from on-home work initially to a full return to the worksite. This collaboration was an excellent example of the potential for creative solutions to issues or barriers identified for individuals. His SLP, Susan Holler, MS, CCC/SLP and his IDT are commended for this effort. It is recognized by the therapy clinicians that this is what is needed but they were very limited by the time they were available. Overall, the monitoring team was very encouraged by the current strategies and plans in place to address communication supports for individuals living at SGSSLC and looks forward to continued progress.

#	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.	Staffing: At the time of this review, there was one full time SLP, Erin Bristo, MS, CCC/SLP. She participated as a member of the PNMT, and provided supports and services in the area of dysphagia rather than communication. She provided NEO training. She was assigned some leadership responsibilities related to this provision as well. There were three additional contract SLPs: Susan Holler, MS, CCC/SLP, Susan Reeves, MS, CCC/SLP, and Amy Armke, MS, CCC/SLP. Ms. Holler was listed as working 20 to 30 hours per week, though per the director had been working only 20 hours. With school out, she was likely to be able to work more hours during the summer months. Ms. Reeves was listed as working16 hours per week, but was actually working 12 to 15 hours only. Ms. Armke was not providing any hours at the time of this review by report. A contracted Speech Assistant, Allyson Steele, worked four hours a week only and provided individual-specific training related to communication. Each of these clinicians provided communication supports and services at SGSSLC. Ms. Holler generally completed update assessments and attended ISPs, ISPAs, BSPC meetings. Ms. Reeves was generally assigned to complete comprehensive assessments for individuals newly admitted to the facility and provided supports to the sex offender program offered at SGSSLC. There were vacant positions both for a SLP and a Speech Assistant at the time of this review. By report, approximately 1200 mailings for the vacant positions had been sent to licensed professionals in Texas and brochures had been sent to all of the state universities with speech programs in March 2012. Recruitment efforts had not been successful. There were four budgeted FTE positions listed for speech therapy (as per the documents submitted to the monitoring team), with two filled, one of which was an audiologist. It was not clear as to who the other FTE employee was because the other five clinicians listed were each contracted staff. The habilitation therapy director may want to review this information to ensure that it consistently and accurately reflects the status of staffing for this department. The facility calculated the speech therapy ratio as 1:234, though reported two full time positions, one of which was the audiologist who provided audiology services only. As each of the clinicians listed were part-time contractors, other than the audiologist it was not clear as to how this was calculated for other communication services. This ratio of clinicians for 234 individuals was extremely high, though only 60 individuals (26% of the total census) were identified as nonverbal or with limited communication skills. Only those SLPs providing direct services in the area of communication should be considered in the calculations of hours provided. This would provide a more accurate measure of personnel needs in the area of communication for the provision of assessments and the implementation of communication systems and plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Qualifications: CVs were submitted for the clinicians working at SGSSLC. Each was listed as licensed to practice in the State of Texas. • 4 of 4 SLPs (100%), including the audiologist and Speech Assistant were licensed to practice in the state of Texas. Evidence that the facility consistently verified both state licensure and ASHA certification for each clinician will be requested prior to the next compliance review. Continuing Education: Evidence of participation in communication-related continuing education was limited with none occurring since the previous review. Ongoing participation in advanced communication –related continuing education is critical to ensure improved clinical assessment and program development skills for AAC and language for individuals with developmental disabilities. It was reported by the director that continuing education opportunities were scheduled in August 2012 with one of the state consultants related to AAC as well as the annual state conference generally held in the Fall. The facility did not provide an adequate number of speech language pathologists or speech assistants with specialized training or experience as evidenced by noncompliance with R2 through R4 below. Facility Policy: A local policy existed (Communication Services 5.2.13), but generally merely reflected the language contained in the Section R provision of the Settlement Agreement rather than clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: • Outlined assessment schedule: Essentially referred only to the Master Plan as the schedule, however. • Timelines for completion of new admission assessments (within 30 days of admission or readmission): This was specifically stated in the policy. There was no reference to the provision of initial screenings, with completion of a Comprehensive Assessment as indicated by the findings from the screening. The following components were not included in this policy: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Frequency of assessments/updates • Timelines for completion of comprehensive assessments (within 30 days of	

#	Provision	Assessment of Status	Compliance
		identification via screening) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT) • Addressed a process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) vs. a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution Though a number of these elements were referenced, the content was limited to policy statements. Details for implementation were not outlined nor were there any specific procedural guidelines associated with this policy. Included with a number of the document submissions, there was a brief description for the monitoring team that described the procedures of a number of activities required of the SLPS and addressed some of the elements listed above, including completion of assessments, for example. These would easily be converted to a formalized policy and/or procedural guidelines by the facility.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> The Master Plan was submitted, though it was called the Communication Services Tracking Log (undated). The total number of individuals included in the log was 236. Individuals were categorized into five priority levels based on their needs as well as those newly admitted to SGSSLC. The Tracking Log outlined the priorities for completion of assessments: • New Admissions: (24) • Priority 1: 35 (individuals with no effective means of communication) • Priority 2: 25 (individuals with limited language skills and potential for exacerbated negative behaviors related to decreased communicative function) • Priority 3: 31(functional means of communicating daily wants and needs through speech or AAC, limited generalized communication skills, however) • Priority 4: 75(appropriate speech and language skills, pragmatics were a concern related to community re-entry) • Priority 5: 45 (effective communication of needs without inference from the listener)	Noncompliance

#	Provision	Assessment of Status	Compliance
		Most of those identified as newly admitted were listed with a comprehensive assessment dated in 2010 (Individual #330), in 2011 (13), and in 2012 (7). Individual #249 was identified as having refused the assessment in October 2011 and November 2011, Individual #338 was not scheduled for an assessment, and the assessment for Individual #43 was incomplete. His ISP had been held on 5/22/12. In addition to Individual #43, seven others had been admitted since 1/26/12. Each of the 35 individuals listed as Priority 1 had comprehensive assessment completion dates listed, though most had been completed prior to 10/20/11 (initiation of the current Communication Assessment format) and as such, did not likely meet the standard of comprehensive as required by the Settlement Agreement. Each of the 25 individuals listed as Priority 2 had comprehensive assessment completion dates listed, though most of these had also been completed in 2010 (2) or 2011(22) and one for Individual #241 on 1/2/12. As identified in the last monitoring review report, previously completed comprehensive assessments for individuals identified as Priority 1 and 2 should be reviewed to determine if they met the current standard of comprehensive. In the case that they did not, they would need to be redone or minimally amended to reflect the missing content. There were 12 of 31 individuals identified as Priority 3 with a comprehensive assessment completed in 2012. Each of the others had been completed prior to 10/20/11 and would not likely be considered comprehensive. The update process would be an effective method to review the status of all of the individuals identified as Priority 3 to address potentially missing content from the assessment and to determine if in fact they would benefit from communication supports and/or AAC. The 120 individuals identified as Priority 4 and 5 were listed with comprehensive assessments in 2008 (2), 2009 (75), and 2010 (34). Only eight had been completed in 2011. At least two of these (Individual #318 and Individual #265) identified a need for communication supports. Again, for these individuals the monitoring team was concerned that there were potentially unidentified needs due to the lack of an adequate comprehensive communication assessment for individuals who may have benefitted from communication supports. The Communication Services Tracking Log had no due dates identified, though annual ISP dates were listed. The order of names in this log did not appear to necessarily direct the order in which assessments were completed by the clinicians. Assessments reported to be completed in the last six months based on the spreadsheets submitted were as follows:	

#	Provision	Assessment of Status	Compliance

Priority level	# of Assessments/Updates Completed	% of Total Assessments (83)
New Admissions	9/0	10.8%
Priority 1	9/3	14.4%
Priority2	4/6	12%
Priority 3	5/9	16.8%
Priority 4	4/23	32.5%
Priority 5	2/7	10.8%
Unknown	1/1	2.4%

Assessments that were completed prior to 10/20/11 for individuals identified as Priority 1 and 2, as well as previously new admissions, were as follows:

Priority Level	# of Assessments Completed Prior to 10/20/11	% of Total
New Admissions	11	45.8%
Priority 1	22	62.8%
Priority 2	10	40%

As described above, SGSSLC was conducting (initiated 4/1/12) audits of the assessments previously completed for individuals who were considered to be Priority 1. If compliance with those assessments was less than 80%, the assessment would be redone. This would be necessary also for individuals at Priority 2. All other assessments were reportedly proceeding as per the Tracking Log, though the existing staff were not able to meet the established deadlines. Clearly additional strategies were needed to address these issues.

Based on review of the Tracking Logs and other documents submitted:

- 5 of 8 individuals (63%) admitted during the last six months had received a communication screening or assessment within 30 days of admission or readmission.
- No individuals identified with therapy needs through a screening (0%), received a comprehensive communication assessment within 30 days of identification. No screenings were listed as completed in the last six months. The initial screenings completed were to identify the priorities for the Master Plan to guide the timely completion of comprehensive assessments.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<u>Communication Assessments:</u>
Communication assessments were requested and submitted as follows:

Individuals in the sample selected by the monitoring team (15/20 were submitted)
Five of the most current assessments by each speech clinician (only six were submitted)
Individuals newly admitted to SGSSLC (five were submitted)
Individuals who participated in direct communication intervention or with AAC (five were submitted)

Thus, there were 32 Speech Language Evaluations plus three Annual Reviews (Individual #17, Individual #318, and Individual #98) submitted. There was no communication assessment in the individual record for Individual #76, Individual #128, Individual #188, Individual #295, and Individual #238.

Priority levels for the individuals for whom assessments/reviews were submitted were as follows:
<table>
<tr><th>Priority Levels</th><th>New Admissions</th><th>Priority 1</th><th>Priority 2</th><th>Priority 3</th><th>Priority 4</th><th>Priority 5</th></tr>
<tr><td></td><td>5</td><td>14</td><td>4</td><td>7</td><td>2</td><td>0</td></tr>
</table>
Assessment templates for Speech-Language Comprehensive Assessment were submitted as requested. The assessments completed in 2012 generally matched this format.

0 of 36 individuals had comprehensive assessments that contained each of the elements outlined below.

The elements most consistently adequately addressed included:

Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day
Identification of need for direct or indirect speech language services
Recommendations for services and supports in the community Manner in which strategies, interventions, and programs should be utilized throughout the day.

The percentage of assessments that did <u>not</u> include each element are listed below:

Dated as completed 10 days prior to the annual ISP (78%)
Diagnoses and relevance of impact on communication (61%)
Individual preferences, strengths, interests, likes, and dislikes (67%)
Medical history and relevance to communication (56%)

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#	Provision	Assessment of Status	Compliance
		• Medications and side effects relevant to communication (67%) • Documentation of how the individual's communication abilities impact their risk levels (75%) • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (33%) • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (92%) • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (81%) • Discussion of the expansion of the individual's current abilities (53%) • Discussion of the individual's potential to develop new communication skills (69%) • Effectiveness of current supports, including monitoring findings (97%) • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC (44%) • Comparative analysis of health and functional status from the previous year (94%) • Comparative analysis of current communication function with previous assessments (86%) • Identify need for direct or indirect speech language services (36%) • Reassessment schedule (67%) • Monitoring schedule (67%) • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (92%) • Factors for community placement (72%) • Recommendations for services and supports in the community (39%) • Manner in which strategies, interventions, and programs should be utilized throughout the day (36%) Additional findings: • 5 of 36 assessments did not contain any of the elements outlined above. • 8 of 36 assessments contained five or fewer of the elements outlined above. • 12 of 36 assessments contained 10 or fewer of the elements outlined above. • 9 of 36 assessments contained 15 or fewer of the elements outlined above. • Only 2 of 36 assessments contained more than 15 of the 23 elements outlined above • Augmentative/Alternative Communication and Assistive Technology: Content in	

#	Provision	Assessment of Status	Compliance
		this section varied across assessments, though most demonstrated an improvement in this area. • Clinical Impressions: The analysis sections of these reports were generally improved, though not all provided sufficient rationale for the recommendations identified. • The assessments did not generally identify important life activities or inventory ways for greater meaningful participation in them. • Some assessments identified preferences, likes, and dislikes in the PFA Supports section of the report. These were important to establishing contexts for communication opportunities, but there was no clear link between these and functional participation in the daily routine consistently established via the clinical analysis and recommendations. • Skill acquisition programs were recommended for only one of the individuals for whom assessments were reviewed (Individual #144), though most had communication needs. A protocol dated 4/10/12 "Assessment Protocol for Competency for Development/Documentation Skills" was used to assess the assessments. To establish initial competency, all assessments were sent to the director/lead clinician who completed an audit using the established audit tool for communication assessments. Each therapist was to achieve three consecutive competency scores at 80%. The therapist then was given two working days to complete the final review and revisions identified in the audit process. Once initial competency was established, one assessment per month was selected by the director for auditing. Assessment audit scores must be at 80%. In the case that the score fell below that, a corrective action plan, that may include retraining or continued audits, was developed to ensure that competence was reinstated and maintained. <u>SLP and Psychology Collaboration:</u> There were 113 individuals with PBSPs and replacement behaviors related to communication. Individuals included on this list were identified across all priority levels and 14 were newly admitted to SGSSLC. Overall, only 48 individuals or 42% of those on this list had received a communication assessment since 10/20/11. There were 33 of those individuals provided this assessment who were identified with functional communication skills at Priority levels 3, 4, or 5. It was of concern that those with behavioral concerns did not appear to drive the completion of assessments. Susan Holler, MS, CCC/SLP attended the BSP Committee meetings on a regular basis to review assessments and BSP strategies and, by report, her contribution was important and meaningful. An example of collaboration with psychology was described in the case	

#	Provision	Assessment of Status	Compliance
		of Individual #183, who was now successfully participating in his work program after an extended separation due to significant behavioral concerns. Collaboration between SLPs and psychology, related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives to improve and enhance communication skills, is required for compliance with this provision. Per the Presentation Book, staffing (vacancies and limited contract hours) continued to be a barrier to acceptable progress with the Master Plan. As stated in the analyses presented, with each assessment completed the clinicians must meet with the IDT, participate in the development of programs, and implement AAC systems as recommended. A number of actions were taken to ensure that the SLPS were able to focus their time on clinical issues. The assessments completed were lengthy and the content areas were comprehensive. There was a marked improvement over previous reviews, though actual content elements required continued improvement as described above and per the facility's own self-assessment. The department was clearly examining their performance in this area with analysis of the compliance with the completion of assessments as well as compliance with the report content.	
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.	<u>Integration of Communication in the ISP:</u> Based on review of the ISPs for individuals in the sample reviewed by the monitoring team, the following was noted: • 4 of 22 ISPs (18%) were not current within the last 12 months. • In 3 of 16 ISPs (19%) for individuals with communication needs, an SLP attended the annual meeting. • In 6 of 11 current ISPs for individuals with AAC and/or communication supports (55%) the specific type was identified for individuals listed with AAC. • 9 of 18 ISPs (50%) included a description of how the individual communicated, including the AAC system if they had one. Most of these descriptions were minimal. • 0 of 11 ISPs (0%) included how communication interventions were to be integrated into the individual's daily routine. • 7 of 11 ISPs (64%) contained skill acquisition programs, though most of these were actually staff supports rather than programs intended to promote increased functional communication for the individual. Some examples included: o Will continue to use facial and other gestures to express herself to other individuals and/or staff (Individual #7). o Speech therapist is setting up program to help develop skills for using communication devices routinely (Individual #210).	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Speech pathologist will apply Dragon software to computer for letter writing (Individual #318). o Staff will continue to use communication dictionary (Individual #66 and Individual #104). o Will continue to make choices for himself (Individual #18) o Request a meeting with SLP to address recommendations for communication strategies (Individual #384). o 0 of 18 current ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. <u>AAC Systems:</u> There were 74 individuals included on the list, "Individuals with Augmentative/Alternative Devices." There were approximately 37 individuals listed with AAC systems, several community use systems, and approximately 47 communication dictionaries. Of those with AAC listed, 64% had a communication dictionary, and for 15 individuals this was the only support provided. While the information that the dictionary provided to staff was recognized as invaluable, this did not offer the individual a means to communicate, but rather only provided cues for staff to interpret the individual's communicative efforts. A number of other individuals were listed with recommendations that were not implemented. Some type of communication support was provided for 100% of individuals identified as Priority 1, 92% of individuals identified as Priority 2, 39% of individuals identified as Priority 3, one individual at Priority 4, and one at Priority 5. While it was commendable that AAC systems and other communication supports were provided for so many individuals with prioritized needs, it continued to be of concern that so many individuals had not actually received an appropriate comprehensive assessment and may continue to have unmet potentials or needs. The design of appropriate AAC systems was dependent on an appropriate assessment, but the rate of assessment completion was very slow. There were generally written communication plans or instructions with photographs that included the use and care of AAC or to outline other communication strategies. The individual AAC systems were intended to be functional, though some were strategically located only in the home or in programming areas and were not necessarily intended to be portable or meaningful across settings. This was also true of the community devices provided. Consistent implementation was an ongoing concern and, as such, meaningful and functional use by the individual often did not occur.	

#	Provision	Assessment of Status	Compliance
		Direct/Indirect Communication Interventions: Direct communication-related interventions were identified as provided for two individuals in the last six months (Individual #339, Individual #183). Generally accepted practice standards for documentation by the SLP related to communication interventions included the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives included in the ISP. • IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • IPN or other SAP documentation described the benefit of device and/or goal to the individual. • IPN or other SAP documentation reported the consistency of implementation. • IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Documentation related to these plans was reviewed. The following was noted: • Direct Intervention: The ISP for Individual #339 dated 1/3/12 documented IDT discussion of a frenectomy (removal of the frenulum which restricted his tongue movement for speech). He agreed at that time to participate in speech therapy if the procedure was done. The SLP was not present at that meeting. A treatment plan was submitted that was dated 2/22/12, which reported that the frenectomy was completed. Individual #339 was to participate in speech therapy one to two times per week for 10 total sessions to gain maximum strength and movement of the tongue. The long-term goal was to increase his intelligibility so that others could understand him without 95% interpretation. He did not attend the first session on 2/22/12. There was no evidence of additional documentation by the SLP. • Indirect Intervention: The ISP (10/14/11) for Individual #183 identified several training objectives related to using a picture schedule, though these did not match the objective stated in the Skill Acquisition Plan (10/11/11). The SLP had attended the ISP meeting on that date. The SAP was implemented by direct support staff. There was no evidence of documentation by the SLP related to this intervention. Documentation for 0 of 2 individuals (0%) was adequate as per the indicators above.	

#	Provision	Assessment of Status	Compliance
		Competency-Based Training and Performance Check-offs: New employees participated in NEO classroom training prior to their assignment in the homes and completed initial competency check-offs at that time for specific skill sets related to PNM and communication. The four-hour training related to communication was provided primarily by Erin Bristo, MS, CCC/SLP. Upon completion of the entire NEO training, they were then assigned to a specific home and in the first five days of their assignment they work with home supervisors and IDT members for further training, called "shadowing." A PNMP ToolKit was provided to each new employee that serves as a cue card for essential PNM-related information. There was one such card providing reminders about how to communicate with an individual who used AAC. The content was as follows: • Maintain eye contact. • Respond as if the individual spoke to you. • Be patient. Use of device may take time. Do not rush the individual. • Do not play with or comment on the device unless the individual needs your help with using the device. • Encourage individuals to use community devices when you notice they are having difficulty communicating. • Communication dictionaries are used to identify behaviors as a form of communication. Based on review of the NEO training curriculum, direct support professionals, PNMPCs and therapy aides were provided with foundational training related to communication as evidenced by the following content areas: • Methods to enhance communication • Implementation of programs • Benefits and use of AAC • Identification of non-verbal means of communication. It could not be determined from the materials submitted, however, if there were sufficient opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. Skills-based check-off forms were not submitted with the training materials so it was not clear if staff were checked-off to determine their competency in performing basic skill sets. Staff training related to communication was not included as an aspect of annual retraining. In the case that a DSP had two noncompliant skill drills in one six month period, he or she would be referred back to the Competency Training and Development department to re-establish competency through additional lectures, practice, and check-offs.	

#	Provision	Assessment of Status	Compliance
		Individual-specific inservice training for PNMPCs and the direct support professionals was provided by the SLPs and/or Speech Assistant upon the introduction of a new communication system/plan or if there were major changes made in the plan. If further staff training was required, the SLP established competency of the PNMPC, home supervisors, and/or nurse case manager, who then in turn completed cascade training for the other staff. It could not be determined from the limited training sheets submitted whether the trainer required return demonstration with a skills-based check-off to establish the competency of staff (Individual #183). The analysis from the self-assessment of this provision indicated that staff appeared to be knowledgeable about the devices and strategies and were using them. In the sample chosen for review by the facility this was not confirmed. Skill drills for AAC were reported at a 94% compliance level. It was concluded that while staff knew what to do, they were not consistently promoting functional use of the communication systems in place. Integration into the ISP with more skill acquisition plans may partially address this concern. This will be an important key to individuals learning how to use their devices initially. Efforts to ensure integration in a meaningful way throughout their daily routine, however, will be critical as well. While the interactions of staff with individuals were generally positive, much of the interaction observed by the monitoring team was specific to a task, with little other interactions that were meaningful. Staff were observed talking to the individuals, but most did not appear to understand how to facilitate better engagement and participation with the individuals. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should continue to be a priority. It was reported that the speech clinicians had initiated communication supports in a variety of settings including the homes, day program areas and work settings. This should be expanded significantly. 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.	

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<tr><td>R4</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.</td><td><u>Monitoring System:</u>
Skill drills (Mealtime, Lifting/Transferring, Positioning, Off Home, Equipment, and AAC) were completed on random staff in conjunction with at risk compliance monitoring. This process was designed to check the presence of written support instructions in the care environment, evaluate staff knowledge regarding the required supports, the condition of the supportive equipment, and the appropriate implementation of the supports. Monitoring and staff drills by the PNMPCs were conducted at least quarterly for individuals who were provided AAC. More frequent drills were conducted as indicated based on routine monitoring, upon referral, and/or the identification of systemic concerns.

The was a local policy (Competency Training and Monitoring of Physical and Nutritional Management Plans) related to monitoring of communication supports.

Completed monitoring sheets (33) were submitted for 22 individuals for March 2012 and April 2012. Results were as follows:

<table><tr><th>100%</th><th>90%</th><th>80%</th></tr><tr><td>26</td><td>6</td><td>1</td></tr></table>
These monitoring sheets were very generic and, as such, did not provide meaningful information about actual implementation. For example, these did not identify the communication activity being monitored, though some had written in the type of AAC provided to that individual. Item number two required that the equipment be present, working, and utilized. All three would have to be observed to score a “yes” for that item. If one was not observed, the score would be “no,” but it was not likely that it would be known what the actual issue was. This lack of discrete indicators in the tool did not permit meaningful analysis of the findings. Additionally, the scores reported were exceptionally high and it was likely that they did not represent the actual implementation of communication systems for those provided these devices.

Communication supports were generally reviewed on an annual basis prior to the ISP and on a quarterly basis by the licensed clinicians as an aspect of PNMP monitoring. Frequency of monitoring required in the interim was generally identified in the assessments completed after 10/20/12. Licensed clinicians should conduct routine reviews of the efficacy of the communication supports provided and observe and validate consistent implementation of AAC systems and Communication Dictionaries. A tracking system was developed to track the timeliness of monitoring and to track identified issues and follow-up. This was documented on a monitoring form, but it did not appear that the findings were documented in the individual record or integrated with the ISP quarterly</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		review process. It also was not clear that SLPs completed these for individuals with AAC systems because some of those forms marked as reviews of communication were completed by other disciplines, such as OTs or PTs. Monitoring of communication programs and systems should be based on level of need related to communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance.	

Recommendations:

1. Continue aggressive efforts to acquire full time SLPs to ensure that the facility is able to meet the identified needs of individuals and meet the requirements of the Settlement Agreement in a timely manner. Completion of assessments was progressing too slowly due to reduced staffing. The development of programs is good but moving too slowly due to reduced staffing.

2. Consider adding SLPA positions to expand supports, services, staff training, monitoring and real-time modeling of effective communication strategies and partner roles and responsibilities. These positions would stretch the services available to individuals, permit more timely completion of assessments and ensure that all individuals who would benefit from communication supports and service would receive them in a timely manner (R1).

3. 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 (R1).

4. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the ISPs and in the PNMPs (R3-R4).

5. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

6. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

7. A dynamic segment for annual re-training that is skills-based should be considered related to how staff can be effective communication partners (R3).

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 Individual Support Plans (ISPs) for: • Individual #151, Individual #44, Individual #369, Individual #388, Individual #12, Individual #389, Individual #53, Individual #367, Individual #254, Individual #238, Individual #291, Individual #304, Individual #292, Individual #173, Individual #243, Individual #396, Individual #346, Individual #323 o Skill Acquisition Plans (SAPs) for: • Individual #254, Individual #238, Individual #291, Individual #304, Individual #292, Individual #173, Individual #243, Individual #396, Individual #346, Individual #323 o SAP data for: • Individual #254, Individual #238, Individual #291, Individual #304, Individual #292, Individual #173, Individual #243, Individual #396, Individual #346, Individual #323 o Quarterly reviews of SAP data for: • Individual #186, Individual #353, Individual #39, Individual #162, Individual #305, Individual #215, Individual #255, Individual #77, Individual #93, Individual #180 o Draft Policy and procedures for Habilitation, Training, Education, and Skill Acquisition Programs, dated 5/10/12 o List of trainings on Skill Acquisition in the last six months o SGSSLC plan of improvement, dated 5/1/12 o SGSSLC action plans, dated 5/1/12 o Community Activity Sheet, dated 10/4/11 o A list of instances of skill training in the community in the last six months o A list of individuals employed on- and off-campus, undated o Description of on-campus and off-campus day and work program sites o Section S presentation book, undated o Section F and T meeting minutes, dated 4/11/12, 4/18/12, and 5/30/12 o List of students participating in public school educational programming, undated but likely May 2012 o Signed memorandum of understanding between SGSSLC and the WISD, signed 3/2/121 o Notes from most recent quarterly meeting with WISD personnel, 5/16/12 o Description of inclusion activities, 6/6/12 o Monthly completed classroom observation tools, SGSSLC classroom and WISD campus school, January 2012 through May 2012 o ISP, ARD/IEP, and recent IEP progress notes for • Individual #99, Individual #292, Individual #175

	Interviews and Meetings Held: o Gary Flores, Director of Cultural Services/Day Habilitation o Tammy Ponce, Active Treatment Coordinator o Michael Davila, QDDP Coordinator o John Church, Assistant Chief Psychologist o Tammy Maricle, SAP Coordinator, Day Programs o Noel Zapata, Director of Vocational Training o Melinda Gentry, ADOP, and Vicki Hinojos, Director of Residential Services Observations Conducted: o Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals. o Classroom at SGSSLC (though not in session)
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two other documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Overall, the self-assessment included relevant activities in the "activities engaged in" sections. For example, S1 included a review of SAPs that focused on many of the same components that the monitoring team reviews. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, for S1 the self-assessment reported that the facility reviewed the section S tool which included some measures that were similar to those described in the report below (e.g., SAPs with all the components necessary for learning), however, it did not appear to address desensitization plans and actual measures of individual engagement. To take this process forward, the monitoring team recommends that the facility review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are

	more likely to line up with each other. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the facility on this much-improved self-assessment. This was a good first step. SGSSLC's self-assessment 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. The self-assessment 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 throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team recommends that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	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. Improvements since the last review included: • Beginning of the integration of Skill Acquisition Plans (SAPs) into day programming (S3) • Improved data reflecting the training of SAPs in the community (S3) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference (S1, S2, S3) • Ensure that each SAP has an individualized plan for maintenance and generalization (S1) • Simplify the collection of engagement data, ensure that it is collected in all homes and day programs, and summarized and shared with managers responsible for improving engagement (S1) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data (S3) • Collect and track SAP integrity measures (S3) • Expand the number of SAPs in day programming (S3) • Establish acceptable percentages of individuals participating in community activities, and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3).

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SGSSLC. As detailed below more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition plans. These plans consisted of Skill Acquisition Plans (SAPs) that were written and monitored by QDDPs (qualified developmental disabilities professionals). SAPs were implemented by direct care professionals (DCPs). An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), 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. As discussed in the last report, the facility recently modified the SAP format to include a rationale for each specific acquisition plan. This appeared to be a very direct way to ensure that SAPs were developed to address individual preferences and needs. Thirty-two SAPs across 10 individuals were reviewed to determine if they appeared to be functional and practical. In five (Individual #238's safe eating SAP, Individual #173's safe eating SAP, Individual #304's SAPs of laundry and safe eating, and Individual #291's SAP of money management) of the 32 SAPs reviewed (16%), the rationale appeared to be based on a clear need and/or preference. This represented a decrease in the percentage of SAPs judged to be practical and functional from the last report (39%). An example of a rationale that was specific enough for the reader to determine if the SAP was practical and functional for that individual was: • The rationale for Individual #238's SAP of safe eating stated …"due to observation of need of frequent reminders during mealtime monitoring, he requires assistance in maintaining safe eating skills." In 27 of the 32 SAPs reviewed (84%), however, the rationales appeared generic; all stating that the particular SAP was chosen because the individual wanted to learn the skill. These rationales were not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #396's SAP of cleaning his room was that his PFA and ISP determined that Individual #396 wanted to learn to keep his room clean.	Noncompliance

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		The monitoring team cautions the facility to avoid attempting to address the need to demonstrate that SAPs are practical and functional, by simply stating that each individual wants to acquire the targeted skill. Rather the facility should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. The rationale for every SAP does not have to be the individual's preference. It can also be based on a need as in the example of Individual #238's rationale. 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 • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology As discussed in the last report, SGSSLC had begun to modify the SAP training sheet to ensure that all of the above components were included. The new SAP training sheet contained a space to list specific consequences for correct and incorrect responses, and a space to discuss how to accomplish generalization. Only three (i.e., Individual #323's SAPs of tooth brushing, purchasing items, and set-up of his plate) of the 32 SAPs reviewed (9%) contained a plan for maintenance. All skill acquisition plans should include all of the above components. Additionally, the new format SAP training sheets did not consistently reflect the processes of maintenance and generalization. A maintenance plan ensures that the newly acquired behavior occurs following the end of formal training, while a generalization plan ensures that the behavior occurs in all the appropriate situations and circumstances outside of the specific training situation. Twelve of the 32 SAPs reviewed (38%) contained a plan for generalization consistent with the definition above. An	

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		example of a good plan for generalization was: • The plan for generalization in Individual #292's SAP for self-medication stated that she should use her self-medication skills when on a community trip. An example of a plan for generalization that was not consistent with the above definition was: • The plan for generalization in Individual #396's SAP of learning to sew stated that Individual #396 "…should be able to sew items into clothing and also alter them once he moves into the community." As discussed above 91% of the SAPs reviewed did not include a plan for maintenance. The three plans for maintenance reviewed were not consistent with the above definition. For example: • The plan for maintenance in Individual #323's SAP of toothbrushing stated, "Anytime John goes to take a shower, present the opportunity for him to maintain his skill at all times." This sounds more like a plan for generalization of skills. An example of a plan for maintenance for Individual #323 would be: • After mastering the use of tooth brushing and the termination of the SAP, he will continue to be requested to brush his teeth in the morning and at shower time in the evening in order to maintain this skill. It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions. At the time of the onsite review, the facility was using the Murdoch Center Foundation skill acquisition system. This system consisted of task analyses, forward and backward chaining instruction, and a self-graphing data procedure. As discussed in the last report, implementation indicated that much more training and monitoring of SAPs at SGSSLC was necessary (see S3). <u>Desensitization skill acquisition</u> The psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. No dental desensitization plans were written since the last review. It is recommended that individualized dental desensitization plans be incorporated into the new SAP format. Outcome data (including the use of sedating medications) from	

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		desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail during future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, SGSSLC included replacement/alternative behaviors in each PBSP. Several of the PBSPs reviewed (e.g., Individual #386) included replacement behaviors written as SAPs (see K9). The format of these replacement behavior SAPs, however, was different then the new SAP format used by the facility. It is recommended that replacement behavior SAPs be written in the same format as other facility SAPs. <u>Communication and language skill acquisition</u> Several of the replacement behavior SAPs targeted the enhancement or establishment of communication and language skills. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs (also see section R). <u>Service objective programming</u> 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 QDDPs. 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 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. As reported in the last review, the monitoring team was encouraged by the overall quality of age appropriate and typical activities at SGSSLC. Consequently, in several homes visited, the individuals were out of the homes, engaging in activities in the	

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		community or 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. A particularly good group activity was found in Home 502 where several individuals were actively engaged in tabletop activities. 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. The monitoring team also observed engagement in day programs. As noted in the table below, the engagement in the day programs was good, however it only represented a small number (i.e., about 35) of the individuals at the facility. The majority of individuals at SGSSLC appeared to be on campus or in their homes. It is recommended that all individuals be actively engaged in meaningful day programing. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 72%, about the same as the last review (71%), and a considerable increase over that observed during the two previous reviews (i.e., 60% and 63%). As indicated above, the monitoring team was pleased with the quality of engagement at several of the homes and day programs at SGSSLC. 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 some room to improve. As discussed in the last report, SGSSLC's engagement data were not being summarized or shared with the staff responsible for improving engagement. It is recommended that engagement data be collected in all homes and day programs. Additionally, these data should be summarized and shared with managers responsible for improving engagement. The facility should establish engagement targets for each home and day program, and sites with low engagement should be identified and plans for improvement implemented.	

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		Engagement Observations: Location / Engaged / Staff-to-individual ratio 509A 1/1 1:1 509B 0/4 1:4 509B 0/3 1:3 509B 1/2 1:2 509B 1/1 0:1 516W 1/3 0:3 516W 3/5 3:5 516E 5/9 5:9 502 1/1 1:1 502 2/3 2:3 505A 2/2 0:2 505B 1/2 1:2 505B 1/1 1:1 504B 1/1 1:1 512 0 /4 1:4 512 2/2 1:2 Imagination Center 2/2 2:2 Suzy Crawford Center 2/2 2:2 Suzy Crawford Center 1/1 1:1 Vocational Workshop 2/2 1:2 Vocational Workshop 10/11 3:11 Vocational Workshop 15/17 3:17	

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		Educational Services SGSSLC maintained a very good relationship with the local school district, the Water Valley Independent School District (WISD). The memorandum of understanding between SGSSLC, WISD, and WISD's consultant, discussed in previous monitoring reports, was finalized. In addition, notes from the most recent three-times-a-year meeting with the public school superintendent and the school principal indicated continued good collaborative work. During this meeting, SGGLC's two new liaisons, Ms. Hinojos and Mr. Flores, were introduced. Both Ms. Hinojos and Mr. Flores were new to having school-related responsibilities. Therefore, they should obtain some training regarding special education laws and processes. The monitoring team and the ADOP discussed a way of potentially obtaining this training from a local educator. Many students had graduated from public school over the past six months. This was good to see. It did not appear that any students graduated from educational services too early. The facility conducted observations and completed an observation tool once per month at either the SGSSLC campus classroom or the WISD campus classroom. This was good to see and the monitoring team hopes it will continue. The two students who were most recently at the WISD campus participated in physical education and music with their typical peers. They did not, however, participate in lunch room. This was good progress from the time of the previous review, but there was still room for more opportunities for inclusion. Each of the ISPs stated that the individual attended public school, but there did not appear to be any attempt to incorporate what the individual was learning in school into his or her home programming. There were numerous interesting and varied educational objectives in the IEP. These should be considered during the development of the ISP. Also, it did not appear that the school progress reports were reviewed at all by the QDDP and/or the IDT. This could easily occur during the ISP quarterly review meetings that were already occurring. School was not in session during the week of this onsite review, therefore, observations of SGSSLC and/or WISD campus classrooms could not occur. The SGSSLC classroom had been painted and looked somewhat better than during the previous onsite review.	

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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 was needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was beginning the use of the Functional Skills Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the ISP attempted to identify individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to 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 had not made progress on this provision item. More work in the areas of integrity of the implementation of SAPs, evidence of data-based decisions concerning the continuation, discontinuation, or modification of SAPs, and the demonstration of practicality and function of SAPs is needed (see S1). Therefore, this item was rated as being in noncompliance. At the time of the onsite review, QDDPs at SGSSLC summarized SAP data monthly and presented those data at quarterly meetings. During the last onsite review, QDDPs graphed SAP outcome data. During this review, however, the monitoring team was not provided with any evidence that monthly SAP outcome data were graphed. The QDDPs simply noted if there was progress, or not, in each month. There was no indication of what that rating of progress was based upon. It is	Noncompliance

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		recommended that a measure of progress (e.g., the level of prompting necessary, or number of steps in the task analysis completed, etc.) be graphed monthly for each SAP to improve data-based decisions regarding the continuation, modification, or discontinuation of SAPs. The monitoring team's visual inspection of monthly SAP data revealed that skill acquisition plans were producing behavior change (as measured by a decrease in the level of prompting necessary) for only one (Individual #323's SAP of toothbrushing) of the 32 SAPs reviewed (3%). This represented a decrease from the last report when 9% of SAPs reviewed were judged to be producing a positive behavior change. Additionally, as reported last time, there were no examples of SAPs modified or discontinued as a result of the absence of progress. It is recommended that the facility ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. The implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. The monitoring team observed Individual #365's vocational SAP of woodworking. The SAP appeared to follow the task analysis in Individual #365's SAP, however the SAP outcome data were inconsistent. Upon further observation it appeared that the variability was due to the size of the piece of work that was being cut. The staff responsible for writing and implementing the SAP appeared to understand the barrier to Individual #365 progressing with this SAP, but she was not familiar enough with the new SAP training methodology to modify the SAP to teach Individual #365 to cut straight lines with increasing larger pieces of wood. Additionally, review of available SAP data indicated that several staff struggled with the implementation of the SAP methodology. Several SAP data sheets reviewed (e.g., Individual #292's independent medication SAP, Individual 238's toothbrushing SAP, Individual 254's safe walking SAP) did not appear to be correctly implemented. These observations suggested that additional training is necessary for those responsible for writing SAPs to ensure that the plans were as effective as possible. The only way to ensure that SAPs are conducted as written, however, is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. The monitoring team also reviewed SAP data sheets to evaluate if data were completed as scheduled. All five SAP data sheets reviewed (100%) documented the training of SAPs as specified in the SAP schedule. This was consistent with the last review when 100% of SAPs reviewed in the homes were completed as scheduled. Finally, during the last onsite review, the facility was planning to expand the use of SAPs to all day programs and therapy/psycho-educational classes (see K8). At the time of this review only five SAPs were implemented during day programing. It is recommended	

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		that the number of day program SAPs be increased.	
	(b) Include to the degree practicable training opportunities in community settings.	SGSSLC improved the collection of data regarding the training of SAPs in the community. Data presented to the monitoring team indicated that the majority of individuals at the facility participated in various recreational activities in the community, and several were provided training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to establish acceptable levels of activities and training in the community, and demonstrate the that those levels are consistently achieved. The facility began a new tracking of training of SAP objectives in the community prior to the onsite review. This tracking system captured community activities that were: • primarily leisure, • for general training (e.g., appropriate behavior in a restaurant), and • training on specific SAPs. The documentation revealed several instances of training of SAPs in the community. The range was large, from 44 instances from December 2011 to April 2012 for home 508A, to only 3 instances during the same period for home 516W. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved. At the time of the onsite review, one individual at SGSSLC worked in the community. This was consistent with the number reported during the last onsite review.	Noncompliance

Recommendations:

1. Ensure that the rationale for the selection of each individual's SAPs is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).

2. Each SAP should include a plan for maintenance (S1).

3. It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).

4. It is recommended that individualized dental desensitization plans be incorporated into the new SAP format (S1).

5. It is recommended that replacement behavior SAPs be written in the same format as other facility SAPs (S1).

6. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs (S1).

7. The facility should attempt to ensure that all individuals are engaged in day programming (S1).

8. Individual engagement data should be summarized and shared with managers responsible for improving engagement. Sites with low engagement levels should be identified, and target engagement levels established (S1).

9. Provide training on special education laws to the two new SGSSLC liaisons (Ms. Hinojos and Mr. Flores) (S1).

10. Engage in actions to support more inclusion of students into school classes and activities (S1).

11. Improve the ISP and the ARD/IEP by:
    a. Incorporation of the IEP into the ISP, as appropriate
    b. Review of WISD progress reports and report cards during the ISP quarterly review (S1).

12. The facility should conduct systematic preference/reinforcer assessments when asking care givers/self reports do not identify practical or potent preferences/reinforcers (S2).

13. It is recommended that a measure of progress be graphed monthly for each SAP to improve data-based decisions regarding the continuation, modification, or discontinuation of SAPs (S3).

14. The facility should ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data (S3).

15. Additional training in the SAP methodology should be provided to those responsible for writing SAPs (S3).

16. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S3).

17. Increase the number of day programming SAPs (S3).

18. The facility should establish acceptable percentages of individuals participating in community activities and training on SAP objectives, and demonstrate that these levels are achieved (S3).

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, attachments, January 2012 o SGSSLC organizational chart, undated, but probably May 2012 o SGSSLC policy lists, 4/19/12 o List of typical meetings that occurred at SGSSLC, 5/22/12 o SGSSLC Self-Assessment, 5/1/12 o SGSSLC Action Plans, 5/1/12 o SGSSLC Provision Actions Information, most recent entries 5/15/12 o SGSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/4/12 o Community Placement Report, last six months, through 6/1/12 o List of individuals who were placed since last onsite review (12 individuals) o List of individuals who were referred for placement since the last review (12 individuals) o List of individuals who were referred and placed since the last review (1 individual) o List of total active referrals (27 individuals) o List of individuals who requested placement, but weren't referred (13 individuals) • Documentation of activities taken for those who did not have an LAR (2 of 3 individuals) • List of individuals who requested placement, but weren't referred due to LAR preference (8 individuals) • 2 individuals on the list were still within the court-ordered evaluation period o List of individuals who were not referred solely due to LAR preference (1 individual) o List of rescinded referrals (9 individuals) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding o List of individuals returned to facility after community placement and related ISPA documentation (0 individual returned during this period) o Special review of 1 individual who returned to the facility during the period of the last monitoring visit. o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement, and a brief narrative for each case (6 individuals) o List of individuals who died after moving from the facility to the community since 7/1/09 (3 individuals, 1 since the last onsite review)

	o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (1 individual) o APC graphs of placement-related data, through April 2012 o APC weekly reports, five, 3/30/12 through 4/20/12 • Statewide weekly enrollment report (four) • Detailed referral and placement report for senior management (none) o Transition Committee minutes, weekly, 4/3/12 to 5/29/12 (8 meetings) o Sections F and T meeting minutes, 4/11 to 5/30/12 (3 meetings) o Variety of documents regarding • Community tours, 12/12/11 through 5/21/12 (12) and ISPAs for some (0) • Trainings/meetings for facility staff (QDDPs, residential managers, activity coordinators, January 2012 through April 2012 (4) • Meetings with local LA/MRA (2) • Self-advocacy meeting information showing focus on referral and placement • CLOIP and permanency plan tracking documents (none) o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o List of individuals who had a CLDP completed since the last review (9 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP (not within the CLDP), none o Planning documents for when an individual went on an overnight pre-selection visit to a provider o DADS central office written feedback on CLDPs (4 individuals) o For the three statewide monitoring tools for section T: • Various tables, bar graphs, and line graphs • Completed tools • Inter rater agreement information o Information presented to QI Council and included in the QA report, April 2012 o List of all individuals and an indication of obstacles (if any) to him or her being referred/placed, undated but probably April 2012 o State obstacles report and SGSSLC addendum, October 2011 • SGSSLC Obstacles report, 2/29/12 o Obstacle-related information from ISPs, table and graph, through March 2012 o PMM tracking sheet, updated with monitoring team 6/5/12 o Descriptions of Community Re-entry and Self-advocacy/Self-determination classes, Summer 2012 o Transition T4 materials for: • Individual #124 o Old-style ISPs and assessments for: • Individual #8, Individual #126, Individual #367, Individual #331, Individual #388, Individual #73, Individual #53, Individual #151, Individual #269, Individual #273, Individual #44, Individual #59, Individual #24

	o CLDPs for: • Individual #293, Individual #312, Individual #261, Individual #234, Individual #230, Individual #309, Individual #75, Individual #55, Individual #262 o Draft CLDP for: • Individual #274 o In-process CLDPs for: • Individual #353, Individual #313, Individual #143 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of the IDT meetings that occurred after each review (for many of the checklists), conducted since last onsite review for: • Individual #302: 90 • Individual #373: 45, 90 • Individual #161: 45, 90 • Individual #307: 7, 45, 90 • Individual #276: P, 7, 45, 90 • Individual #149: P, 7, 45, 90 • Individual #336: P, 7, 45, 90 • Individual #293: P, 7, 45, 90 • Individual #312: P, 7, 45, 90 • Individual #261: P, 7, 45, 90 • Individual #234: P, 7, 45, 90ftypo • Individual #230: P, 7, 45 • Individual #309: P, 7 • Individual #75: P, 7 • Individual #81: P, 7 • Individual #55: P • Individual #262: P <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor; James Reid, Janet Jordan, Transition Specialists o Roy Smith, Human Rights Officer, Zula White, Human Rights Assistant, and Melissa Deere, Assistant Independent Ombudsman o Program director and staff at Mosaic community group home, San Angelo, TX <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #274(via audio recording and written transcript) o CLDP assessment review meeting for: • Individual #143

	o ISP Meeting for: • Individual #322, Individual #188, Individual #274 o Community group home visit for: • Individual #55: 7-day post move monitoring o Self-advocacy meeting, 6/5/12
	Facility Self-Assessment SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the APC described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with the APC regarding the new self-assessment. He was interested and eager to implement this new process correctly and in a way that would be beneficial to his department. The most difficult aspects of this appeared to be (a) including the proper activities to engage in to conduct the self-assessment, and (b) understanding the somewhat subtle difference between assessing whether substantial compliance was met versus engaging in activities to meet substantial compliance. There were three self-monitoring tools used by all of the SSLCs to self-monitor section T. There were, however, numerous problems with these tools. These problems included content, administration and implementation, interpretation of data, and reliability. The state office was aware of these problems and reported that new tools were being developed. It is possible that the new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. For example, the self-assessment completed by the APC for this review relied heavily on the current self-monitoring tools. As a result, in one part of T1a, he reported on the ratings given by the raters as to whether the transfer/referral was consistent with the determination of professionals. A reading of T1a in the report, however, shows that the monitoring team looks at if and how this was addressed in IDT assessments, ISP meetings, and ISP documents. In addition, the monitoring team looked at the number of individuals referred and placed, whether adequate reviews occurred for individuals who requested

	placement, if root cause analyses were done for placement failures and other untoward incidents, and if senior management was regularly and adequately informed of individuals' referral and placement status. Thus, the item in the current self-monitoring tool was insufficient for assessing the many aspects of T1a. Other examples of where the self-assessment should better line up with the monitoring team's activities were evident in T1b1 (the monitoring team looked at nine different areas of education), T1c, and T1c1. In T1d, the monitoring team, in addition to looking at whether the assessments were done within 45 days, also looked at whether all assessments that should have been done were done, and whether every assessment was focused on the individual's impending move to a new place to live and work. On the other hand, the tool for T1b looked at facility-specific policies for transition and discharge and it looked at training requirements. These were appropriate for the self-assessment of T1b. Similarly, the items self-monitored for T1h and T4 were also appropriate. For T1e, the self-rating rationale correctly determined that the lists of essential and nonessential supports were inadequate, even though the results of the self-assessment were self-rated at 100% for all items (i.e., the scoring system was only based on presence of ENE supports, not quality of ENE supports). T1b1 has a lot of overlap with section F and the activities of the QDDPs. Therefore, it might make sense to coordinate the self-monitoring of some aspects of T1b1 with the QDDP department. T2b might be self-monitored if the APC should conduct any observations of the PMM while she is completing an onsite post move monitoring. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with four provision items: T1c2, T1c3, T1d, and T1h. The monitoring team agreed with all four of these. In addition, the monitoring team rated T2a, T2b, and T4 as being in substantial compliance.
	Summary of Monitor's Assessment SGSSLC continued to make progress towards substantial compliance. The monitoring team remained impressed with the department's knowledgeable staff. The specific numbers of individuals who were placed remained extremely stable, at an annual rate of approximately 10%, and approximately 11% of the individuals were on the active referral list. 12 individuals were placed in the community since the last review. 26 were on the active referral list. The APC and QDDP coordinator created a group to address the overlapping Settlement Agreement requirements of sections F and T. In addition, the QDDP educator formed an ISP support team.

	Opinions and determinations of professionals regarding community placement were not being adequately presented in the ISP. To help meet this requirement, a new-style ISP meeting and a new-style ISP document were created at the state level, but had not yet been implemented at SGSSLC. In reading the professionals' opinions, the monitoring team noted different "approaches" to these comments. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. The nine CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. The monitoring team, however, learned that the psychology department had very recently started two new classes, one called Community Re-entry and one called Self-Advocacy/Self-Determination. Obstacles were noted for each individual in all of the written ISPs (in different formats, such as paragraph form or bulleted form), and obstacles were somewhat discussed in the ISP meetings observed. There was, however, no indication if the identification of these obstacles led to a plan to address them. SGSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. For the most part, the CLDPs were developed in a timely manner, more so for the more recent CLDPs. Of the nine CLDPs, six (67%) were developed in a timely manner. IDT members continued to be very involved in the placement activities of the individuals. They took action when necessary. For example, the IDT abandoned one possible provider when the proposed home turned out to be in a very bad neighborhood. Another individual visited numerous providers, two times each, before a decision was made. The CLDP meeting held during the week of the onsite review was a great improvement in content, style, and participant involvement compared to the one observed during the last onsite review. IDT meetings occurred after post move monitoring visit, even if there were no problematic issues. The CLDPs identified the need for training for community provider staff. The CLDPs included some descriptions of the content of what was to be trained, but more detail was needed regarding this training. The sets of CLDP assessments were all completed within 45 days prior to the individual leaving the facility. The assessments need to focus more upon the individual moving to a new residential and day setting. The lists of ENE supports still needed more work because a number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included.

	The amount of items missing, however, was improved since the last onsite review. The monitoring team recommends that the IDT receive training specific to the development of ENE supports once an individual is referred. The APC should create a self-assessment specifically for the ENE supports. Since the last review, 34 post move monitorings for 15 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All 34 (100%) occurred within the required timelines. This was no easy feat given the locations of day and residential sites all over the state (e.g., Houston, Amarillo). All 34 (100%) were documented in the proper format, in line with Appendix C of the Settlement Agreement. Of the 15 individuals who received post move monitoring, 10 (67%) appeared to be doing very well and having a great life. Many of the post move monitoring reports noted that families were very happy to have their loved one nearby. Three individuals (20%) had experienced some problems, but these seemed to be resolving. One individual was doing very badly, including being moved from her group home for placement with her mother, and one individual died at around the time of the 90-day review.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available	SGSSLC continued to make progress towards substantial compliance with the items of this provision. Tim Welch, the facility's Admissions and Placement Coordinator (APC) continued as the lead for this provision. He continued to be assisted by the two transition specialists, James Reid and Janet Jordan, and by the post move monitor (PMM), Denise Copeland. The APC anticipated that there would be new one transition specialist appointed to the facility sometime in the next few months. The monitoring team remained impressed with the department's knowledgeable staff. They were motivated to achieve substantial compliance. Moreover, the APC was very responsive to many of the suggestions and recommendations made in the last monitoring report and during the last onsite review. The specific numbers of individuals who were placed remained extremely stable, at an annual rate of approximately 10% and approximately 11% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 12 individuals were placed in the community since the last onsite review. This compared with 13, 10, 10, and 17 individuals who had been placed during the periods preceding the previous reviews, respectively. o This demonstrated a stable trend. o The 12 individuals were from all three of the units.	Noncompliance

	to the State, and the needs of others with developmental disabilities.	• 12 individuals were referred for placement since the last onsite review. o This compared with 23 who were newly referred at the time of the previous review. o 0 of these 12 individuals were both referred and placed since the last onsite review. • 27 individuals were on the active referral list. This compared with 33, 27, 21, and 19 individuals at the time of the previous reviews, respectively. o Although lower than six months ago, overall, this was a stable number. • 13 individuals were described as having requested placement, but were not referred. This compared with 27, 21, 44, and 80 individuals at the time of the previous reviews, respectively. o 3 were not referred due to what SGSSLC called behavior/psychiatric issues. For 2, a thoughtful and individualized review process (called a lack of consensus review) was held. This was another improvement since the last monitoring review. After the facility's lack of consensus review was completed, the independent ombudsman also reviewed the cases. In one of the cases, the independent ombudsman did not agree that the team had followed all of the referral processes because the PSBP hadn't been revised in over a year. At the time of this writing, the monitoring team did not have an update as to the facility's response. Documentation was not provided for the third case (Individual #14). o 8 were not referred due to LA preference. o 2 were not referred because they were in the court-ordered evaluation period. o 0 were not referred due to LA not being present. LA presence was no longer required. This change in process was an improvement from what was found during previous reviews. • The list of individuals not being referred solely due to LAR preference contained 1 name (compared to 12, 5, and 8 individuals at the time of the previous reviews, respectively). o The APC should work with the QDDP coordinator and ensure that this number is correct. • The referrals of 9 individuals were rescinded since the last review. This compared to 2, 3, 5, and 4 at the time of the previous reviews, respectively. o An increase in the number of rescinded referrals should not be viewed as an increase in failure by the facility. Rather, the IDTs were moving forward in referring individuals, however, given the complex needs, behaviors, and histories of many of these individuals, many of their referrals had to be discontinued, at least temporarily. o Each individual's IDT met and an ISPA report was issued that provided information indicating that the decision to rescind was reasonable and	

done thoughtfully. All of the rescindings were due to increases in serious behavioral and psychiatric problems (e.g., inappropriate sexual behaviors, aggression, suicidal actions, refusals to participation).
    - The database listing, however, did not accurately reflect the reasons for the rescinding. They reasons were either Individual Choice or LAR Choice. These descriptors were misleading and inadequately described the reasons for the rescinding (i.e., behavior and psychiatric problems).
    - A special review team meeting was also held for each of these rescinded referrals.
    - As recommended in previous reports, however, the APC should do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been done during the time the individual was an active referral. Note that the ISPA and the SRT notes provided a lot of detail regarding the decision to rescind. The purpose of the APC review is to assess the referral and placement processes (as was done following one individual's return from the community, see below).
- 0 individuals were returned to the facility after community placement. This compared with 2, 0, and 1 individuals at the time of the previous reviews.
    - The APC did a special review of one of the individuals who was returned to the facility after a failed community placement that occurred during the week of the previous onsite review. As part of the review, the APC had the group discuss "Could anything have been done differently, and if so, what?" A number of some good ideas were discussed, including:
        - The LA should have contacted SGSSLC sooner so that the facility's IDT could have helped.
        - Immediate psychological/psychiatric intervention in the community might have helped.
        - During the placement process, there was more focus on the individual choosing a provider that she liked versus one that could meet her emotional and mental health needs.
        - Individual counseling was included as a nonessential support, but should have been an essential support.
        - The IDT could have perhaps, by design, been more involved with the provider, especially during the first 30 to 60 days (in addition to the standard post move monitoring).

      This type of discussion was what the monitoring team had been recommending in previous reports and was hoping to see. These helpful comments should be incorporated, perhaps via a list or guide, for use by the transition specialists, because they oversee the CLDP process.
- Data for individuals who were hospitalized for psychiatric reasons, incarcerated,

		or who had run away from their community placements were available for the first time, another positive action taken by the APC. The APC initiated a simple spreadsheet database with 7 categories (police involvement, psychiatric hospitalization, emergency room/hospitalization, unauthorized departure, death, transfer to another provider or another home with the same provider, and returned to the facility). The APC and the monitoring team discussed the facility obtaining these data for one year post-move. Data were readily available through the first 90 days due to post move monitoring. A simple phone call to each provider at 12 months appeared to be a reasonable and relatively easy task. o 5 individuals had one or more of these incidents occur since the last onsite review. o A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events in order to assess the referral and placement processes (as was done for the one individual who returned to the facility in December 2011). • 1 individual had died since being placed since the last onsite review. • 1 individual was discharged under alternate discharge procedures (see T4). Another area of progress was the APC's graphing of most of the above bullets, as also recommended in previous reports. Eight bar graphs were presented with month-to-month data. This was an excellent start. The monitoring team recommends that line graphs be used rather than bar graphs, that each graph specify whether the data were for new individuals for that month versus cumulative/ongoing, and add a graph for number of individuals who experienced serious post move incidents. This new graph should not count individuals more than once if, for example, one individual had more than one incident or more than one type of incident. These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). <u>Other activities</u> SGSSLC engaged in three other new activities towards meeting the requirements of T1a. First, since the last onsite review, the APC and QDDP coordinator created a group to address the overlapping Settlement Agreement requirements of sections F and T. This so-named "F and T Team" had met three times and was in the early stages of setting up goals and outcomes. Overall, however, it appeared to be a good idea and the agenda topics looked very relevant. Second, a transition committee was created out of the previous admissions and transfers committee. This group now reviewed the status of some referrals in addition to admissions and within-facility transfers between homes. Third, the QDDP educator formed an ISP support team. This was a group of about a dozen staff who were trained and were in agreement about the key components of an ISP	

		meeting. They attended meetings, provided coaching, and provided feedback to IDTs following the meeting. This group will increase the likelihood of good implementation of the new ISP process when it is brought to SGSSLC over the next few months. <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 ISP assessment process, occur during the annual ISP meeting, and be documented in the written ISP. To help meet this requirement, a new-style ISP meeting and a new-style ISP document were created. Training and initiation of these, however, had not yet occurred at SGSSLC. Even so, some progress was noted at the facility, perhaps based on knowledge of the upcoming trainings and changes, as well as comments in previous monitoring reports. First, for the written assessments (for a sample of annual ISPs reviewed by the monitoring team), many included a statement by the professional regarding his or her opinion about community referral and placement. It appeared that more assessments included these statements since March 2012 than did so before that month. Statements, however, occurred inconsistently across types of assessments. They were most regularly found in the annual medical assessment, annual nursing assessment, and OTPT assessments. They were found in some, but not all, of the assessments by psychology and by speech and language. They were rarely, if ever, found in the assessments from other disciplines. In reading the professionals' opinions, the monitoring team noted different "approaches" to these comments. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. It may be that all three of these aspects of the professional's opinion should be addressed (that is the belief of the monitoring team). 1. A description of what supports that individual would need if he or she lived in the community. This was not really an adequate indication of the professional's opinion. 2. A statement of whether needed supports could be provided in the community, based upon the professional's knowledge of available community supports. 3. A specific declarative statement regarding whether the professional believed the individual should be referred and whether the individual was likely to do well in the community. Second, the monitoring team reviewed a set of completed ISP documents and found that there was discussion of living options in every one of them. However, the ISP document	

		did not specifically include any statements regarding each professional's determination regarding most integrated settings and community placement. There continued to be a statement at the end of the ISP narrative, but it did not reference the opinions of the IDT members. Third, in all of the ISP meetings observed during the week of the onsite review, living options were discussed. Professionals were not asked to give their opinions, though some did. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by SGSSLC IDT members. The facility's human rights officer and assistant independent ombudsman worked tirelessly, and in an integrated and reasonable manner, to support individual's self-advocacy, decision-making, problem solving, and rights. <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> There was no mechanism to provide the kind of detail that senior management should have regarding the status of individuals who were on the referral list. The monitoring team continues to recommend that the APC continued to keep facility senior management well informed of the status of all referrals. A brief weekly oral presentation might be one way to do so.	
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, dated 3/31/10. A revision was completed and the DADS state office was expecting to disseminate it very soon. The admissions and placement staff reported that the facility followed the state's policy. The facility-specific policies were unchanged since the last onsite review and any comments from previous monitoring reports were still applicable. Implementation of the new state policy will require updating of facility policies to make them in line with the new state policy.	Noncompliance
	1. The IDT will identify in each individual's ISP the	The new-style ISP process described in the previous report had not yet been brought to SGSSLC. This new process was designed to address the many items that were required	Noncompliance

	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.	by the Settlement Agreement, ICF regulations, and DADS central office. Further, the new ISP was to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), and the identification of individual obstacles (T1b1). Due to the delay in training and implementation, ISP assessments, meetings, and documents remained in what was now called the old-style. <u>Protections, Services, and Supports</u> Because the ISP will be changing, recommendations (other than to implement the new ISP process) are not presented here. Instead, the reader should see sections F and S of this report regarding the monitoring team's finding about the current status of ISPs. In the ISP meeting for Individual #322, there was much discussion regarding his refusals to attend day programming and to engage in good personal hygiene. A number of health and safety supports were discussed and included in his ISP. There was, however, inadequate attention paid to developing any new skills (e.g., SAPs). The nine CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that training objectives were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC seek out the IDT, and the QDDP coordinator and QDDP educator to talk about what training objectives might be considered now that the individual was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. The monitoring team learned that the psychology department had started two new classes, one called Community Re-entry and one called Self-Advocacy/Self-Determination. The Community Re-entry class was specifically designed for individuals during the six-month period before their move. Approximately nine individuals attended the men's or women's class. The class, however, had only very recently begun and it was too early to evaluate attendance and participation, outcomes, and quality. <u>Obstacles to Movement</u> SGSSLC continued to make progress regarding this aspect of this provision item, though much more work was needed. Obstacles were noted for each individual in all of the written ISPs reviewed by the monitoring team (in different formats, such as paragraph form or bulleted form), and obstacles were somewhat discussed in the ISP meetings observed. There was, however, no indication if the identification of these obstacles led to a plan to address them. Discussion during Individual #322's ISP illustrated QDDP and IDT struggles in	

		identifying and addressing obstacles. The QDDP asked the IDT if there were any obstacles. The psychologist noted physical aggression and inappropriate sexual behavior. The QDDP said that the IDT could select up to three obstacles. She later noted that one obstacle was regarding employment. After the ISP meeting, the QDDP coordinator (as a member of the ISP Support Team) gave some feedback to the team, suggesting that they create a plan with goals and tracking to address obstacles. The APC further developed the spreadsheet of obstacles that was shown to the monitoring team during the previous review. It was not clear to the monitoring team as to how, or if, the information in this spreadsheet was used in any way. A new self-review process, however, was initiated and this was very good to see. It began in January 2012 and was a monthly review of about 20 ISPs to determine if (a) obstacles were clearly identified, (b) a plan to overcome obstacles was stated, and (c) a form called an AV6 was completed. Data showed that about half of the ISPs included clearly stated obstacles and about one-third included a plan to address or overcome those obstacles. This important review and data should be included in the department's data presentation to QI Council and in the facility's overall QA program. The new-style ISP process will help the IDTs identify obstacles and plan strategies to potentially overcome them in a way that will move the facility towards substantial compliance with this provision item. The APC should also see section F1e of this report for additional information relevant to this provision item.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The monitoring teams, DADS central office, and DOJ recently agreed on the specific criteria for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. SGSSLC was engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Below are the agreed-upon activities (the closed and open bullets) followed by SGSSLC's status for each. The bulleted lists can be used for the facility's next revision of its self-assessment. <u>Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. <u>SGSSLC status</u>: SGSSLC continued to follow the old-style ISP format, which did not address all three of the bullets listed immediately above. Some ISPs described what	Noncompliance

		the individual had done, whereas others described what the individual might do during the upcoming year. The new ISP format will provide more guidance to the IDT and QDDP in addressing the education of each individual and LAR, however, the QDDPs will need to ensure that they address each of the three bullets listed immediately above. Provider fair • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs SGSSLC status: The annual provider fair was held in October 2011 and comments from the previous report are not repeated here. The monitoring team was not provided with any information regarding the next upcoming provider fair and what, if any, changes and/or improvements were being planned. Local MRA/LA • Regular SSLC meeting with local MRA/LA SGSSLC status: The APC appeared to have a good working relationship with the local authority. Quarterly meetings (two since the last onsite review) were occurring as scheduled. Topics appeared to be relevant. The annual inservice with the LA had occurred prior to the previous onsite review and was not due to occur again for another few months. Education about community options • Outcomes/measures are determined and data collected on: o Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities SGSSLC status: SGSSLC had not yet started to address this activity. The APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the MRA/LA CLOIP workers. Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. SGSSLC status: The APC had made good progress since the last onsite review. More	

		tour opportunities had occurred (12) compared to the previous reviews (9). The APC made a list of the tours, and he created a spreadsheet showing the number of individuals scheduled, number who cancelled, the number of providers visited, the number of staff who attended, the number of IDT members who attended, and whether any family members attended. This was a very good start to a system to manage tours. After each tour, the accompanying staff wrote good descriptions about the individuals' reactions. Going forward, this system should next: o Ensure the information about each individual gets to the IDT so that it can be used by the team for planning purposes (such as for the individualized plan noted above). o Make sure there is a comment about each one of the individuals following each tour. o Include these data in the QA program and perhaps graph the number of individuals who went on community tours in the set of graphs described in T1a. o Some individuals may have gone on more than one tour. In the data, separate out these totals. <u>Visit friends who live in the community</u> <u>SGSSLC status</u>: SGSSLC was not yet implementing this activity in any organized manner. <u>Education may be provided at</u> • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate <u>SGSSLC status</u>: SGSSLC continued to provide a lot of information to individuals, especially via the monthly self-advocacy committee. Since the last review, individuals who had moved to the community had come to speak at one or more meetings. The human rights officer reported that the presentations were outstanding and led to good discussion among the attendees. Further, it led to the creation of a day program class called "Community Re-entry." The APC and human rights officer might consider also taking advantage of the weekly meetings that occurred on each home. To that end, they might talk with the unit directors about where it might make sense to conduct a presentation and discussion about community living. <u>A plan for staff to learn more about community options</u> • management staff • clinical staff	

		• direct support professionals SGSSLC status: SGSSLC made good progress on this activity. For instance, there were two sessions with QDDPs (January 2012 and April 2012), a training on the CLDP process for house managers, psychologists, and QDDPs (April 2012), and a CLOIP workshop (February 2012). The facility might consider a standard set at one of the other SSLCs: newly hired QDDPs were expected to attend a community tour within their first six months of employment and all IDT members were expected to go on at least one community tour each year. The initiation of providing more information to senior management, as noted in T1a, might also help the facility work towards meeting this aspect of this provision item. Individuals and families who are reluctant have opportunities to learn about success stories • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition SGSSLC status: The APC was not yet implementing this activity.	
	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 during the living options discussion at the annual ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. The QDDP had primary responsibility for this process. In addition, a listing was given to the monitoring team showing every individual, the individual's preference, and whether the IDT referred the individual for community. The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the facility will need to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments. o This was somewhat occurring as noted in T1a. Implementation of the new ISP process will likely help this to occur facility-wide. • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting. o This was not occurring at SGSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting. o This was evident during the observed ISP meetings at SGSSLC, however,	Noncompliance

		as noted in T1a, more training and support for QDDPs will be necessary as the new ISP process unfolds. In one ISP meeting, the individual was scheduled to move within the upcoming month. In a second ISP meeting, the team spoke at length about her on and off again desire to move, her recent serious psychiatric issues, and the role/factor of her boyfriend in her desire to move. In the third meeting, the team quickly rejected the individual's desire to ultimately move due to psychiatric/behavioral problems and refusals to participate in any treatment or activities. • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR o Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in with enough detail.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted nine CLDPs to the monitoring team for individuals placed since the last review. This was 75% of the 12 CLDPs completed since the last review. Two of the other three were near completion at the time of the last review and one was not submitted to the monitoring team (Individual #81). The APC used the statewide self-monitoring tool for CLDPs to review the department's CLDP quality, however, as noted in sections E and T1f, these tools need to be (and fortunately were being) revised to reflect more valid content. As a result of the invalid tools, the APC's self-rating scores appeared to be inflated. <u>Timeliness</u>: For the most part, the CLDPs were developed in a timely manner, more so for the more recent CLDPs. Of the nine CLDPs, six (67%) were developed in a timely manner. This included Individual #55's referral: even though the amount of time from referral to placement took a long time, the reasons for the delay were explained very well. For the other three individuals, there were long gaps, often many months, when there did not appear to be any activity regarding placement, or any explanation as to why there was no activity. The APC developed a bar graph showing the dates of referral to placement. The monitoring team recommends that he also summarize these into two data graphs to show the length of time that each individual was on the referral list. This should be done for individuals were placed, and for individuals still on the referral list. This would allow for a comparison that might likely show a decrease in amount of time from referral to placement.	Noncompliance

		Initiation of the CLDP: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This was now occurring at SGSSLC, usually at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. Three of these in-process CLDPs were reviewed. They were for referrals that occurred two, three, and four months ago. These CLDP contained some relevant information. Two of the three (67%) were initiated within a couple of weeks of the referral. One was initiated approximately two months after the referral. CLDPs need to be initiated and developed in a more timely manner for all individuals. IDT member participation: IDT members continued to be very involved in the placement activities of the individuals. The types of examples presented in the previous report were also evident this time. Team members thoughtfully evaluated the homes and day programs being explored by the individual. By being highly involved, and with the leadership of the APC, every one of the placements was individualized and the path that each individual took to placement was based around his or her needs and preferences. To accomplish this, there were many visits to providers, overnight trials, and IDT meetings to review and discuss. At SGSSLC, a Site Visit Notice and Medication Request was prepared and distributed prior to any overnight visit. Briefly, for example, the IDT abandoned one possible provider for Individual #312 when the proposed home turned out to be in a very bad neighborhood; and Individual #55 visited numerous providers, two times each, before a decision was made. The transition specialists now coordinated the pre-selection visits by handling the scheduling and arranging for any necessary trainings. This was a good idea and was very helpful to the workload of the QDDPs. Moreover, the transition specialists now entered all ISPA information into the CLDP, thereby no longer requiring the QDDP to do that, too. CLDP meeting prior to move: The CLDP meeting held during the week of the onsite review for Individual #274 was a great improvement in content, style, and participant involvement compared to the one observed during the last onsite review. Although this meeting was conducted by a different transition specialist than observed last time, it seemed clear to the monitoring team that the APC and his staff had worked to make all CLDP meetings more engaging and efficient. First, the transition specialist used most of the meeting to discuss ENE supports. Second, she regularly involved the individual and	

		other participants. Third, she came well prepared, but did not overly control the meeting. Fourth, the meeting lasted about 90 minutes. The monitoring team liked that the transition specialist raised some of her own concerns during the meeting. For example, she identified that the IDT had recommended discontinuing the BSP. She smartly suggested that this group talk about it and, as a result, they decided to keep the current BSP in place given that this was going to be such a change in lifestyle for the individual. Further, the transition specialist quickly worked through the proposed ENE list, ensuring that there was some evidence to be identified for each ENE support (though more improvement was needed, as noted throughout section T of this report). She did, however, talk about a monitoring log for the provider to keep track of a number of ENE supports that were daily tasks, such as using a bathing chair, taking care of her dry skin, and participating in leisure and community activities. This was very good to see. <u>Post post-move monitoring IDT meetings</u>: IDT meetings occurred after post move monitoring visit, even if there were no problematic issues. The monitoring team was given documentation for 30 of the 34 post move monitoring visits conducted since the last review. The four that were not done were scheduled to be held and, given that the IDTs had held the first 30, the monitoring team considers that all (100%) of the post move monitoring reviews to have been followed by an IDT meeting (also see T2a).	
	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.	Nine CLDPs developed and completed since the last onsite review were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. Some comments regarding the actions in the CLDP are presented below. Note that SGSSLC had made good progress in all of these areas. This progress was seen in some, but not yet all, of the CLDPs, representing an improvement from the previous monitoring review. • The CLDPs identified the need for training for community provider staff. The CLDPs included some descriptions of the content of what was to be trained, but more detail was needed regarding this training. o All of the specific community provider staff who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff) were not identified. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP. o Training should have a competency demonstration component. Many of	Noncompliance

		the descriptions of inservicing now noted that staff were to be required to give a verbal description and to answer questions, or to answer a multiple choice paper quiz (e.g., Individual #234). This was an improvement from the previous review. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate and now included the name of the responsible person. The completion of these activities also needs to be documented. • Actual implementation of ENE supports by staff should be required in the essential and nonessential support sections, not only inservicing. This needed a lot of improvement (see T1e). • Also see comments in T1e below. DADS central office continued to conduct reviews of CLDPs at SGSSLC, but only for four of the CLDPs and for none of the more recent ones. Feedback from central office had been very helpful to the facility and should continue. Compared to the time of the previous review, there seemed to be fewer needed corrections, facility staff now responded to each question, and DADS comments were now used by the staff to edit and finalize the CLDP.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions. This included ENE supports and other pre- and post-move activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual and LAR review. Individuals and their LARs were very involved in the process. The monitoring team was impressed with this aspect of SGSSLC's referral and placement program. Many examples were provided in the CLDPs reviewed by the monitoring team.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. Therefore, the CLDP document referenced these updated/summarized assessments, rather than full assessments. The updated assessments were attached to the CLDP. This was an adequate process. An IDT meeting was held about a month prior to the CLDP meeting to review assessments and determine which disciplines needed to provide new or updated assessments.	Substantial Compliance

		The monitoring team's review of the nine CLDPs indicated that the sets of assessments were all completed within 45 days prior to the individual leaving the facility. Even so, there were problems with the assessments and the way they were handled in the CLDP. These must be corrected or this item will not remain in substantial compliance. • The assessments need to focus more upon the individual moving to a new residential and day setting. All of the staff who wrote assessments were well aware of where the individual was moving (as evidenced in the CLDP meeting), however, their assessments usually made little reference to the new home or day program. The monitoring team recommends that the assessment updates have prompts to the writer, such as "Instructions to provider" and/or "Recommendations in the community setting." These sections can help focus the professionals on the individual's specialized needs in his or her upcoming new home and day settings. The APC and his staff should thoroughly look at these recommendations to ensure that they are sufficiently future-oriented. • The IDT often did not ask for more than five or six assessments. Although this was their decision to make, the monitoring team recommends that the IDT take this one last opportunity to ensure that all relevant information and recommendations get to the provider. For instance, for many of the individuals, there was no nursing assessment (or perhaps it was combined with the medical assessment) and no risk assessment. • SGSSLC made progress in describing, in each subsection of the CLDP, deliberations (discussion) that occurred during the CLDP meeting, and in clearly identifying what recommendations came out of the CLDP meeting. o If a recommendation in an assessment does not make it into the list of ENE supports, it should be documented as to why. • In addition, sometimes the bulk of the text from the professional assessment was cut and pasted into the CLDP, though not always. The facility should make a decision to either insert all text from all assessments in this section of the CLDP, or to insert none at all.	
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	SGSSLC made progress in identifying essential and nonessential (ENE) supports. The transition specialists described some of the processes they put in place that resulted in this progress, such as pre-CLDP meetings and comparing the ENE list to what was in the ISP. This was all good to hear about, however, more work will be needed in order for the facility to achieve substantial compliance. The systems in place at SGSSLC provided many opportunities for the development of an adequate and well-written list of ENE supports. Examples included the APC-PMM-IDT meeting, the meeting to discuss discharge assessment updates, the preparation of	Noncompliance

	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.	discharge assessment updates, the pre-CLDP meeting, and the CLDP meeting. For example, during the meeting to discuss discharge assessment updates for Individual #143 during the week of the onsite review, the monitoring team asked questions and gave guidance to the IDT about the development of ENE supports. This seemed to be helpful to the QDDP, psychologist, and other team members. The transition specialist should be a leader in these types of meetings in regards to the ENE supports. IDT members should be encouraged to challenge each other and ask each other questions about possible missing supports, inadequately worded supports, and supports that were not written in a way that would clearly direct the provider as to what the staff were to do, and clearly direct the PMM as to what she was to look for during post move monitoring. • The development of adequate, well-worded ENE supports is so very important to the success of the individual. SGSSLC, however, continued to struggle with this. • Therefore, the monitoring team recommends that the IDT receive training specific to the development of ENE supports once an individual is referred. This was also noted as a recommendation in the provision action information under T1a, 1/24/12, as part of the APC's review of the return of Individual #197 to the facility after a failed community placement. It appeared that the IDT often limited the list of ENE supports to what was written in the set of professional assessments and assessment updates. To address this, the transition specialist should, while reviewing the assessment updates and while assembling the draft CLDP in preparation for the CLDP meeting, read everything in the entire CLDP and in every assessment. Based on this, she should then create her own list of important items to bring to the CLDP meeting (or to one of the other pre-CLDP meeting activities). Further, the monitoring team believes that the APC needs to create a self-assessment specifically for the ENE supports component of the CLDP. Although progress was seen compared to the time of the previous onsite review, the monitoring team believes that a self-assessment <u>prior</u> to completion of the list of ENE supports is the only way substantial compliance will ever be obtained. By doing so, it will also be more likely that <u>all</u> CLDPs will have <u>all</u> of these issues addressed, rather than <u>most</u> of the CLDPs having <u>some</u> of these issues addressed. The monitoring team believes this is necessary because it has been providing similar feedback in a number of successive reports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below. • Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. • All safety, medical, and supervision needs were addressed. • What was important to the individual was captured in the list of ENE supports. • The list of supports thoroughly addressed the individual's need/desire for employment. Many individuals are excited to move to the community and do	

not fully understand that it may take months, if not longer, to find a job.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports.
- There were ENE supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day.
    - Each individual at SGSSLC had something called a training guide. Detail must be provided so that the provider knows what to implement, and the PMM knows what to look for during post move monitoring.
    - Any ENE support that calls for an inservice should have a corresponding ENE support for implementation of what was inserviced. A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation.
- Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. For example, this was done in the CLDP for Individual #230.
- Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence).
    - Evidence should be described in observable terms and should have criteria when appropriate. Evidence such as random interviews, conversations with staff, and daily progress notes are insufficient. A staff checklist, as discussed with the APC, transition specialists, and PMM might be one way to address this.

The lists of ENE supports still needed more work because a number of important supports and services, based on the individual's preferences, safety needs, and personal development needs were not included. The amount of items missing, however, was improved since the last onsite review. Some examples are below.

Individual #75:

- She had a history of physical and verbal aggression, self-injury, running away, and schizophrenia. Moreover, she had a very serious incident at the emergency room of a local hospital that involved the police during her trial visit to the provider. This should have resulted in better preparing for her behavior outbursts, including especially ensuring the positive aspects of her plan were being implemented every day.
- Staff were to follow the BSP, but the ENE supports did not require them to document implementation. This was important because this individual had many procedures in her BSP that were likely critical to her success, such as problem solving, redirection, counseling, extinction, modeling, and correction. Instead, the ENE supports only required a copy of the BSP and data sheets as

		evidence. • Her weight problems were not addressed via an ENE support. • Her assessments referred to the importance of having a meaningful workshop activity, but this was not addressed. • The monitoring team wondered if a criterion of engaging in meaningful activities "at least once per week" was frequent enough for her. • Her placement ultimately failed at the group home. At the time of this review, she was living with her mother. Individual #309: • There was very little required of the provider for implementation of behavioral programming other than there be staff training documentation, a copy of the BSP, and data sheets. There were many other important aspects of the BSP that were not required to be implemented, such as social and token reinforcement, counseling, redirection, relocation, extinction, and correction. • Weight problems were not addressed via an ENE support. • It was good, however, to see a specific essential support regarding the management of any psychotic episodes. • It was also good to see some individualized ENE supports, such as gardening, and reading and math classes. Individual #230: • He had a previous failed placement and based upon his assessments, it appeared that an LSOTP program was important, however, it was not included in his list of ENE supports. • He appeared to need a lot of structure in his day, relaxation opportunities, support for problem solving, opportunities to earn reinforcers, and to be able to talk with staff. Again, the only ENE support was to continue the BSP. • It was good, however, to see ENE supports for an all male staff and for Clozaril monitoring. Individual #234: • There was an ENE support to continue the behavior support plan, but it did not specifically address important components, such as his reinforcement system and the use of problem solving. • Some important topics noted in the CLDP and in some assessments did not appear to have been addressed in the ENE supports. Examples were going to school, learning to take public transportation, and skill training. Individual #261: • Again, the IDT included a support to continue the BSP, but it needed to include	

		all of the important aspects of the BSP that were also noted, such as social and token reinforcement. • It was good to see that two training objectives were carried forward, laundry and tooth brushing. Individual #312: • Her LAR stated that the individual needed more social interaction to prepare for her move, however, nothing was done to address this. • Anger management and counseling were not included as ENE supports. These were important aspects of her success. Instead, there was an ENE support for a new psychological evaluation. It seemed to the monitoring team that the IDT should have found this to be inadequate. Individual #293: • He had serious medical and psychiatric diagnoses, including anti-social personality disorder, heart issues, and obesity. • Although individual and group counseling were reported as being very important, there was an ENE only for there to be a review by a new psychologist. • It was good to see that three training objectives were brought forward from the ISP into the ENE list of supports. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. For each of the individuals, the pre-move site review was conducted by the PMM. The PMM might consider bringing an IDT member along as well, though distance of many of the sites may make it too prohibitive to do so. Each review indicated that each essential support was in place. • Each of the nonessential supports should have an implementation date. All of them did. • Some facilities hold an IDT meeting immediately following the pre-move site review before the individual moved. SGSSLC might consider this.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The APC engaged in a number of activities related to this provision item. One was the completion of the statewide self-monitoring tools that were developed for the living options discussion, the CLDP, and post move monitoring. These were completed by the APC, transition specialists, PMM, and QA department staff. The monitoring team was given 18 completed forms (eight for living options discussions, five for CLDPs, and five for post move monitorings). Based on these reviews, the APC created line graphs showing scores from month to month, bar graphs showing detail for each month, and a report (and oral presentation) of	Noncompliance

		these same data in the QI Council and QA report. The APC made some thoughtful comments about his department's data in the QA report. These were all very good activities, however, as noted in sections E and T1c (and in previous monitoring reports), the content of these three checklists, criteria and definitions of items, the way in which they were implemented, and the face validity of the tools needed to be addressed. This was not lost on the APC and the state office continuity of service coordinator. To address this, state office was developing new tools and a new self-assessment for all of provision T. To create a more organized (and thereby more effective and useful) process, the state office and APCs should align their activities with the content of the Settlement Agreement and with the content of the monitoring team's report. That is, the APC, when self-assessing provision T, should be looking at the same activities and documents that the monitoring team looks at. The APC should then judge both the occurrence/presence and the quality of those activities and documents. This means that the department will need to self-assess its performance on every provision item by observing, collecting data, reporting data, and making changes based upon these data. Please also see the comments at the beginning of this section of the report in Facility Self-Assessment. As noted in T1e, a more detailed self-assessment tool might be needed for some of the items of provision T. The APC would benefit from working closely with the QA department.	
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	Activities at the state and facility levels demonstrated some progress towards substantial compliance with this provision item. At the facility level, the APC completed an annual and a quarterly narrative, the most recent dated 2/29/12. In it were also some data taken from a recent set of ISPs. Surprisingly, in the most recent report, the APC reported that obstacles due to challenging behaviors, mental health needs, and forensic needs accounted for only 16% of the individuals at the facility. This was surprising given the population at the facility as well as the data in the annual report that showed about 40%. The APC noted in both reports, however, that better data integrity, QDDP training, and implementation of the new ISP process were necessary for good data to be available so that a good obstacles report could be written. Of note, was that one obstacle was eliminated, that is, an LA representative was no longer required to be present for a referral to occur. This had been an obstacle for many individuals in the past.	Noncompliance

	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.	The APC also created a spreadsheet that listed every individual at the facility and obstacles identified by the IDT. Further, if any of the obstacles were individual and/or LAR reluctance, the reason for the reluctance was listed. The spreadsheet was created to generate data for the annual and quarterly report, however, other departments and staff might have uses for the data, such as the QDDP department, the human rights officer, and senior management at the facility. The facility should also consider a data system that needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. Assistance from the QA department and from state office might be helpful in analyzing data once it is collected. At the state level, DADS created a report summarizing obstacles across the state and included the facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	

T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 12/1/11 through 6/1/12. Although not yet included, the facility and state's intention was to include, in future Community Placement Reports, a list of those individuals who would be referred by the IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted in T1a, the APC had created this list; it should be included in this report, too. Curiously, the list contained only one name.	Substantial Compliance

T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the 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.	SGSSLC achieved substantial compliance with this provision item. <u>Timeliness of Visits</u>: Since the last review, 34 post move monitorings for 15 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All of these were completed by the PMM, Denise Copeland. All 34 (100%) were reviewed by the monitoring team. All 34 (100%) occurred within the required timelines. This was no easy feat given the locations of day and residential sites all over the state (e.g., Houston, Amarillo). The PMM visited both the residential and the day program sites. As discussed with the APC, the monitoring team recommends that a simple review be done of all placements to find out if any serious incidents occurred for the period of one year following placement. As noted in T1a, a simple phone call would be an easy way to obtain this information. <u>Content of Review Tool</u>: All 34 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. • Post move monitoring report forms were completed correctly and thoroughly. Good information was included. • The PMM added comments into the evidence box, so that this box described not only what she was to look at, but additional information as well. This was good. • The monitoring team also very much liked that the PMM wrote detailed comments throughout the report. This helped provide a broader picture of the PMM's overall opinion of the placement. Please continue to provide this. • The monitoring team also liked that the PMM completed the checklists in a cumulative format, that is, she scored each item as yes/no for the current review, but she kept her comments (with dates) from any previous reviews in all of the boxes on the form. Thus, the 90-day checklist became a single cumulative document showing every visit from pre-move through the 90-day. This made it very easy for read to follow the individual through his or her first 90 days in the community. • The PMM made appropriate lists of follow-up activities/actions for the PMM at the end of each report. • The assertiveness and follow-up exhibited by the PMM was greatly increased	Substantial Compliance

		from the time of the previous review. Substantial compliance was achieved by SSLC. Even so, the following comments should be considered as the PMM and APC move forward with ongoing post move monitoring: • Be sure to continue with assertive follow-up. o The monitoring team noted that behavioral or medical issues came up right at the time of the 90-day review for a number of the individuals (Individual #234, Individual #261, Individual #312, Individual #336, Individual #302). Even so, the PMM did not do any further monitoring after 90 days (although at the time of this writing, Individual #261's IDT had not yet met to review his 90-day report, so it is possible that they did decide to do so). The PMM and the APC, along with the IDT, should determine if further post move monitoring is warranted if issues are not resolved or if the individual is in distress or crisis at the 90-day review. They might require paperwork follow-up, or even another visit at 120-days. At the next onsite review, in order to maintain substantial compliance, the monitoring team will look for these determinations/discussions to have occurred. • The individual's psychiatric diagnoses, psychiatric medications, and medical conditions might be inserted right into the post move monitoring form within the series of additional questions. This will make it easier for the PMM as well as for the reader to understand the individual's issues and what it is that the provider staff were expected to be informed about. • Please be careful about typographical errors in the reports, such as using Individual #309's name in Individual #75's report, and Individual #261's name in Individual #309's 7-day post move monitoring ISPA. Of the 15 individuals who received post move monitoring, 10 (67%) appeared to be doing very well and having a great life. This was well reflected in their post move monitoring reports. Many of the post move monitoring reports noted that families were very happy to have their loved one nearby. Three individuals (20%) had experienced some problems, but these seemed to be resolving. One individual was doing very badly, including being moved from her group home for placement with her mother (Individual #75), and one individual died at around the time of the 90-day review. It was probably not surprising that Individual #75 exhibited problem behaviors shortly after her move given that she was exhibiting these same behaviors before the move and during her pre-placement overnight visits. This indicated some very likely problems in planning for her transition.	

		<u>Use of Best Efforts to Ensure Supports Are Implemented:</u> IDTs, the APC, and the PMM put a lot of effort into these placements. The PMM did a good job of following up when there were problems. IDT meetings were held following 30 of the 34 post move monitoring visits. The remaining four were the most recent and were being scheduled.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	SGSSLC achieved substantial compliance with this provision item. The monitoring team accompanied the PMM on a 7-day post move monitoring visit to the home of Individual #55. The PMM was thorough, that is, she covered all of the ENE supports, asked a lot of questions, and looked for evidence. The home was very nice, the best one the monitoring team has visited in San Angelo since monitoring began. It was run by Mosaic services. The individual also participated and answered "Perfect" when the PMM asked her "How's it going?" The PMM went through the ENE supports one by one, talking with the associate program director and direct care staff. The PMM asked for staffing schedule through today, and she asked the direct care staff about behavior and psychiatric diagnosis and medical related conditions. She looked at the MAR, too. Later, when seeing the home and the individual's bedroom, the PMM took an opportunity when alone with the individual to ask her some questions about her life, staff, and housemates. All responses were positive.	Substantial Compliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	

T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite 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.	One individual was discharged under this T4 provision. He was transferred to another SSLC. The discharge was done properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team.	Substantial Compliance

Recommendations:

1. Create an accurate list of individuals who would be referred by their IDTs, if not for LAR preference. This list should include all individuals, not only those who themselves requested referral. The APC should work with the QDDP coordinator and ensure that this number is correct (T1a, T1h).

2. Correctly report the reasons for why individual's referrals were rescinded. Individual choice and LAR choice did not accurately reflect the reasons in the recent set of rescinded referrals (T1a).

3. Collect information on untoward post move events for one year post move (T1a, T2a).

4. Do a detailed review (i.e., root cause analysis) of each rescinded referral and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a, T2a).

5. Determine how to use the information/suggestions from these root cause type reviews in the standard procedures used by the APC and transition specialists (T1a).

6. Improve graphs as described in T1a. Ensure data are included in the QA department's data list/inventory (T1a).

7. Written ISP assessments need to include an explicit statement regarding the professional's opinion about whether the individual could be supported in a less restrictive, more integrated (i.e., community) setting (T1a, T1b3).

8. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a).

9. Regularly inform senior management of status of referrals. The monitoring team suggests this be done verbally, perhaps during an already occurring senior management meeting twice per month.

10. Facility-specific policies will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

11. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

12. Address obstacles to referral and placement at the individual level (T1b1).

13. Attend to the detail provided in T1b2. The nine bulleted lists might be used in the facility's self-assessment process (T1b2).

14. Initiate and then develop the CLDPs in a timely manner (T1c).

15. Provide more information on the training of provider staff (T1c1).

16. Collaborate with community and provider clinicians (T1c1).

17. Document completion of day of move activities (T1c1).
18. Continue DADS feedback to the APC and transition specialists on CLDPs (T1c1).
19. The discharge assessments need to focus upon the individual moving to a new residential and day setting (T1d).
20. Consider whether more assessments should be updated prior to the CLDP (T1d).
21. Decide whether to include all, or none, of the text from the assessment updates that are attached to the CLDP (T1d).
22. If a recommendation in an assessment does not make it into the list of ENE supports, it should be documented as to why (T1d).
23. Provide training, specifically on developing a good list of ENE supports, to the individual's IDT after the individual is referred (T1e).
24. Transition specialists might develop their own list of ENE supports to help ensure that all ENE supports are included (T1e).
25. Create a self-assessment specifically for the list of ENE supports to ensure it is comprehensive and that supports are written correctly (T1e).
26. Ensure all of the individual's needs and preferences are included in the list of ENE supports (T1e).
27. Develop an organized QA program for section T (T1f).
28. Share obstacle data with other potentially interested departments, such as the QDDP department, the human rights officer, and senior management at the facility (T1g).
29. Extend post move monitoring past 90 days if issues are not resolved (T2a).
30. Insert the individual's psychiatric diagnoses, psychiatric medications, and medical conditions right into the post move monitoring form within the series of additional questions (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o QDDP Check Sheet for ISP Process with Informed Consent Tool o SGSSLC Policy: Rights of Individuals with Developmental Disabilities dated 10/12/01 o SGSSLC Policy: Informed Consent dated 5/10/02 o SGSSLC Policy: Guardianship dated 5/10/02 o SGSSLC Section U Presentation Book o SGSSLC Priority List of individuals lacking both functional capacity to render a decision regarding health or welfare and a LAR to render such a decision o List of individuals for whom an LAR had been obtained in the last six months (1) o Documentation of activities the facility had taken to obtain LARs or advocates for individuals o Individual Support Plans and Rights Assessments for : • Individual #53, Individual #151, Individual #269, Individual #94, Individual #44, Individual #59, Individual #273, Individual #389, Individual #369, Individual #12, Individual #24, Individual #66, Individual #331, and Individual #139. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Dana Robertson, POI Coordinator o John Church, Psychologist o Jalown McCleery, Incident Management Coordinator o Michael Davila, QDDP Coordinator o Michael Fletcher, QDDP Educator o Roy Smith, Rights and Protection Officer o Zula White, Administrative Assistant <u>Observations Conducted</u>: o Observations at residences and day programs o 505B IDT Meeting 6/5/12 o 511B Home Meeting 6/5/12 o Unit I Morning Meeting 6/6/12 o Incident Management Review Team Meeting 6/6/12 o Annual ISP meetings for Individual #274 and Individual #322 o Human Rights Committee Meeting o Restraint Reduction Committee Meeting

	Facility Self-Assessment: SGSSLC submitted its self-assessment. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct meet compliance with Section U, the results of the facility self-assessment, and a self-rating for each item. The facility had implemented an audit process using the tool developed by the state office to measure compliance with the Settlement Agreement. The tool was used in conjunction additional assessment measures including policy review and observation of ISP meetings. Results of this audit were included in the self-assessment. The facility self-assessment described criteria used to evaluate compliance for each item or details on specific findings. For example, for item U2, the self-assessment activities engaged in by the facility included: review ISP monitoring data to ensure IDTs are discussing guardianship during the ISP meeting. The results of the self-assessment noted: discussion by the IDT of the legal status of individuals, including the need for a guardian or advocate occurred in 83% in January 2012, 100% in February 2012, and 100% in March 2012. The facility self-rated U1 as in substantial compliance and U2 as not in compliance. The monitoring did not agree with the facility's compliance rating for U1. The facility continued to make progress in holding a meaningful discussion regarding the need for guardianship, as noted in section U1 of this report, this discussion was still not always adequate.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a self-advocacy group comprised of individuals residing at the facility. • The Rights and Protection Officer continued to work with families applying for guardianship and maintained contact with community resources for guardians and advocates. • A check sheet had been developed with a series of questions to prompt IDTs to evaluate each individual's ability to give informed consent during the annual ISP meeting. • The prioritized list for individuals who need guardians had been updated. • The Rights and Protection Officer continued to provide training and support to IDTs regarding guardianship and rights.

	• A letter was sent out to 55 past employees of SGSSLC regarding opportunities to become advocates for individuals at the facility. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not yet developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility continued to make progress towards compliance with Section U. • IDTs need additional training and support to adequately determine the need for guardianship based on each individual's ability to capacity to make decisions. • The facility should continue to seek guardians and/or advocates for individuals with a prioritized need for assistance in making decisions.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with	QDDPs had begun using the Informed Consent Tool, which included prompts to facilitate the IDT discussion of whether or not individuals had the ability to give informed consent in a number of areas including: • Medical • Financial • Release of information • Photograph/video release • Programming • Placement/transfer from the SSLC A list had been developed that included individuals at the facility, 33 of whom had been prioritized as priority 1 (high) need for guardianship, 20 prioritized as priority 2, and 17 as priority 3. A sample of 14 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Ten (71%) individuals in the sample did not have guardians. There was evidence in all (100%) of the 14 ISPs reviewed that teams were discussing the need for guardianship, however, discussion was not always adequate for determining the need for an LAR based on the individual's functional capacity to render a decision regarding health or welfare. For example, • The ISP for Individual #273 noted that her brother was her guardian in the past,	Noncompliance

#	Provision	Assessment of Status	Compliance
	potential guardianship resources.	but had let guardianship expire. There was no discussion regarding her current capacity to make informed decisions or her need for guardianship. • The ISP for Individual #59 stated that he did not have the ability to provide or withdraw informed consent due to his dementia. The team agreed that he would benefit from an advocate. He had significant healthcare issues. There was no discussion, however, regarding the need for an LAR to make medical, financial, or programmatic decisions for him. An example of an ISP that did include adequate discussion regarding capacity to give consent was the ISP for Individual #369. The team stopped short of making a determination regarding his need for guardianship. The discussion of an individual's ability to give informed consent should result in a priority rating for the need for an LAR when it is determined that an individual cannot give informed consent. Although progress had been made, IDTs were not consistently holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be based on this discussion. The facility was 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 LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The Rights and Protection Officer had made additional efforts to gain guardians and advocates for individuals. The facility was taking steps to pursue guardianship when deemed appropriate by the IDT. A guardian had been procured for one individual at the facility in the past six months after the individual's IDT had determined the need for guardianship. The Rights and Protection Officer noted that a lack of people willing to act as a guardian was the greatest barrier to obtaining guardians for individuals with a need. The facility did have some rights protections in place, including an independent assistant 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. Observation of the HRC process during the monitoring team's visit confirmed that the committee engaged in good discussion around rights issues for each individual. Alternative strategies were discussed prior to restricting an individual's rights in any area and the committee required strategies to be in place to reduce the need for long term restrictions when appropriate.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility continued to offer a spectrum of self-advocacy training and opportunities for individuals at the facility, including an active self-advocacy group, classes to teach independence and decision making skills, and home meetings where individuals were encouraged to participate in planning and voice concerns. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. Maintain a prioritized list of individuals who need a guardian (U1).

3. 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 (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SGSSLC organizational chart, undated, but probably May 2012 o SGSSLC policy lists, 4/19/12 o List of typical meetings that occurred at SGSSLC, 5/22/12 o SGSSLC Self-Assessment, 5/1/12 o SGSSLC Action Plans, 5/1/12 o SGSSLC Provision Actions Information, most recent entries 5/15/12 o SGSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 6/4/12 o List of all staff responsible for management of unified records o List of other binders or books used by staff to record data, listed house by house o Notes from home secretary meetings, January 2012 through April 2012 (three meetings) o New employee orientation schedule, showing unified records on Day 12 (six months) o Materials presented by URC at new employee orientation o Sign in sheet for a 2/24/12 meeting between the URC and habilitation and nursing staff o Tables of contents for the active records and individual notebooks, updated 5/23/12, and master records, updated 2/7/12 o Examples of various types of documents that were inserted into various IPNs o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, 4/19/12 o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Blank tools used by the URC o List of individuals whose unified record was audited by the URC, December 2011 through May 2012 o List of individuals whose active record and individual notebook were audited by the home secretary, January 2012 through April 2012 o Completed unified record audit tools for 10 individuals, from March 2012 through April 2012: • Active record and individual notebook • Master record • Statewide self-monitoring tool • V4 questionnaire • Emails from URC requesting corrections be made o Variety of spreadsheets and graphs of audit review data o SGSSLC URC audit tracking form, for the 10 records audited, approximately three pages per record o Summary data table from results of home secretary audits

	o Review of active records and/or individual notebooks of: • Individual #295, Individual #247, Individual #64, Individual #222, Individual #150, Individual #52, Individual #94, Individual #126, Individual #78, Individual #365 o Review of master records of: • Individual #1, Individual #10 <u>Interviews and Meetings Held</u>: o Marsha Jones, Unified Records Coordinator o Juanita Brake, Director of Client Records Department o Leticia Williams, QA staff member o James Mitchell, DSP I <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area in administration building o Shared drive
	Facility Self-Assessment: SGSSLC had made a considerable revision to its self-assessment, previously called the POI. The self-assessment now stood alone as its own document separate from two others documents, one that listed all of the action plans for each provision of the Settlement Agreement, and one that listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the URC described, for each provision item, the activities she engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. During the week of the onsite review, the monitoring team engaged in lots of discussion with the URC regarding the new self-assessment. She was eager to implement this new process correctly and in a way that would be beneficial to recordkeeping activities. Overall, the self-assessment should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at. This can be determined by a thorough reading of the report. Section V is one of the only provisions of the Settlement Agreement that contains a provision item requiring a self-assessment of another provision. That is, to a certain extent, the activities to meet V3 might be, in large part, the self-assessment of V1. Then, the self-assessment of V3 would be to determine if the self-assessment activities were being conducted correctly (i.e., a self-assessment of the V3 self-assessment process). In this self-assessment, the URC correctly used some of the results of the V3 audits to determine if V1 was

	in substantial compliance. The URC should include all aspects of this V3 audit, as well as all of the other activities, actions, documents, and outcomes that the monitoring team reviewed and writes about in this report below. Similarly, the URC was on the right track by looking at implementation of the audits to self-assess V3. She should look, in more detail, at each aspect reviewed by the monitoring team in V3. For V4, each of the six components should now be self-assessed. The statewide self-monitoring tool should also be re-evaluated as to whether it is providing the recordkeeping department with adequate information related to self-assessing the facility's performance with the four provision items of this section. Further, the self-assessment (and possibly any new self-monitoring tools that might be developed) should be modified after each monitoring report is issued. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the URC and believes that the facility was proceeding in the right direction. This was a good first step. The facility self-rated itself as being in substantial compliance with one of the four provision items: V3. The monitoring team, however, rated all four items as being in noncompliance. That being said, as is evident in the report below, much progress was made in V3 and it is very possible that substantial compliance will be obtained soon.
	Summary of Monitor's Assessment: SGSSLC demonstrated continued progress with this provision item. The URC, Marsha Jones, continued to be diligent in her work and was knowledgeable about recordkeeping processes. Overall, the active records were organized and well maintained. Since the last review, IPNs and observations notes had improved in meeting the requirements of Appendix D. Entries were neater and followed the requirements more so than during the previous review. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. Frequently, there were items in the IPNs or in the observation notes that did not belong there, such as psychiatric progress notes and signature pages, lab results, and pelvic exam forms. This should be corrected. The monitoring team recently learned that state office was preparing to disseminate specific guidelines about what can and cannot be included in the IPNs. SGSSLC continued to use individual notebooks successfully. SGSSLC maintained the same satisfactory system of managing the master records. The staff had not, however, resolved what to do about items that should be in the master record, but were not. A process is needed and should be delineated. SGSSLC had a two-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy or policies that related to each of these state policies.

	Not all state policies were yet in place, though continued progress was evident. The URC continued to do a thorough job conducting quality assurance audits of the unified record. She completed five each month, as required. In addition, the home secretaries, the unit directors' secretaries, and the QA staff conducted one review each month each. Thus, many records were reviewed every month. Overall, the monitoring team was satisfied with the audit procedures that were being implemented at SGSSLC, however, to achieve substantial compliance, the URC should consider developing a new audit tool that incorporates the components of the statewide tool and the table of contents tools. A list of medical consultations also needs to be created so that the URC knows what to look for in the medical consultation section of the active record. The monitoring team recommends that the URC create a set of graphs as described in V3, and that these graphs be included in the SGSSLC QA program. The URC recently received the list of actions and topics that were now to comprise V4. The monitoring team discussed these at length during the onsite review. The actions should now set the occasion for SGSSLC to be able to more directly address the requirements of V4.

#	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 progress with this provision item. The URC, Marsha Jones, continued to be diligent in her work and was knowledgeable about recordkeeping processes. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. There were nine home secretaries who were supervised by the unit directors. A monthly meeting was held by the URC. Minutes indicated relevant topics were discussed. The URC also conducted new employee training. One hour was allotted on Day 12. This was a very short amount of time, however, it was part of a lengthy orientation for staff for all of their job duties. The materials presented appeared to be appropriate. Overall, the unified records were in pretty good shape, though more work was needed to bring all of the items of this provision into substantial compliance. <u>Active records</u> Overall, the active records were organized and well maintained. The URC and the home secretaries did a good job of managing the active records. Since the last review, there were improvements as follows: • IPNs and observations notes had improved in meeting the requirements of Appendix D. Entries were neater and followed the requirements more so than	Noncompliance

#	Provision	Assessment of Status	Compliance
		during the previous review. Even so, there was still further improvement needed as identified in the facility's own reviews and in the monitoring team's reviews of a sample of records as per Appendix D. • The URC recently updated the table of contents for the active record. • A new tab labeled Therapy was added in the psychology section. This was for documentation about counseling and other types of non-PBSP treatment (i.e., see section K8). The addition of the new tab came about through collaboration between the recordkeeping department and the psychology department. To move forward with the active records, in addition to continuing to improve the IPNs and observations notes as noted above: • Frequently, there were items in the IPNs or in the observation notes that did not belong there, such as psychiatric progress notes and signature pages, lab results, and pelvic exam forms. This should be corrected. The monitoring team recently learned that state office was preparing to disseminate specific guidelines about what can and cannot be included in the IPNs. • Consider dating all forms so that clinicians, reviewers, readers, etc. will know if they're looking at the latest one. This may require the creation of a database of all forms to be maintained by the recordkeeping department. <u>Individual notebooks</u> SGSSLC continued to use individual notebooks exclusively for the recording of individual information throughout the day and month, though there were some homes in which behavioral data were kept in a separate binder. Overall, this seemed to be working satisfactorily. <u>Master records</u> SGSSLC maintained the same satisfactory system of managing the master records. The staff had not, however, resolved what to do about items that should be in the master record, but were not. A process is needed and should be delineated. It may be that the staff who manage the master records indicate what actions they've taken to try to obtain the document, or indicate the rationale for why no further action is needed. <u>Shared drive</u> The shared drive was maintained in the same way as during the previous review. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	

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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.	SGSSLC had a two-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, and the facility-specific policy or policies that related to each of these state policies. Not all state policies were yet in place, though continued progress was evident. The spreadsheet, however, should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12, such as, at a minimum, whether or not the facility-specific policy was reviewed by state office (though this was no longer a DADS requirement). The facility submitted more than 60 pages of signature sheets regarding trainings on policies, but the monitoring team could not determine how these trainings fit into an overall system of managing the trainings on policies. For the next onsite review, the facility should develop a policy and procedure regarding the training of staff that: • Incorporates mechanisms already in place, such as an email/correspondence. • Notes the list of job categories to whom training should be provided. • Defines, for each policy o who will be responsible for certifying that staff who need to be trained have successfully completed the training, o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and o documentation necessary to confirm that training occurred. Some of this responsibility may be with the Competency Training Department. • Includes timeframes for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). • Includes a system to track which staff completed which training.	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	The URC continued to do a thorough job conducting quality assurance audits of the unified record. She completed five each month, as required. In addition, the home secretaries did one audit per month (nine total), the unit directors' secretaries did one per month (two total), and the QA staff conducted one per month (one total). Thus, many records were reviewed every month. The URC's audits were the ones used for the purposes of meeting the requirements of this provision item. Once again, the reviews were done in a consistent and thorough manner. The review consisted of six components: (1) the table of contents review of the	Noncompliance

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	review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	active record and individual notebook, (2) a checklist review of the master record, (3) the statewide self-monitoring tool, (4) the V4 questionnaire, (5) copies of emails showing that facility staff were notified of any needed corrections, and (6) a spreadsheet to note follow-up status for any item that needed correction. The URC scored each item on the table of contents form as yes, no, or not applicable. All items scored with a no resulted in what she called a recommendation. Every recommendation was emailed directly to the responsible staff person. There were approximately 50 recommendations for each unified record review. Hundreds of these emails were copied and shared with the monitoring team. Interobserver agreement was obtained on the statewide tool. It should also be obtained on the table of contents tools. The URC entered her review results directly into her electronic spreadsheet rather than completing it by hand and then entering it later. This saved a lot of time, however, it made it difficult for her to conduct while on the units because she did not have easy access to a computer. The URC might review ways to solve this problem with her supervisor. Overall, the monitoring team was satisfied with the audit procedures that were being implemented at SGSSLC, however, to achieve substantial compliance, the monitoring team recommends the following: • Consider developing a new audit tool that incorporates the components of the statewide tool and the table of contents tools. The monitoring team and the URC discussed this during the onsite review. • A list of medical consultations needs to be created so that the URC knows what to look for in the medical consultation section of the active record. This was also discussed during the previous onsite review. • Similarly, there was some confusion regarding the titles of some OTPT documents. This should be resolved between the recordkeeping staff and the habilitation department. • A cut off date to end follow-up on recommendations had still to be determined. The monitoring team and the URC talked about using two months as the cut off time. • Consider whether the monthly audit should include anything about the shared drive contents for the individuals being audited. More and more documents were being created and stored on the shared drive. It might make sense to include the shared drive in the audit process. • Create a set of graphs as follows, and include them in the SGSSLC QA program:	

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		o Number of reviews done per month o Average score on the statewide self-monitoring tool o The average number of recommendations per review o The average number of recommendations that were not corrected as of the cut off date (e.g., two months). o Data should be presented unit-by-unit (and perhaps by department/discipline) as well as for the facility as a whole.	
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.	Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. The URC recently received this list and the monitoring team discussed it at length during the onsite review. It is likely that the DADS state office coordinator for recordkeeping will provide additional direction and guidance to the URC. SGSSLC should now be able to more directly address the requirements for this provision item. <u>Records are accessible to staff, clinicians, and others</u> SGSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Records were accessible to physicians once they were present in the home areas. • Habilitation therapy staff accessed records as needed. • Records were less consistently available during the later afternoon and early evening hours. • The facility made good use of individual notebooks. o Current ISPs were available to DSPs in individual notebooks in all residences. This was an improvement over the findings during the last onsite visit. o Risk Rating Forms and Risk Action Plans were also found to be in place in a sample of individual notebooks reviewed. <u>Data are filed in the record timely and accurately</u> SGSSLC was assessing this during the monthly audits, that is, when the URC and home secretaries indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be summarized so that it can be used to satisfy this requirement. • For nursing, there were a number of missing assessments and plans, and it was unclear whether or not the problem was the result of documents that were not completed or documents that were completed, but not filed in a timely manner. • Habilitation therapy assessments were filed in the Therapies section, though a number were not the most current or were more than 12 months old without an associated update. The effectiveness monitoring completed used a separate monitoring form that was maintained by Habilitation Therapies and did not	Noncompliance

#	Provision	Assessment of Status	Compliance
		become a part of the individual record. An alternate system might be considered to ensure that effectiveness monitoring findings are also recorded in the IPNs for each individual in a timely manner. • Data were not always available to support that individuals were receiving all services specified in the ISP. Many action steps in the ISP did not specify what type of data would be collected. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> SGSSLC was not yet self-assessing this. The monitoring team, however, observed that: • Behavior Support Plan data were recorded regularly and were up to date. • PNM data sheets were completed in the Individual Notebooks. The completion of this was monitored routinely by PNMPCs and therapy clinicians. Issued identified were addressed through corrective actions generated from that process. • There were blanks in individuals' MARs, many missing entries in individuals' health status information, such as blood-glucose, intake, output, weekly weight, etc., which were supposed to be recorded on MARs and/or other tracking logs. There were also missing data related to the triggers of individuals' risk of aspiration, seizure activity, and other significant changes in health. • The medical components of the active records did not include many <u>important</u> documents, such as Active Problem Lists, Preventive Care Flowsheets, and immunization records. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> SGSSLC was self-assessing this as part of the statewide self-monitoring tool. To do so, the URC answered a question related to this item on the statewide form, however, there was no explanation as to how she arrived at the rating. In addition, the monitoring team observed that: • The number of unsigned physician orders, the lack of immunization records, the lack of APLs, the lack of QDRRs, the lack of medication profiles for QDRRs present, providers who repeatedly failed to time notes and orders resulted in records that were of very poor quality from a health care perspective. The reader could not determine if providers used the records because documentation overall was scarce and treatments were provided with little documentation of care. • Health care practitioners crossed out the notes of other providers when they disagreed (this is an unacceptable practice). This led to assumption that staff had little knowledge about recordkeeping practices. • There was little evidence that nurses' reviewed individuals' records to make	

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		care/treatment/training decisions. Usually, nurses' made these decisions based upon their assessment or evaluation of a particular situation. For example, nurses made decisions to provide care/treatment for an individual's particular episode of illness/injury based upon their assessment/evaluation of the circumstances of the particular episode of illness/injury. The IPNs failed to reveal that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries as part of their evaluation and/or when they made care, treatment, and training decisions. • For habilitation therapies, IPNs were used for progress notes. IPNs did not, however, reflect baselines for targeted issues requiring intervention. Follow-up was inconsistently documented and the notations did not close the loop to resolution of identified issues or concerns. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC conducted a brief, but informative, interview with one IDT member each month for the individuals whom she audited. The results of these interviews were given to the monitoring team. o Some of the comments were interesting, but the results were not used in any way by the facility, other than perhaps to assist the URC in scoring the statewide self-monitoring tool question for V4. The reviewers and/or URC should summarize and bring forward any interesting comments or suggestions to the QA department for consideration by QI Council. • When a random sample of nurses were asked about how they used the individuals' record to make care/treatment/training decisions, the responses ranged from reports that they used the record to document what they did to reports that the QA and/or the facility's record department were the staff members responsible to review records and report findings to the QIC. <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> SGSSLC was not yet assessing this, however, the monitoring team found the following: • The active record and individual notebook were present at the annual ISP meetings. o Even so, their records were not used during discussion of their levels of risk and/or their responses to their risk action plans. • The record was referenced during PNMT meetings to aid in discussion for determining interventions and supports, as well as identifying the effectiveness of these. • Records were available during psychiatry clinic and staff referred to them and	

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		reviewed documentation. • The paper work task placed upon the psychiatry team was somewhat onerous. Recommendations of reconstructing the psychiatric clinic process to facilitate documentation and sharing between disciplines was outlined in section J.	

Recommendations:

1. Continue to work on reducing the number of gaps in entries, and ensuring proper filing in the active record (though there had been much improvement since the last review) (V1).
2. Determine what should and should not be in the IPNs. State office guidance may be forthcoming (V1).
3. Consider initiating a facility-wide practice of putting a date on every form used at the facility (V1).
4. In the master record, document efforts of the URC and/or master records staff when a document that is not optional could not be obtained (V1).
5. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).
6. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
7. Consider developing a new audit tool that incorporates the components of the statewide tool and the table of contents tools (V3).
8. The URC and home secretaries responsible for conducting record audits should be aware of the contents required for certain records. For example, documents, such as QDRRs should not be present without the required drug profiles. This may require expansion of the table of contents tool (V3).
9. Obtain interobserver agreement on the table of contents too, too (V3).
10. A list of medical consultations needs to be created so that the URC knows what to look for in the medical consultation sections (V3).
11. Resolve any confusion regarding the titles of some OTPT documents (V3).
12. Follow-up on all needed corrections until corrected, or until a standard cut-off time, such as two months (V3).
13. Determine how to include the shared drive in the audits of the unified records (V3).
14. Graph important recordkeeping outcomes and include in the facility's QA program (V3).
15. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six areas highlighted with underlined headings in section V4 (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations
APRN	Advanced Practice Registered Nurse

APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency

CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMA	Certified Medication Aide
CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CPT	Certified Pharmacy Technician
CPT	Certified Psychiatric Technician
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services

DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DERST	Dental Education Rehearsal Simulation Training
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
ECG	Electrocardiogram
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank

EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FLACC	Face, Legs, Activity, Cry, Console-ability
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer

HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HOBE	Head of Bed Evaluation
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICA	Intense Care Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Intellectually Disabled
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
IV	Intravenous
JD	Juris Doctor

K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MHA	Masters, Healthcare Administration
MI	Myocardial Infarction

MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOT	Masters, Occupational Therapy
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MPT	Masters, Physical Therapy
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech

OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PAI	Provision Action Information
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRQ	Psychiatric Medication Review Quarterly
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
POX	Pulse Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RML	Right Middle Lobe
RN	Registered Nurse

RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIDT	Special Interdisciplinary Team
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAC	Texas Administrative Code
TAR	Treatment Administration Record

TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old