United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: August 12-16, 2013

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Monitor

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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 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 offsite review.

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

(c) **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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.

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

Organization of Report

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

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the 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 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. The facility director, Charles Njemanze, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Moreover, Mr. Njemanze initiated immediate action when issues were brought to his attention, such as regarding pneumonias and a stalled community transition.

The Settlement Agreement Coordinator, Misty Mendez, did a great job, before, during, and after the onsite review. She was available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed.

Second, management, clinical, and direct support 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, including frequent questions about what it would take to come into substantial compliance. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist SGSSLC in doing so.

Third, 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.

<u>Restraint</u>

- Overall, the facility had made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention, including that there had been a reduction in the number of restraints in the past six months.
    - Trauma Informed Care was being taught during new employee orientation.
    - The Restraint Reduction Coordinator was doing quarterly training during monthly home meetings.
    - The section C Coordinator was attending all ISPA meetings to review three or more restraints in a 30 day period.

- There were 383 restraints used for crisis intervention involving 82 individuals between 12/1/12 and 7/31/13. The number of restraint incidents had decreased since the last onsite review when there had been 485 restraints during the review period. Five individuals accounted for 108 of the 383 (28%) restraints used for crisis intervention.
- A number of individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). The facility was not consistently documenting and monitoring these restraints.
- Areas of focus should include:
    - Continuing to develop desensitization strategies to address the use of chemical pretreatment sedation for routine appointments;
    - Documenting protective medical restraints in compliance with the state policy;
    - Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines;
    - Ensuring that staff complete restraint training annually.

<u>Abuse, Neglect, and Incident Management</u>

- DFPS conducted 616 investigations between 12/1/12 and 5/30/13. Of these, there were six confirmed cases of physical abuse, five confirmed cases of verbal/emotional abuse, 26 confirmed cases of neglect, and one confirmed case of exploitation. The 616 investigations were the result of 198 allegations of physical abuse, 144 allegations of emotional/verbal abuse, seven allegations of exploitation, 47 allegations of sexual abuse, and 227 allegations of neglect. An additional 45 other serious incidents were investigated by the facility.
- There were 2127 injuries reported between 12/1/12 and 5/31/13 that included 23 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive.
- The facility reported progress in the following areas:
    - Implementation of the state office Client Injury Audit Tool;
    - Providing IDTs with individual injury and incident trending data prior to annual ISP meetings;
    - Developing a process for tracking and trending the effectiveness of recommendations made in regards to investigations; and
    - Providing injury and incident data to the Clinical IDT as individuals were scheduled for review.
- Minimal progress, however, had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. The facility was beginning to focus on developing action plans to address trends at the facility, but the process was in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring.

Quality Assurance

- The QA program at SGSSLC continued to mature and progress continued to be made. Tremendous progress was made in the data list inventory. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators.
- A set of key indicators was included for 15 of the 20 sections of the Settlement Agreement. Data that could be used to identify the information specified in E1 was in most of these sections, however, data were not being used in this manner for most of the sections. The exceptions sections C, D, and V.
- Monthly meetings, called benchmark meetings at SGSSLC, occurred regularly over the past six months. The QAD and SAC created a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory).
- The facility now called the QI Council the Administrative IDT. This group met every Thursday morning. Sometimes, the meeting also included a detailed review of a challenging clinical case. During two QI Council/Administrative IDT meetings observed by the monitoring team, there was active participation of participants other than the presenter
- There were 43 active CAPs for 12 of the 20 sections of the Settlement Agreement, primarily in nursing (10) and habilitation services (14). All included the actions to be taken and the anticipated outcome, however, there were no specific criteria to determine if the CAP was met, or if progress had occurred.

Integrated Protections, Services, Treatment, and Support

- There was positive progress evident with the new ISP process. At the ISP meetings and one pre-ISP meetings observed by the monitoring team, it was noted that significant progress had been made towards integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. IDTs observed were moving in a positive direction.
- Additional action taken to address the requirements of section F included:
    - Designated three QIDPs without assigned caseloads to facilitate all of the ISP meetings.
    - Began process to alert department heads of delinquent assessments.
    - Implemented new ISP monitoring system to capture flow from pre-ISP meeting to annual ISP meeting to documentation review.
    - Completed additional training with IDT members on developing meaningful objectives in the IHCP and ISP.
    - Implemented new format for QIDP monthly reviews.
- The new process, thus far, however, was not resulting in adequate supports and measurable outcomes in many cases. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

Integrated Clinical Services

- It was clear that staff had a continued awareness of the importance of integration of clinical services. Throughout the week of the review, the monitoring team learned through committee meetings, but more importantly, through discussions and planning for specific individuals, how services were integrated. Most departments were refining processes in a manner that would encourage integration.
- The medical director described a number of initiatives that he believed would promote integration, such as the decision to provide more respiratory services and have weekly meetings with nursing to discuss issues.
- For Provision G2, it was reported that there was no change or progress. The facility did not monitor the requirements for this provision item.

Minimum Common Elements of Clinical Care

- Progress continued in this area. The facility had defined many elements that needed to be reviewed and measured. The section H audits that were completed provided very good detailed information for the clinical disciplines. Many issues were identified, addressed, and corrected. Progress seen in the completion of assessments in several areas was likely due to the continual auditing and feedback shared with the departments.
- Much of the data should be generated through the quality reviews and quality systems of the departments. Medical audits should be completed within the medical department and data provided to the QA department for inclusion in Section H. In fact, elements that assess the quality and appropriateness of care must be completed as a peer review/quality process. The lack of such review systems limited the amount of progress that was seen since the last compliance review.

At-Risk Individuals

- Good progress had been made. The facility continued to take an integrated approach to looking at risk. This was evident at both the administrative level and at the individual IDT level. At both annual IDT meetings observed, the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified.
- Some important assessment information was not collected and shared prior to the meeting that could have contributed to team's ability to make informed decision regarding appropriate interventions.
- Teams were also not using the IHCP to track the completion of assessments and document resulting recommendations. Teams were reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented.

Psychiatric Care and Services

- Progress was made in section J since the last review. More progress is likely given the lead psychiatrist no longer being in the role of interim medical director.
- 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, however, must be spelled out in the psychiatric documentation.
- There was some integration between psychiatry, primary care, and psychology achieved by case reviews in various committee meetings (i.e., polypharmacy and medication review committee). Additionally, the psychiatric clinic included representatives from multiple disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings.
- There were an inadequate number of psychiatric assessments completed and this affected the quality regarding diagnostics and justification for treatment with medication. This task was likely hindered by a lack of consistent and insufficient number of psychiatric resources.
  There was intent to conduct a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy, but this did not occur as planned.
- The facility made progress in the area of informed consent, but remained in noncompliance with J14 due to the lack of completed informed consent practices. The psychiatry department was now responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication.

Psychological Care and Services

- SGSSLC made many improvements since the last onsite review. These improvements resulted in substantial compliance in three new items (K5, K7, and K11). Additionally, the facility maintained substantial compliance on the three items (K2, K3, and K8). Improvements included an increase in the percentage of psychologists who are board certified behavior analysts, IOA collection procedures, and timeliness and quality of functional assessments, psychological assessments, and PBSPs.
- Areas for continued work included a need to ensure that replacement/alternative behaviors are collected for all individuals with PBSPs, that data collection reliability data are collected across both first and second shifts, and that minimal frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved. When individuals are not making expected progress, the progress note should consistently indicates that some activity had occurred.
- PBSPs need to be consistently implemented within 14 days of receiving consent and every staff assigned to work with an individual, including float/relief staff, must be trained in the implementation of the PBSP prior to PBSP implementation, and at least annually thereafter.

Medical Care

- The monitoring team found improvement in some areas, no change in other areas, and regression in a few areas. This was not unexpected given the recent staffing challenges in both the medical and pharmacy departments.
- The new medical director, along with a full time locum tenens primary provider, was beginning to set the tone for a series of changes within the medical department. They both expressed the desire to work collaboratively with other departments, so that the facility could move forward.
- Improvement was seen in the provision of preventive care. There were modest increases in the compliance rates for most cancer screenings.
- The management of pneumonia at SGSSLC remained problematic. This was a significant problem because most of the deaths in 2013 were associated with the diagnosis of pneumonia. The reported pneumonia data did not appear to represent the true incidence of the condition. A pneumonia review policy and guidelines were developed, but this did not occur until May 2013. Documentation by the medical providers did not present a clear plan for management of pneumonia, nor did it reflect that the pneumonia guidelines were actually being considered.
- External medical audits were completed and corrective action plans developed. The corrective actions for the audits were not completed. The mortality reviews were not all completed at the time of the compliance review.

Nursing Care

- The facility had made progress in all provisions with the exception of M.6. It was evident that nursing leadership was enthusiast and motivated, especially given the most recent positive staffing changes occurring within nursing administration and new facility medical director.
- There was little improvement in the recruitment and retention of nursing staff. The facility continued to report its failure to meet minimum staffing requirements. The facility reported 20 vacancies at the time of the onsite review.
- A more organized case management system, beginning with timely annual and quarterly nursing assessments, identifying risk, and strengthening the development of acute care and integrated health care plans remained a need.
- The data from the Clinical IDT meeting reported a 17% increase in the number of nursing assessments from May 2013 to July 2013. More work, however, was needed.
- There was significant improvement in documenting individual's illness and injury when following nursing protocols. There must be demonstration of an understanding of the policies and procedures, documentation of training, and evidence of clinical practices.
- There were omissions of accepted standard of care practices when administering medications.

Pharmacy Services and Safe Medication Practices

- The state informed the monitoring team that due to the complete turnover of staff in the pharmacy department, the facility was not in compliance with any of the provision items for section N and requested that a full monitoring review not be done at SGSSLC.
- Throughout the week, the monitoring team met with the pharmacy staff to review each provision item and discuss the current status of the provision and the next steps that were needed to move towards substantial compliance.
- Two issues surfaced during meetings that the monitoring team deemed worthy of highlighting. First, it will be important for the new pharmacy staff to have a clear understanding of the ICF regulatory framework as they work to provide services, develop, and implement systemic changes.
- Second, the breakdown of the medication variance system appeared apparent. The facility should consider reconciliation of medications and correction of identified problems a priority matter in order to ensure that individuals are receiving medications as prescribed.

Physical and Nutritional Management

- Progress was made, including substantial compliance in provision O1. The PNMT was fully staffed, and the membership had remained consistent. The active participation of Dr. Jolivet and Dr. Cal was also very positive additions.
- PNMT meeting again involved excellent active participation by the IDT members. The team had identified measurable outcomes and in addition to specific status updates, the PNMT reviewed progress toward these goals and clinical indicators of improved health, individual benchmarks and efficacy of interventions provided, as well as readiness for discharge from the PNMT.
- Continued strides were noted in the area of mealtimes. Trouble spots noted on previous visits had made clear progress with regard to staff implementation of strategies in the Dining Plans, organization of meal preparation, and service.
- Positioning, particularly in wheelchairs, and repositioning of individuals continued to be a weak area of staff performance. Staff awareness of improper position was not consistent and proper techniques were not always effectively used.

Physical and Occupational Therapy

- There was continued progress including maintenance of substantial compliance for P1, with 19/21 (90%) of the elements listed found in 90% or more of the assessments reviewed. Further, there had been a continued significant effort to ensure that assessments were completed, and done so 10 days prior to the ISP.
- While the assessments were excellent, they continued to focus primarily on the clinical aspects of health and safety, with rather limited focus on skill acquisition and/or motor skill improvements. Documentation showed that services

were consistently reviewed regarding the individual's status related to the objectives. Documentation of the interventions selected for review met generally accepted standards.
- Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs.

Dental Services
- The facility made significant progress in the provision of dental services. The dental director was involved in all aspects of the clinic's operation. He provided direct patient care, participated in Settlement Agreement activities, and participated in many facility meetings and committees.
- Oral hygiene ratings showed improvement. Individuals with poor ratings were enrolled in the clinic's toothbrushing program. Suction toothbrushing was provided to more individuals and documentation indicated that the treatments were being completed. Individuals with modified diet consistencies were receiving additional supports as well.
- The clinic failure rate increased. The majority of failed appointments were due to missed appointments of undetermined etiology. Refusals continued to occur and were addressed by psychology staff.

Communication
- There was continued progress toward substantial compliance in all aspects of provision R. The therapists appeared to be applying a creative approach to the selection of AAC. These devices appeared to be functional and meaningful to the individual. Refresher training related to communication was observed and the trainers did an excellent job with instruction of the content material.
- Many assessments were not yet completed and many assessments were completed after the established deadlines. This clearly created a void in the development of ISPs in an integrated team manner. Significant information related to communication was based either on very old assessments or none at all.
- The content aspect of assessments reflected progress in that 80% of the assessments reviewed contained more than 90% of the 24 essential elements and, moreover, 100% of the assessments contained 83% or more of the required elements. Improvements from the previous review were noted in 46% of the 24 elements.
- Maintaining equipment already provided to individuals was reported as an ongoing and costly problem. Clear expectations from administration and supervisory staff regarding the care of these is essential in order that they are always available to the individuals who need them. Further, there was a need to expand the time available for staff training related to communication to further emphasize its importance throughout the day for every individual who lives at SGSSLC.

Habilitation, Training, Education, and Skill Acquisition Programs

- Although no items of this provision were found to be in substantial compliance, there were improvements since the last review. These included the establishment of a SAP review committee and improvements in the quality of SAPs, individual engagement, documentation of how the results of individualized assessments impacted the selection of skill acquisition plans, and data based action concerning the continuation, discontinuation, or revision of SAPs.
- Areas for continued work included a need to ensure that each SAP contains a rationale for its selection, and a plan for generalization. The facility should also establish acceptable levels of engagement in each treatment area, and ensure that those levels are achieved.
- Measures of skill training in the community need to be accurate, and an acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, should be established and achieved.

Most Integrated Setting Practices

- SGSSLC continued to make progress across much of section T, including the addition of some new processes and the collection of additional data. The number of individuals placed was at an annual rate of about 12%. Approximately 9% of the individuals at the facility were on the active referral list. 19 individuals had been placed and 28 individuals had been referred for placement since the last onsite review (12/1/12 through 8/31). 18 individuals were on the active referral list as of 8/31/13.
- Although some individuals continued to have difficulty following community placement, a higher percentage of individuals were doing better than during the time of the previous onsite review. This was likely due to more thoughtful choices of providers, better preparation of providers, and more careful transitions. Root cause analysis type reviews were being conducted for the individuals who returned to the facility. Three individuals returned to the facility (2 in December 2012, 1 in August 2013).
- Transitions were occurring at a reasonable pace. There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 6 of the 8 (75 %) individuals whose CLDPs were reviewed in detail.
- ISPs identified obstacles to referral, however, most did not do so adequately or thoroughly. Similarly, plans to address obstacles, when identified, were not usually individualized or designed to address the obstacle identified in the ISP.
- CLDPs were initiated and worked on throughout each individual's transition. There were very good improvements in the development of lists of pre- and post-move supports.
- Discharge assessments were prepared and included good information about the individual, but they were not developed with the individual's new home, day, and employment environments in mind.
- Post move monitoring was occurring as required. It was done thoroughly and as required.

Guardianship and Consent

- The facility had not yet developed an adequate assessment process for determining the need for guardianship. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs were not holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent.

Recordkeeping Practices

- SGSSLC achieved substantial compliance with two of the provisions, V1 and V3. For each record reviewed, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement.
- The active records continued to improve. Fewer documents were missing than during the last onsite review. Very few old or outdated documents were found by the monitoring team. Overall, medical documentation continued to improve, but legibility remained a problem for some providers.
- An individual notebook existed for each individual. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. The individual notebooks now contained the ISP, IRRF, and IHCP.
- Progress was made in the quality and management of the monthly reviews of unified records. There was support and responsiveness from the facility's clinical staff, DSPs, home managers, residential and unit mangers, and QA director.
- The URC summarized, analyzed, and reported on her data. She also engaged in actions to correct problems based upon her data and findings. She actively participated in the QA program activities at SGSSLC.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Policy: Use of Restraints revised 5/24/12 o SGSSLC Policy: PMAB Investigations revised 2/10/06 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines dated 9/9/05 o Training Curriculum: Restraint Ordering, Assessing, and Evaluating (RES0300) o Training Curriculum: Restraint Monitor o SGSSLC Self-Assessment o SGSSLC Provision Action Information Log o SGSSLC Section C Presentation Book o Restraint Trend Analysis Reports for the past two quarters o Sample of IMRT Minutes from the past six months o Restraint Reduction Committee minutes for the past six months o List of all restraint monitors and date training was completed o List of all restraint by Individual in the past six months o List of all chemical restraints 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 List of all individual that were restrained off the grounds of the facility (1) o List of all injuries that occurred during restraint o SGSSLC "Do Not Restrain" list o List of individuals with crisis intervention plans o List of individuals with desensitization plans o Sample #C.1: • 30 records of physical, mechanical or chemical restraint used in a crisis intervention for 7 different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual's Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint documents requested included:

Individual	Type of Restraint	Date
#43	Physical	4/16/13
#43	Physical	3/5/13 @7:37 pm
#43	Physical	3/5/13 @7:30 pm
#43	Physical	2/26/13
#43	Physical	2/23/13
#43	Physical	2/8/13
#43	Physical	2/6/13 @3:21 pm
#43	Physical	2/6/13 @3:10 pm
#43	Physical	1/27/13 @9:30 am
#43	Physical	1/27/13 @9:20 am
#9	Physical	5/16/13 @11:57 pm
#9	Physical	5/16/13 @11:52 pm
#9	Physical	3/21/14 @ 5:10 pm
#9	Physical	3/21/13 @ 5:20 pm
#9	Physical	2/16/13 @ 6:12 pm
#9	Physical	2/16/13 @5:56 pm
#9	Physical	2/15/13
#9	Physical	1/28/13
#100	Physical	5/25/13
#100	Physical	3/20/13
#100	Physical	2/28/13
#100	Physical	2/26/13
#100	Physical	2/7/13
#100	Chemical	2/5/13
#97	Physical	5/25/13
#196	Physical	5/26/13 @3:15 pm
#196	Physical	5/26/13 @3:20 pm
#196	Chemical	5/26/13 @3:55 pm
#372	Chemical	5/31/13
#215	Chemical	5/30/13

- Sample #C.2: The following documentation were requested for a selected sample of 24 staff:
  - Their start dates;
  - The dates they were assigned to work with individuals;
  - Their training transcripts showing date of most recent:
  - PMAB training;
  - Training on use of restraints; and
  - Training on abuse/neglect/exploitation; and

- The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

o Sample #C.3 chosen from the list provided in response to document request II.5.b of 45 restraint reports involving medical/dental restraint for 19 individuals, between 12/1/12 and 5/30/13. The sample of 22% of the 45 restraint episodes or 10 records was drawn, involving seven individuals. Records for this sample included: the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any applicable desensitization plan. For the following:

Individual	Date
#201	5/30/13
#294	5/30/13
#38	5/21/13
#38	4/16/13
#178	5/1/13
#59	5/1/13
#59	4/26/13
#59	4/5/13
#344	4/26/13
#134	4/26/13

o Sample #C.4 chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was 104, involving 41 individuals. Sample size was four, involving four individuals, or 10% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual	Date
#100	2/5/13
#196	5/26/13
#372	5/31/13
#215	5/30/13

o Sample #C.5: There was one restraint off-campus. No sample was drawn.

o Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
- Positive Behavior Support Plans (PBSPs) for:

- Individual #100, Individual #196, Individual #9, Individual #129, and Individual #145
- Crisis Intervention Plans for:
  - Individual #100, Individual #196, Individual #9, and Individual #129
- ISPA meeting minutes for:
  - Individual #395

o Sample #C.7 was chosen from the list of individuals for whom protective mechanical restraints were used. This included review of Protective Mechanical Restraint Plans, Individual Support Plan (ISP), ISP Addendums, ISP Action Plan.

Individual	Date
#346	5/23/13
#346	5/25/13
#346	5/26/13

o Sample #C.8 was chosen from the list of individuals for whom restraint was used to complete medical appointments**.** This included review of Medical/Dental Restraint Checklist, Face-to-Face Assessment and Debriefing Forms, the Physician's Orders for the restraint, Post Chemical Restraint Clinical Review, Consents for Treatment, Individual Support Plan (ISP), and Behavior Support Plan.

Individual	Date
#178	5/1/13
#59	5/1/13 and 4/26/13
#134	4/26/13
#38	5/21/13
#201	5/30/13

<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, Provision Coordinator/Leader
- o Cynthia Lackey, Restraint Reduction Coordinator
- o Jalown McCleery, Incident Management Coordinator
- o Michael Davila, QDDP Coordinator
- o Roy Smith, Human Rights Officer

<u>Observations Conducted</u>:

- o Observations at residences and day programs
- o Incident Management Review Team Meeting 8/13/13 and 8/14/13
- o Annual IDT Meeting for Individual #132 and Individual #379
- o ISPA regarding restraints for Individual #395

	o Human Rights Committee Restraint Review Meeting o Restraint Reduction Committee Meeting o Human Rights Committee Meeting o Pre-ISP Meeting for Individual #76
	Facility Self-Assessment: SGSSLC submitted its self-assessment. The self-assessment was updated on 7/8/13. 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 reviewed all crisis intervention restraints from 12/1/12 through 5/30/13 to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were completed along with the review of restraint documentation. For instance, to assess compliance with C1, the facility also compared the list of all individuals that received pretreatment sedation for medical and dental appointments to the list of individuals with desensitization plans. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings. The facility assigned a self-rating of substantial compliance to C2, C3, and C6. C1, C4, C5, C7, and C8 were self-rated as noncompliant. The monitoring team found compliance with C2, C3, C6, C7g, and C8. For C3, the facility found compliance by looking at the number of staff trained on restraints usage. The monitoring team also looked at the timeliness of that training.
	Summary of Monitor's Assessment: Based on a list of all restraints provided by the facility (document II.6), there were 383 restraints used for crisis intervention involving 82 individuals between 12/1/12 and 7/31/13. The number of restraint incidents had decreased since the last onsite review when it was reported that there had been 485 restraints during the review period. Five individuals accounted for 108 of the 383 (28%) restraints used for crisis intervention. These were Individual #43, Individual #100, Individual #9, Individual #37, and Individual #346. A log of all dental/medical restraints provided by the facility included 51 instances of dental/medical restraint from 11/1/12 through 5/31/13 involving 19 individuals. A number of individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility needs to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the

	least restrictive restraint necessary. Progress noted by the facility included: • There had been a reduction in the number of restraints in the past six months. • Trauma Informed Care was being taught during new employee orientation. • The Restraint Reduction Coordinator was doing quarterly training during monthly home meetings. • The section C Coordinator was attending all ISPA meetings to review three or more restraints in a 30 day period. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Overall, the facility had made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility continues to need to focus on providing meaningful training opportunities and active engagement during the day. Increased engagement in activities based on individual's preferences and needs should impact the number of behavioral incidents leading to restraint. Additionally areas of focus should include: • Continuing to develop desensitization and other strategies to address the use of chemical pretreatment sedation for routine appointments; • Documenting protective medical restraints in compliance with the state policy; • Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines; • Ensuring that staff complete restraint training annually.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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</td><td>According to a list of all restraints implemented at the facility (Document II.5),

<table><tr><th>Type of Restraint</th><th>June 2012-Nov 2012</th><th>Dec 2012-May 2013</th></tr><tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>390</td><td>207</td></tr><tr><td>Chemical restraints during a behavioral crisis</td><td>74</td><td>80</td></tr><tr><td>Mechanical restraints during a behavioral crisis</td><td>21</td><td>**1</td></tr><tr><td>TOTAL restraints used in behavioral crisis</td><td>485</td><td>287</td></tr><tr><td>TOTAL individuals restrained in behavioral crisis</td><td>34</td><td>72</td></tr><tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>Not available</td><td>14</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.		

Medical/dental restraints	Not available	46
TOTAL individuals restrained for medical/dental reasons	Not available	16
Protective mechanical restraints	Not available	3

**Individual #346 wore Kevlar gloves daily due to SIB. Two other individuals required short term mechanical restraints classified as medical restraint to promote healing.

Prone Restraint

a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (list of all restraints between 12/1/12 and 5/31/13) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 12/1/12 and 5/31/13. Sample #C.1 was a sample of 30 restraints for seven individuals, representing 11% of restraint records over the last six-month period and 10% of the individuals involved in restraints. The sample included 26 physical restraints and four chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as four individuals who were subject to some of the most recent application of restraints.

c. Based on a review of the restraint records for individuals in Sample #C.1 involving seven individuals, zero (0%) showed use of prone restraint.

d. Based on questions with five direct support professionals, five (100%) were aware of the prohibition on prone restraint.

Other Restraint Requirements

e. Based on document review, the facility and state 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; and 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 the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review:

#	Provision	Assessment of Status	Compliance
		• f. In 30 of the 30 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 30 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 30 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. • h. In 28 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. o The restraint checklists for Individual #9 dated 5/16/13 at 11:52 pm and 11:57 pm indicated that staff did not encourage replacement behaviors as recommended in the PBSP. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 30 restraints, involving seven individuals, 30 (100%) were approved restraints. k. In 22 of 30 of these records (73%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. • Individual #9 was restrained 23 times over a six month period. Her ISP was unclear in describing how she spent most of her day. She was enrolled in one art class. Her vocational assessment indicated that she was interested in work, though she was no longer enrolled in the vocational program due to her refusals to attend the sheltered workshop. It was not evident that vocational programming or alternate day habilitation services based on her preferences had been explored. Her skill acquisition plans offered little opportunities for training based on her preferences and needs. Her structural and functional assessment noted that she appears to do better when she is actively engaged in programming. It further noted that challenging behavior was less likely to occur when she was "out on campus" and "engaged in a preferred activity." l. Three restraints were reviewed that were considered to be PMR-SIB by the facility, (Sample C.7). Of these, three (100%) followed state policy regarding the use, management, and review of PMR. The facility made progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. To move in the direction of substantial	

#	Provision	Assessment of Status	Compliance
		compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Provide meaningful training opportunities and active engagement during the day. Increased engagement in activities based on individual's preferences and needs should impact the number of behavioral incidents leading to restraint. 2. Ensure that behavior supports plans are implemented as written and revised when not effective based on a review of data.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the seven individuals in Sample #C.1 were reviewed. One individual in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individual involved in physical restraint who had a Crisis Intervention Plan (Individual #9), seven of eight (88%) restraint checklists included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. • Restraint checklist that indicated the individual was released when no longer a danger to themselves or others included: o 5/16/13 at 11:52 pm o 3/21/13 at 5:20 pm o 2/16/13 at 5:56 pm o 2/16/13 at 6:12 pm o 1/28/13 at 7:03 pm • The monitoring team was unable to determine if the restraint on 2/15/13 ended immediately when she was no longer a danger to herself. Staff used the release code "T" for release completed without indicating the behavior of the individual at the time of release. • For two restraints, the restraint ended when staff could not maintain a correct hold. b. For six individuals who did not have Crisis Intervention Plans, 22 of 22 (100%) included sufficient documentation to show that the individual was released according to facility policy or as soon as the individual was no longer a danger to him/herself. Three of the restraint checklists in the sample indicated that staff released then individual when they could no longer maintain an approved hold. Based on this review, the facility is in compliance with C2.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. 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: • 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 17 of the 20 (85%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave.. • 24 of the 24 (100%) had completed PMAB training within the past 12 months. • 19 of the 20 (95%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training unless documentation indicated that the employee was on leave.. c. Based on responses to questions, five direct support professionals answered the following questions correctly: • Describe two verbal or redirection techniques (100%); • Describe two approved restraint techniques. (100%); and • How would you supervise an individual in restraint? (100%). d. In 28 of the records (93%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • The debriefing form for Individual #9 dated 5/16/13 at 11:57 pm and 11:52 pm indicated that staff did not use replacement behaviors included in her PBSP. Staff were retrained on her CIP.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	a. Based on a review of 30 restraint records (Sample #C.1), in 30 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. In review of Positive Behavior Support Plans for Individual #9, Individual #43, and Individual #100, in three (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. d. In 30 of 30 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list maintained by the facility. According to a list of all restraints (document II.6), however, two individuals had been restrained in contradiction to the facility's "Do Not Restrain" list since 12/1/12. These were: • Individual #145 was restrained using a bear hug on 3/20/13 and a horizontal restraint of 12/8/12. • Individual #24 was restrained using a horizontal hold on 1/31/13. e. Restraints from Sample #C.1 for Individual #9, Individual #43, and Individual #100 were reviewed. In 24 of 24 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the form used by the facility to document restraint considerations/restrictions. f. In 30 of 30 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing documentation (Sample #C.8) for five individuals for whom restraint had been used for the completion of medical or dental work: • g. Five (100%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • h. 0 (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; o Individual #201 and Individual #134 required the use of chemical sedation prior to both medical and dental appointments. Both had a dental desensitization plan in place, but did not have a plan to address medical desensitization.	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Individual #38 had been assessed for dental desensitization. He also required the use of sedation prior to medical appointments. There was no documentation that the team had discussed strategies to reduce or eliminate his need for sedation prior to medical appointments. o Individual #178 was sedated prior to a dental appointment on 5/1/13. His dental desensitization assessment indicated that he was cooperative with dental appointments and recommended trying routine dental procedure without pretreatment sedation. • i. 0 (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled A number of individuals at the facility were wearing mechanical restraints considered protective equipment (e.g., helmets for falls). The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility needs to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. Based on this review, the facility was not substantial compliance with C4. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Desensitization or other individualized strategies will need to be considered for all individuals who require the use of pretreatment sedation for routine medical and dental appointments. 2. Ensure that all IDTs are holding adequate discussion regarding the use of protective mechanical restraints. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.	
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	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. Seventeen staff had been deemed competent to monitor restraints. c. Based on review of document request II.19, 17 staff who performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct	Noncompliance

#	Provision	Assessment of Status	Compliance
	15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 30 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 28 out of 30 incidents of restraint (93%) by an adequately trained staff member. Exceptions were Individual #9 dated 5/16/13 at 11:57 pm and 11:52 pm. The restraint monitor's name was not found on the list of staff that had completed training to monitor restraints. • e. In 30 out of 30 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • f. In 30 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 30 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. A sample of ___ records for which physicians had ordered alternative monitoring schedules was reviewed. (none submitted) • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 30 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 26 (87%) of the instance of restraint. Assessments did not begin within 30 minutes for the following restraints: o Individual #43 on 3/5/13 (x2) o Individual #43 on 1/27/13 (x2) • k. Monitored and documented vital signs in 30 (100%). • l. Monitored and documented mental status in 30 (100%). Based on documentation provided by the facility, one restraint had occurred off the grounds of the facility in the last six months. A sample of 1 was not reviewed, but will be during future reviews. The monitoring team will be looking to see that a licensed health care professional: • m. Conducted monitoring within 30 minutes of the individual's return to the facility in __ out of ___ (__%). Records that did not contain documentation of this included: • n. Monitored and documented vital signs in ___ (___%). Records that did not contain documentation of this included…	

#	Provision	Assessment of Status	Compliance
		• o. Monitored and documented mental status in ___ (___%). Records that did not contain documentation of this include: Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, p. In 10 out of 10 (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • q. In zero out of zero (N/A), the physician specified the type of monitoring required if it was different than the facility policy. o r. In six out of 10 of the medical restraints (60%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Four of the restraint checklists in the sample did not indicate the time that the individual returned to the facility following medical appointments requiring pretreatment sedation. The monitoring team was unable to verify that the nurse began her assessment within 30 minutes of their return to the facility. These were: ▪ Individual #38 on 5/21/13, ▪ Individual #59 on 4/5/13 and 4/26/13, and ▪ Individual #134 on 4/26/13. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that post restraint assessments by nursing staff commence within 30 minutes of the initiation of the restraint and are adequately documented.	
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	A sample (Sample #C.1) of 30 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In 30 (100%), continuous one-to-one supervision was provided; • b. In 30 (100%), the date and time restraint was begun; • c. In 30 (100%), the location of the restraint; • d. In 30 (100%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. • e. In 30 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • f. In 30 (100%), the specific reasons for the use of the restraint • g. In 30 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 30 (100%), the names of staff involved in the restraint episode;	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	• Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 30 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest restraint in the sample was 14 minutes. o j. In ___ (___%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; (there were none) o k. In ___ (___%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. (there were none) • l. In 30 (100%), the level of supervision provided during the restraint episode; • m. In 30 (100%), the date and time the individual was released from restraint; and • n. In 29 (97%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. o The restraint checklist for Individual #196 on 5/26/13 at 3:15 pm indicated that the nursing assessment was not completed until three days after the restraint. o. In a sample of 30 records (Sample #C.1), restraint debriefing forms had been completed for 30 (100%). p. A sample of 10 individuals subject to medical restraint was reviewed (Sample #C.3). See comments in C5 regarding restraints that were not monitored in accordance to state policies. Sample #C.4 was a subsample of the four chemical restraints included in Sample #C.1. q. In four (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met.	

#	Provision	Assessment of Status	Compliance
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 19 individuals were placed in restraint more than three times in a rolling 30-day period. This was similar to the last review when 18 individuals were placed in restraint more than three times in a rolling 30-day period. Five of these individuals (i.e., Individual #9, Individual #145, Individual #196, Individual #129, and Individual #100) were reviewed (28%) to determine if the requirements of the Settlement Agreement were met. PBSPs, crisis intervention plans, and individual support plan addendums (ISPAs) following more than three restraints in a rolling 30-day period were requested for all five individuals. Individual #145 did not have a crisis intervention plan. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual 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. Two (Individual #196 and Individual #129) of the five (40%) ISPs reviewed were judged to attain the above requirements. This represented a slight decrease from the last review when 67% of the ISPAs reviewed reflected a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and a plan to address them. Of the remaining three ISPA minutes judged as incomplete, one (i.e., Individual #100) did not reflect a discussion of the individual's adaptive skills, biological/medical status, and psychosocial factors. Individual #145 and Individual #9's ISPAs did discuss adaptive, medical, biological, medical and psychosocial issues affecting the behavior provoking restraint, but did not discuss a plan to address these issues. Simply listing these factors is not likely to be useful in better understanding, and ultimately decreasing, the behaviors provoking restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	This item was rated in noncompliance because only two of the five ISPAs reviewed (40%) reflected a discussion of potential contributing environmental factors (e.g., noisy or crowded environments) and, for those hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint. This represented a slight decrease from the last review when 67% of the ISPAs reviewed reflected a discussion of the potential contributing environmental conditions, and a plan to address them. The two complete ISPAs were: • Individual #9's ISPA identified the level of supervision and being in her room as potential environmental conditions contributing to her restraints. Her ISPA also discussed a plan to maintain routine supervision, and encourage her to be out of her room. • Individual #196's ISPA indicated that environmental conditions did not play a role in her restraints. The three incomplete ISPAs were: • Individual #100's ISPA did not reflect a discussion of contributing environment conditions. • Individual #129 and Individual #145's ISPAs identified potential contributing environmental conditions, however, no discussion of how these environmental factor would be addressed was provided.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as noncompliance because only three (i.e., Individual #9, Individual #196, Individual #145) of the five ISPAs reviewed (60%), discussed potential antecedents to restraint and a plan to address them. This represented a slight decrease from the last review when 67% of the ISPAs reviewed reflected a discussion of the potential antecedents to the dangerous behaviors that provoke restraint, and a plan to address them. An example of a complete ISPA was: • Individual #9's ISPA reflected a discussion that identified staff prompts as a potential antecedent to the behaviors that provoked restraint. Additionally, the ISPA indicated that the action to address these antecedents was to encourage staff to minimize prompts, and consistently use the replacement behaviors described in Individual #9's PBSP. The remaining two ISPAs were rated as incomplete because they identified potential antecedents, but no further discussion or no action to attempt to eliminate or reduce the antecedents to dangerous behavior was evident in the ISPA minutes.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In order to achieve compliance with this provision item, ISPA minutes for at least 85% of the ISPAs reviewed 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.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because only one (i.e., Individual #9) of the five ISPA meeting minutes reviewed (20%) reflected a discussion of variables potentially maintaining the behavior provoking restraints, and suggestions for modifying them to prevent the future probability of restraint. This represented a slight decrease from the last review when 33% of the ISPAs reviewed reflected a discussion of the variable (s) maintaining the dangerous behavior provoking restraint, and a plan to address these variables. Individual #9's ISPA suggested that the dangerous behavior that provokes restraint was maintained by staff attention. The ISPA discussed several strategies to consistently reduce staff attention following dangerous behavior (e.g., reducing supervision level). Individual #100 and Individual #145's ISPAs did not directly address the potential role maintaining variables. Individual #129 and Individual #196's ISPAs included a discussion indicating variables potentially maintaining the dangerous behavior that provoked restraint. Neither of the ISPAs, however, reflected a discussion of potential action to address these hypothesized variables maintaining the individual's dangerous behavior that provoked restraint. In order to achieve compliance with this provision item, at least 85% of the ISPAs reviewed should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors) to address this potential source of motivation for the target behavior that provokes restraint.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to	All five individuals reviewed (100%) had a PBSP to address the behaviors provoking restraint. The following was found: • All five PBSPs reviewed (100%) specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • Four (Individual #9 was the exception) of the five PBSPs reviewed (80%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	initiates the use of the restraint, • All five of the PBSPs reviewed (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint, and • All five of the PBSPs reviewed (100%) contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. Four (Individual #145 was the exception) of the five Individuals reviewed (80%) had a crisis intervention plan. The following was found: • For all four of the crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • For all four of the crisis intervention plans reviewed (100%), the maximum duration of restraint authorized was specified, • For all four (100%), the designated approved restraint situation was specified, and • For all four (100%), the criteria for terminating the use of the restraint were specified. In order to achieve substantial compliance with this provision item, SGSSLC needs to ensure that all individuals that were placed in restraint more than three times in a rolling 30-day period have a crisis intervention plan, and that at least 85% of PBSPs plans include functional (when practical and possible) replacement behaviors.	
	(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 only two (Individual #9 and Individual #196) of the individuals reviewed (40%) was there evidence that demonstrated that the PBSP was implemented with a high level of treatment integrity (see K10 for a more detailed discussion of treatment integrity at the facility). This was an improvement from the last review when integrity data were available for only 33% of individuals reviewed. In order to achieve substantial compliance with this provision item, SGSSLC needs to ensure that at least 85% of individuals with individuals with more than three restraints in a rolling 30-day period have treatment integrity data that indicates that at least 85% the PBSP was implemented as written.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	This item is now rated as substantial compliance. All five of the ISPAs reviewed (100%) documented that the PBSPs were reviewed, and indicated that they did not need to be revised. This represents an improvement from the last review when 60% of the individuals had ISPAs that documented that PBSPs were reviewed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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 documentation related to 30 incidents of non-medical restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 26 (87%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • b. In 26 (87%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • c. In 30 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 30 (100%), the review conducted by the restraint monitor was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. • e. No referrals were made to the team, that is, there was no documentation of referral, however, IDTs routinely met to review restraints; and • f. Of the ___ referred to the team, ____ appropriate changes were made to the individuals' ISPs and/or PBSPs (not applicable). The facility had begun tracking completion of recommendations by the restraint monitor. Documentation indicated that recommendations were routinely implemented. For example, • The restraint monitor recommended that new staff should be trained to introduce themselves to individuals who they would be working with following a restraint that occurred when Individual #100 became upset on 2/7/13 because he did not know the staff member that was assigned to provide one-to-one supervision to him. Training was documented in the restraint record.	Substantial Compliance

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Section D Presentation Book o SGSSLC Section D Self-Assessment o DADS Policy: Incident Management #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 o SGSSLC Policy: Protection from Harm - Abuse, Neglect, and Exploitation dated 1/28/13 o SGSSLC Policy: Spurious Allegations of Abuse, Neglect, and Exploitation revised 5/30/13 o QAQI Data Summary May 2013 o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Review Committee meeting minutes for each Monday of the past six months 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 within the last 2 months (69) o Training and background checks for the last three employees hired o List of DFPS investigators assigned to complete investigations at SGSSLC (21) o Abuse/Neglect/Exploitation Trend Reports FY13 o Injury Trend Reports FY13 o List of incidents 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 A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #362, Individual #166, Individual #277, Individual #375, Individual #52, Individual #104, Individual #151, Individual #388, Individual #345, and Individual #76, Individual #53, Individual #379, Individual #268, and Individual #318. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious incidents and injuries since 12/1/12 o List of all ANE allegations since 12/1/12 including case disposition o A list of all investigations completed by the facility in the last six months. o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect. o Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42750095	Emotional/Verbal Abuse	Unconfirmed	5/18/13 9:04 am	5/18/13 3:53 pm	5/28/13
#42747041	Physical Abuse	Unconfirmed	5/15/13 6:17 pm	5/16/13 2:25 pm	5/25/13
#42745025	Neglect Physical Abuse (2)	Unfounded Unfounded (2)	5/14/13 1:13 pm	5/15/13 10:05 am	5/23/13
#42745640	Emotional/Verbal Abuse	Confirmed	5/14/13 8:18 pm	5/15/13 8:21 pm	5/23/13
#42742913	Neglect Physical Abuse	Confirmed Unconfirmed	5/12/13 10:55 am	5/12/13 5:53 pm	5/22/13
#42741562	Physical Abuse	Unconfirmed	5/10/13 1:18 pm	5/10/13 2:27 pm	5/20/13
#42742087	Neglect	Unconfirmed	5/10/13 8:19 pm	5/11/13 11:41 am	5/23/13
#42734966	Emotional/Verbal Abuse Physical Abuse	Confirmed Unconfirmed	5/4/13 8:42 pm	5/5/13 3:17 pm	5/17/13
#42730673	Physical Abuse	Unconfirmed	5/1/13 8:40 am	5/1/13 4:55 pm	5/8/13
#42704741	Neglect (2) Sexual Abuse (2)	Unconfirmed (2) Unconfirmed (2)	4/6/13 9:15 pm	4/7/13 6:40 pm	4/15/13
#42704355	Emotional/Verbal Abuse (2) Physical Abuse (2)	Unfounded (2) Unfounded (2)	4/6/13 10:00 am	4/6/13 11:25 am	4/16/13
#42693340	Emotional/Verbal Abuse	Unconfirmed	3/26/13 2:55 pm	3/27/13 1:58 pm	4/5/13
#42687096	Neglect (3)	Inconclusive3 (2) Confirmed (1)	3/20/13 12:19 pm	3/20/13 8:11 pm	4/5/13
#42621305	Physical Abuse	Unconfirmed	1/16/13 4:46 am	1/16/13 1:30 pm	1/24/13
#42584920	Neglect	Confirmed	12/16/12 10:59 am	12/16/12 6:14 pm	12/19/12
#42691396	Neglect (2) Physical Abuse (1)	Confirmed (2) Other (1)	3/25/13 8:59 am	3/25/13 5:50 pm	4/2/13
#42687910	Neglect (3)	Unconfirmed (1) Confirmed (2)	3/20/13 9:51 pm	3/21/13 8:00 pm	3/30/13
#42683993	Neglect (4)	Confirmed (2) Inconclusive (2)	3/17/13 7:22 pm	3/17/13 8:45 pm	3/27/13

#42760686	Neglect	Referred Back	5/29/13 8:05 am		5/30/13
#42646558	Neglect	Referred Back	2/6/13 2:34 pm		2/14/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**			
#13-5778	Serious Injury	5/27/13 11:58 pm			
#13-5755	Serious Injury	5/18/13 Unknown			
#13-5743	Serious Injury	5/16/13 9:30 am			
#13-5622	Serious Injury	4/5/13 Unknown			
#13-5604	Serious Injury	3/28/13 7:15 pm			
#13-5570	Serious Injury	3/13/13 8:30 pm			
#13-5512	Unauthorized Departure	2/15/13 3:20 pm			

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/Leader
- Cynthia Lackey, Restraint Reduction Coordinator
- Jalown McCleery, Incident Management Coordinator
- Michael Davila, QDDP Coordinator
- Roy Smith, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 8/13/13 and 8/14/13
- Annual IDT Meeting for Individual #132 and Individual #379
- ISPA regarding restraints for Individual #(Kendra Banks)
- Human Rights Committee Restraint Review Meeting
- Restraint Reduction Committee Meeting
- Human Rights Committee Meeting
- Pre-ISP Meeting for Individual #76

	Facility Self-Assessment: SGSSLC submitted its self-assessment. Along with the self-assessment, the facility had two other documents that addressed progress towards meeting the requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement. The second document 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 similar activities implemented by the monitoring team to assess compliance. A sample of completed investigations was reviewed monthly using the statewide section D audit tool. Additionally, the facility looked at other documentation relevant to each provision. The facility's review of its own performance found compliance with 22 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 17 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirements that: • Staff were to immediately report all serious incidents to the appropriate parties (D2a); • Mechanisms were in place to educate LARs and individuals on identifying and reporting unusual incidents, including allegations of abuse, neglect and exploitation (D2e); • Investigations included adequate recommendations for corrective action (D3e); • The facility will implement action to prevent similar incidents from occurring promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i); and • Sufficient corrective action was taken to address trends of incidents and injuries (D4). The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by SGSSLC, DFPS conducted investigations involving 616 allegations at the facility between 12/1/12 and 5/30/13, including 198 allegations of physical abuse, 144 allegations of emotional/verbal abuse, seven allegations of exploitation, 47 allegations of sexual abuse, and 227 allegations of neglect. Of the 616 allegations, there were six confirmed cases of physical abuse, five confirmed cases of verbal/emotional abuse, 26 confirmed cases of neglect, and one confirmed case of exploitation. An additional 45 other serious incidents were investigated by the facility. There were a total of 2127 injuries reported between 12/1/12 and 5/31/13. These 2127 injuries included 23 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive.

	The facility reported progress in the following areas: • Implementation of the state office Client Injury Audit Tool; • Providing IDTs with individual injury and incident trending data prior to annual ISP meetings; • Developing a process for tracking and trending the effectiveness of recommendations made in regards to investigations; and • Providing injury and incident data to the Clinical IDT as individuals were scheduled for review. Minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. As discussed in D4, the facility was beginning to focus on developing action plans to address trends at the facility, but the process was in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring. The facility made general recommendations with a focus on systemic issues that were identified following investigations, incidents, and injuries. Recommendations did not include measurable outcomes and it was difficult to track follow-up to recommendations. For example, to address an increase in incidents in one of the residential units, the incident management department recommended that the unit IDT review all incidents. While the incident management and quality assurance departments were beginning to focus on trends and systemic issues that contribute to incidents and injuries, it was not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. Individuals at the facility remained at risk for harm due inadequate follow-up to incidents.

#	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. 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

#	Provision	Assessment of Status	Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The 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. Although in the paragraphs that follow, the monitoring team has provided some data with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the facility would need to conduct analyses to determine causes, and to review carefully whether, for incidents that were preventable, adequate action had been taken to prevent their recurrence. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to section D4. According to a summary of all abuse, neglect, and exploitation investigations provided in response to document request III.18, investigations of 616 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last onsite visit (12/1/12 to 5/31/13). From these 616 allegations, there were: • 198 allegations of physical abuse including, o 6 confirmed; o 147 unconfirmed; o 14 inconclusive; o 16 unfounded; o 4 referred back to the facility for further investigation; o 4 merged into other cases; o 6 other (unknown outcome); and o 1 pending.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 47 allegations of sexual abuse including o 0 confirmed o 30 unconfirmed; o 3 inconclusive; o 9 unfounded; o 1 referred back to the facility for further investigation; o 1 merged into other cases; and o 3 other (unknown outcome). • 144 allegations of verbal/emotional abuse including: o 5 confirmed; o 91 unconfirmed; o 11 inconclusive; o 22 unfounded; o 13 referred back to the facility for further investigation; o 1 merged into other cases; and o 1 other (unknown outcome). o 227 allegations of neglect including, o 26 confirmed; o 80 unconfirmed; o 19 inconclusive; o 2 unfounded; o 98 referred back to the facility for further investigation; and o 2 other (unknown outcome). • 7 allegations of exploitation including, o 1 confirmed; o 3 unconfirmed; o 2 merged into other cases; and o 1 referred back to the facility for further investigation. According to a list provided by the facility (document III.18), there were 45 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 14 serious injuries/determined cause, • 2 serious injuries from peer-to-peer aggression, • 2 serious injury/undetermined cause • 13 sexual incidents, • 3 choking incidents,	

#	Provision	Assessment of Status	Compliance
		• 2 unauthorized departures, • 3 deaths, • 1 suicide threat, • 1 encounter with law enforcement, and • 4 others unspecified. From all investigations since 12/1/12 reported by the facility, 27 investigations were selected for review. The 27 comprised two 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 (20 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (seven cases). Based on responses to questions about reporting, two of six (33%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Four staff indicated that they would notify their supervisor or switchboard operator rather than DFPS. Two cases in the sample (10%) reviewed indicated that staff witnessing neglect did not immediately notify DFPS. This included DFPS case #42691396 and case #42687910. Based on a review of the 20 investigative reports included in Sample #D.1: • 18 of 20 reports in the sample (90%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. o The facility did not notify DFPS until the following day in DFPS case #42691396 when an individual was injured due to staff negligence. The injury was documented on 3/24/13, but not reported to DFPS until 3/25/13. o In DPS case #42687910, witness statements indicated that a staff person witnessed the incident that led to a confirmed case of neglect. The incident occurred at 5:46 pm on 3/20/13, but was not reported to DFPS until 9:51 pm. • 20 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 20 of 20 (100%) indicated the facility director or designee was notified of the incident within one hour. o 20 of 20 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate.	

#	Provision	Assessment of Status	Compliance
		o 20 of 20 (100%) documented that the state office was notified as required. Based on a review of seven investigation reports included in Sample #D.2: • Three (43%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/facility policy. o UIR #13-5778 was investigation of a serious injury. The facility director was not notified until two days after the incident. o For UIR #13-5743, physician's orders dated 5/16/13 at 11:20 am indicated that Individual #153 received sutures above his right eye following a fall. The facility director was not notified until 1:35 pm. Based on additional information provided by the facility, one factor may have been the locum tenens physician not being aware of this part of the reporting process. o For UIR #13-5778, the investigation documented that the physician deemed the injury serious at 9:00 am. The facility director was notified at 11:00 am. o UIR #13-5755 did not document notification of the state office. • Six (86%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/facility policy. o UIR #13-5755 did not document notification of the state office. The facility had a standardized reporting format. 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. Based on a review of 27 investigation reports included in Samples #D.1 and #D.2, 27 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. 67 of 69 (97%) new employees hired between 3/1/13 and 5/31/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A random sample of 24 employees at the facility were chosen. Twenty-four of 24 employees (100%) in the sample signed this form annually as required by state policy. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • The facility should ensure that staff know to call the DFPS toll free number	

#	Provision	Assessment of Status	Compliance
		immediately if they witness or suspect abuse, neglect, or exploitation. • All serious incidents should be reported to the appropriate parties in accordance with state policy.	
	(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 had 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. The monitoring team was provided with a log of employees who had been reassigned between 12/4/12 and 5/31/13. The log included the applicable investigation case number, date of reassignment, any disciplinary actions taken, and the date the employee was returned to work. Based on a review of 20 investigation reports included in Sample D.1, in 18 out of 20 cases (90%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. The exceptions were DFPS case #42691396 and case #42734966. The supervisors failed to remove the AP from client contact. In both cases, the supervisors were retrained on procedures for removing an AP from client contact. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 20 out of 20 cases (100%), where there was a known alleged perpetrator, 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 20 investigation files in Sample D.1, 20 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. The facility was in substantial compliance with this provision.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The 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. • 19 (95%) of 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 19 (95%) of the 20 employees (employed over one year) with current training completed this training within 12 months of the date of previous training unless documentation indicated that the employee was on leave.	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 that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. 24 (100%) of 24 employees in the sample had a current signed acknowledgement form. Additionally, the facility provided the signed statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS for employees hired March 2013-May 2013. Of 69 new employees, 67 (97%) had signed the acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that two cases where staff failed to report abuse or neglect as required. One staff person resigned and the second person was retrained on reporting requirements.	Substantial Compliance

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	(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. It was a clear and 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 14 ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #362, Individual #166, Individual #277, Individual #375, Individual #52, Individual #104, Individual #151, Individual #388, Individual #345, and Individual #76, Individual #53, Individual #379, Individual #268, and Individual #318. • Nine (64%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception were the ISPs for Individual #151, Individual #388, Individual #345, Individual #76, and Individual #318. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility was not in substantial compliance with this item. The facility needs to ensure that attempts to educate individuals and their LARs on recognizing and reporting abuse, neglect and exploitation are documented in the ISP.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of 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. The Alternate Duty Safety Officer completed an environmental checklist monthly to ensure that posters remained in place and visible.	Substantial Compliance

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		There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group.	
	(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 20 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 20 (100%), when appropriate. OIG investigated three cases in the sample and criminal activity was substantiated in zero of three (0%) cases.	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. • "No Tolerance" posters were displayed in all living and day areas throughout the facility. 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. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility had implemented an injury audit process to determine if all injuries that should have been reported for investigation were investigated. This included those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries both witnessed and discovered	Substantial Compliance

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		Reviews included a monthly sample of Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to identify any incidents that should have resulted in completing a Client Injury Report, and a comparison to determine if incident reports were filed. The facility conducted audits at least quarterly, during the preceding six months. The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. Injuries were identified by the audit that had not previously been reported or investigated. Residential staff in the homes where the injuries occurred were retrained on reporting procedures.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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. Eleven DFPS investigators were assigned to complete investigations at SGSSLC. Eleven DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SGSSLC had 21 employees designated to complete investigations. This included the IMC, Facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, 21 (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation,	Substantial Compliance

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		• Unusual Incidents, and • Comprehensive Investigator Training. Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator.	
	(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. There was no indication that staff did not cooperate with any outside agency conducting investigations. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The 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." The facility continued to meet quarterly with OIG, DFPS, and the assistant ombudsman to address any issues concerning cooperation and coordination of investigations. Based on a review of the investigations completed by DFPS, the following was found: • Of the 20 investigations completed by DFPS (Sample #D.1), OIG investigated three of the incidents. 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.	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	Substantial Compliance

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		(Sample #D.2): • 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.	
	(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.	<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 with the alleged victim occurred within 24 hours in 20 of 20 (100%) investigations. DFPS is commended for efforts to ensure testimonial evidence was gathered quickly. o 20 (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering documentary evidence and making initial contact with the facility. • 19 of 20 (95%) were completed within 10 calendar days of the incident. Those not completed within 10 days included: o Case #42734966 was submitted on the 13th day (extension filed – OIG involvement). • All 20 (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 12 of 20 (60%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Two of those cases resulted in a referral back to the facility for further investigation. o Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in seven of seven cases (100%). • Seven of seven (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Six of seven (86%) included recommendations for follow-up action to address the incident (the seventh should have, but did not, include recommendations). Five of seven (71%) included adequate recommendations. o There were no recommendation made regarding UIR #13-5622. An	Noncompliance

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		investigation was initiated when it was discovered that Individual #59 had sustained a bilateral subdural hematoma on 4/5/13. IPNs reviewed during the investigation indicated that he had been treated for headaches, some severe enough to cause sleeplessness and agitation, 29 times during February 2013 and March 2013. He was not sent for a CT to try to determine the cause of headaches until 4/5/13. At that time, he was diagnosed with a bilateral hematoma. There were no comments or recommendations regarding the lack of follow-up by medical staff to determine the cause of his frequent headaches. o UIR #13-5570 was the investigation of a serious injury that occurred when Individual #400 climbed on the roof of a building and deliberately cut himself several times with a piece of glass from the rooftop. This was preceded by a similar incident on 1/25/13 when he used broken glass from the same area to cut himself. Although the investigator and his IDT made recommendations regarding programming and supervision, neither made recommendations to ensure that the glass was removed from the rooftop to prevent a similar incident from occurring. During the week of the monitoring team's visit, Individual #400 climbed up on the roof again and used glass found on the rooftop to cut himself. To meet the requirements of this provision, the facility needs to ensure that follow-up recommendations adequately address factors that contribute to the reoccurrence of incidents.	
	(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	Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 20 out of 20 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In 20 (100%), each unusual/serious incident or allegations of wrongdoing; o In 20 (100%), the name(s) of all witnesses;	Substantial Compliance

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	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.	o In 20 (100%), the name(s) of all alleged victims and perpetrators; o In 20 (100%), the names of all persons interviewed during the investigation; o In 20 (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 20 (100%), all documents reviewed during the investigation; o In 20 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations included a statement noting whether or not prior investigations were considered in the course of the investigation. Facility UIRs included a list of previous similar investigations with a statement regarding the outcome of those investigations. o In 20 (100%), the investigator's findings; and o In 20 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of five facility investigations: • The report utilized a standardized format that set forth explicitly and separately: o In seven (100%), each unusual/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; o In seven (100%), the names of all persons interviewed during the investigation; o In seven (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 seven (100%), all documents reviewed during the investigation; o In seven (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In seven (100%), the investigator's findings; and • In seven (100%), the investigator's reasons for his/her conclusions. • In seven out of seven investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.	

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	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 20 DFPS investigations included in Sample #D.1: • In 20 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; • The facility Incident Review Team (IRT) accepted all (100%) investigations in the sample. • The monitoring team did not note problems with regard to Sections D.3.e, and/or D.3.f for DFPS investigations in the sample. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1, • 20 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 19 (95%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o DFPS case #42734966 was submitted to the facility by DFPS on 5/17/13. The IMC signed the completed investigation on 6/6/13 and the IMC signed off on 6/7/13. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations in samples #D.2: • In seven out of seven investigation files reviewed (100%), there was evidence that the supervisor had conducted a prompt review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. • The supervisor did not identified concerns in any of the investigations. • The monitoring team did not identify deficiencies in any of the investigations.	Substantial Compliance

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		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. The facility was in substantial compliance with the requirement for review of all investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent.	
	(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 reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. The facility-only investigations met the requirements outlined in Section D.3.f.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. The IMRT considered and accepted or provided a reason for not accepting recommendations in the DFPS or UIR reports. In addition, the policy and procedures did specify the facility system for tracking and documenting such actions and the corresponding outcomes. The facility had implemented a tracking log to document completion of all recommendations from investigations. A subsample of investigations was reviewed to confirm that appropriate disciplinary action was taken following the investigation when warranted. This sample included a total of seven cases: 5 DFPS cases #42742913, #42734966, #42687096, #42691396, #42687910, and 2 facility investigations #13-5778 and #13-5755. For three out of five of the DFPS investigations reviewed in which disciplinary action was warranted, in all three (100%), prompt and adequate disciplinary action had been taken and documented. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: For four out of seven of the investigations reviewed (58%), prompt and thorough programmatic action had been taken and documented. For the other three: • In DFPS case #42742913, the DFPS investigator appropriately expressed concern that there were 11 similar incidents investigated. Recommendations were made to address a trend of similar incidents for the individual involved. The IDT met but did not implement any programmatic changes to prevent	Noncompliance

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		similar incidents from occurring. • In DFPS case #42687096, the same individual as above was involved in a similar incident. The outcome included a confirmed allegation against the facility as a systems issue for not having appropriate supports in place to prevent injury to the individual. Adequate supports were not implemented to address the recommendations by the DFPS investigator. • UIR #13-5755 was another similar incident that resulted in a serious injury to the same individual. Recommendations were made for the individual to receive individual counseling to address his behavior resulting in frequent injuries. Documentation did not clearly indicate the status of counseling sessions. The investigator also recommended staff training in regards documentation by residential staff. The training was completed and documented.	
	(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.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had fully implemented the statewide system to collect data on unusual incidents and investigations. For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending 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 investigation. Over the past two quarters, the facility's trend analyses: • Were conducted at least quarterly; and • Addressed the minimum data elements. • A narrative description/explanation of the results and conclusions was generated; and • Recommendations for corrective actions were made to address some trends identified.	Noncompliance

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		Based on a review of trend reports, IMRT minutes, and QI Council minutes, when a negative pattern or trend was identified, adequate corrective action plans were not developed. Corrective action plans were not fully developed to address both specific individuals and systemic issues. The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. As noted below, when trends were identified, the incident management department often recommended that the IDT meet to review a pattern of incidents. Documentation was completed when the IDT met, but the adequacy of that review was not considered. The report and minutes did not review, as appropriate, the effectiveness of previous corrective actions. When appropriate, corrective action plans should be developed in response to the trends and data analysis. The plans should identify the strategies the facility intends to implement to reduce the risk of similar events occurring in the future for specific individuals, as well as at a systemic level. Each corrective action plan should identify: • Changes to be implemented to reduce risk or a referral to another group to develop such a plan, such as a referral for an IDT meeting, or review by PNMT. Such changes should be expected to correct the identified issue. When referrals are made to other groups, a process should be in place to ensure the IMRT and/or QAQI Council review/approve the resulting plan, and will be provided follow-up information; • Who is responsible for implementation and when the action will be implemented, including any pilot testing. Timeframes should be reasonable based on the seriousness of the issue and the time necessary for the action to be completed; and • The method for assessing the effectiveness and sustainability of the actions. It was not evident that IDTs were aggressively addressing risk factors by developing measurable action steps, assigning dates and responsibility for team members to complete action steps, and then following up to monitor and/or revise action steps when appropriate. For example, • UIR #13-5570 was the investigation of a serious injury that occurred when Individual #400 climbed on the roof of a building and deliberately cut himself several times with a piece of glass from the rooftop. This was preceded by a	

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		similar incident on 1/25/13 when he used broken glass from the same area to cut himself. The investigator recommended that maintenance ensure that individuals would not have access to the roof. There was no documentation that this recommendation had been implemented. There was no recommendations to ensure that the glass was removed from the rooftop to prevent a similar incident from occurring. During the week of the monitor's visit, Individual #400 climbed up on the roof again and used glass found on the rooftop to cut himself. • The incident management department identified a trend of injuries for Individual #48 in both April 2013 (seven injuries) and May 2013 (six injuries). The IDT met In June 2013 and July 2013 to address the trend of injuries. At both ISPA meetings, the team recommended continuing the supports that were already in place. • The incident management department requested that the IDT meet for Individual #236 to address 11 injuries documented in April 2013 and May 2013. The IDT met to review her injuries and recommended continuing all supports in place to address her risk for injuries. No new supports were recommended. • Data regarding a trend of injuries and ANE allegations was submitted to the IDT for Individual #215 including nine incidents documented in May 2013. The team reviewed the pattern of ANE allegations. They discussed her behavior supports and recommended continuation of all supports in place. Three of the injuries were due to trips or falls. The team did not document the review of those injuries or discuss a possible assessment to determine factors that might be contributing to those injuries. It was not evident that trends were being addressed with adequate changes in supports when needed. To move forward, the facility will need to ensure that as risk are identified and • Measurable outcomes and action steps are developed; • Specific staff are assigned to monitor implementation; and • A date is set to review efficacy of the plan and make revisions when needed. The facility had made significant progress in identifying incident trends at the facility. Using trend data to develop supports is a new process for the IDTs. IDTs at SGSSLC are still learning how to best use this information to develop and implement supports. IDTs need to aggressively address trends in injuries and implement protections to reduce these incidents and injuries.	

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility 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 FY13, criminal background checks were submitted for 1408 applicants. Thirty-three applicants 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 24 of 24 employees (100%).	Substantial Compliance

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, dated 1/26/12 o SGSSLC facility-specific policies: • Quality Assurance Process, dated 4/14/11, updated 4/19/12 • QA plan, 4/14/11, updated 11/1/12 • QA CAP tracking, 4/14/11, updated 4/19/12 • Policy/procedure approval and review committee, 1/4/11, updated 11/29/12 o SGSSLC organizational chart, undated, probably July 2013 o SGSSLC policy lists, 6/25/13 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 7/8/13 o SGSSLC Action Plans, 7/8/13 o SGSSLC Provision Action Information, 7/22/13 o SGSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/12/13 o SGSSLC DADS regulatory review reports, December 2012-June 2013 o List of all QA department staff and their responsibilities, 6/25/13 o SGSSLC QA department meeting notes, 2/12/13 through 6/18/13 (7 meetings), and handout for meeting attended 9/5/13 o SGSSLC data listing/inventory, hard copy (electronic version in Access), 7/1/13, 8/20/13 • Version with department revision dates included, 9/4/13 o SGSSLC QA plan narrative, 11/1/12 o SGSSLC QA plan matrix, 7/1/13, 8/20/13 o Set of blank tools used by QA department staff (1 tool) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, last two quarters o Monthly QA director report, data and analysis of program audits and family surveys, January 2013 to June 2013 o Various emails from QA director regarding schedule of presentations for sections at QI Council, preparation for monthly benchmark meetings, etc. January 2013 to June 2013 o Monthly QAD-SAC-Department meeting (i.e., benchmark): January 2013 to June 2013 (six) • Summary notes from meeting and benchmark activity data (1 page each) • Data, graphs, summaries, etc., submitted by the department (May 2013 and June 2013) o Newly proposed QAD-SAC expectation criteria, 15 items, presented at Administrative IDT 9/6/13 o SGSSLC QA Reports, monthly, February 2013 through May 2013 o Administrative IDT (replaced QI Council) minutes, weekly, 12/13/12 to 9/6/13, 36 meetings (including two meetings attended by the monitoring team)

	o PIT/workgroups: various meeting minutes for the three PITs: healthy campus, active treatment, dental desensitization o SGSSLC Corrective Action Plan tracking • Active CAPs, 26 pages, 6/18/13 • Closed/complete CAPs, 77 pages, 6/18/13 • Graph of percentage of sections/provisions that updated their CAPs info, October 2012 o DADS SSLC family satisfaction survey: summarized data, monthly to month graph, narrative analysis, actions taken and follow-up, 27 respondents, December 2013 to May 2013 o Self-advocacy monthly meeting minutes/notes, December 2012 to May 2013, and August 2013 o Aktion Club community meal delivery activities, one page list, for February 2013 o Home meetings (for individuals) agenda and notes, last two requested from each home, submissions from September 2012 to June 2013 o Facility newsletters, most recent 3; 1 email about recent All About Me (individuals) activities o Quality Improvement Process workbook and handbook <u>Interviews and Meetings Held</u>: o Angela Kissko, Director of Quality Assurance o Misty Mendez, Settlement Agreement Coordinator o Roy Smith, Human Rights Officer, Zula White, Human Rights Office Assistant, Melissa Deere, Assistant Independent Ombudsman, Jalown McCleery, Incident Management Coordinator o Charles Njemanze, Facility Director <u>Observations Conducted</u>: o Administrative IDT meeting, 8/15/13, 9/6/13 o Clinical IDT meeting, 8/15/13 o Self-advocacy meeting, 9/4/13 o Benchmark meetings for sections K and M, 8/12/13, 8/13/13 o Medical department's QA meeting, 9/4/13 o QA department's staff meeting, 9/5/13
	Facility Self-Assessment The areas of the self-assessment were identical to the previous self-assessment, but with current data. The QA director should use the current report and the recently submitted list of indicators for her next self-assessment. The facility self-rated itself as being in noncompliance with four of the five provisions of section E. The monitoring team agreed with these self-ratings.

	Summary of Monitor's Assessment: The QA program at SGSSLC continued to mature. Processes put in place over the past few years had become regular parts of the facility's operations and had evolved to become more efficient and relevant to senior management. Tremendous progress was made in the data list inventory. The inventory listed the most recent QI Council approval date and now also included a column for the most recent date that the inventory was updated by the department leader. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. For the 20 sections of the Settlement Agreement, a set of key indicators was included for 15 of the 20. Data that could be used to identify the information specified in E1 was in most of these sections, however, data were not being used in this manner for most of the sections. The exceptions sections C, D, and V. Data from 19 of the 20 sections of the Settlement Agreement were summarized and graphed showing trends over time (all but section N). Monthly meetings, called benchmark meetings at SGSSLC, occurred regularly over the past six months. The meetings had continued to evolve and improve since the last onsite review. Many section leaders were conducting QA meetings with their own department staff. The QAD and SAC created a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory). A facility QA report was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 19 (95%) appeared in a QA report at least once each quarter in the last six months. The facility now called the QI Council the Administrative IDT. This group met every Thursday morning. Sometimes, the meeting also included a detailed review of a challenging clinical case. During two QI Council/Administrative IDT meetings observed by the monitoring team, there was active participation of participants other than the presenter There were 43 active CAPs for 12 of the 20 sections of the Settlement Agreement. The 43 CAPs were primarily in nursing (10) and habilitation services (14). All included the actions to be taken to remedy and/or prevent the reoccurrence and the anticipated outcome of each action step. However, there were no specific criteria to determine if the CAP was met, or if progress had occurred. Also, the monitoring team could not determine that all aspects of CAPs were implemented fully and in a timely manner.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The QA program at SGSSLC continued to mature. Processes put in place over the past few years had become regular parts of the facility's operations and had evolved to become more efficient and relevant to senior management. This continued progress was under the leadership of the QA director, Angela Kissko, along with the Settlement Agreement Coordinator, Misty Mendez. <u>Policies</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. There were SGSSLC facility policies that adequately supported the state policy for quality assurance. They remained unchanged since the last review. The QA director reported that facility QA policies would be updated as the QA program continued to develop. QA department staff were trained in the current policies. Once the facility-specific policy (or policies) is updated, training should again be provided to QA department staff.	Noncompliance

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		QA Department The QA department continued to be led by Angela Kissko. To repeat from previous reports, she was in this role for many years, understood the workings of the QA program at the facility, and worked well with the many managers, clinicians, and department heads at the facility. The Settlement Agreement Coordinator, Misty Mendez, was also experienced in her position as SAC, was knowledgeable about the facility, and played an important role in the QA program, too. The collaborative and organized work of the QA director and SAC led to the continued progress seen in this provision. QA staff meetings were held at least once each month. Topics were relevant, such as data collection and projects. There were no topics, however, related to professional development or to the field of quality assurance. The other QA department staff remained the same as during the last review. They were experienced, professional, and involved in data collection, attending meetings, and participating in projects as needed. Quality Assurance Data List/Inventory There was not yet a complete and adequate data list inventory at the facility though tremendous progress was made. The QA director reported that she worked with each section lead (usually during the benchmark meetings) to ensure the inventory was comprehensive and correct (though see below). There were not, however, any items related to section G. The data list inventory was not current. Even so, ongoing updating was evident to the monitoring team. The facility submitted the inventory dated 7/1/13, but during the onsite review, the monitoring team requested a new inventory because the QA director and SAC said that there had been some updates. Updated inventories were sent dated 8/20/13 and 9/4/13 and numerous changes had been made. The inventory listed the most recent QI Council approval date and now also included a column for the most recent date that the inventory was updated by the department leader, even if these newest updates were not yet reviewed by QI Council. This was very good to see. Many of the dates of the most recent QIC review, however, were more than a year ago, and many of the sections did not yet list a date of the most recent departmental update (i.e., were blank). The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. To that end, beginning in September 2013, they were going to examine (with the section leader) whether all data in the inventory, QA matrix, departmental review, QA report, presentation to QI	

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		Council/Admin IDT, and self-assessment lined up with each other. They also reported that continued development was evident and pointed to the medical department's inventory as an example. <u>Quality Assurance Plan Narrative</u> The QA plan narrative at the facility was not current, complete, and adequate. It had not been updated since the last review, however, this seemed to be reasonable because many of the QA processes were evolving and changing. The QA director reported that she would be updating the QA plan narrative over the next six months. The comments in the previous monitoring report may be of value to the QA director in this endeavor. <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; these data are then included in the QA reports and presented to the QI Council. SGSSLC had a QA plan matrix. The monitoring team reviewed the 7/1/13 QA matrix as well as an updated version dated 8/20/13. For the 20 sections of the Settlement Agreement, a set of key indicators was included for 15 of the 20 (75%). There were no indicators for section G. For section I, the indicators did not address the content of the three provision items. This was likely due to the section being related to risk management, rather than addressing the at-risk status of individuals. The 8/20/13 addition of a risk section to the inventory had not yet been added to the matrix. Likely, this will happen in the near future. Section L appeared to be missing many important medical indicators. The QA director will have to determine how to tie in the medical quality program once it is developed (section L3). The section N indicators did not include all items related to the Settlement Agreement. Section S indicators did not include anything related to SAPs. Data from the four components of the statewide trend analysis report were not explicitly included, but should be within sections C (restraint) and D (allegations, incidents, injuries). The monitoring team spoke about this with the QAD and she pointed to some items in the matrix that were related to the trend analysis, however, after further review, the monitoring team could still not determine how/if data from the trend analysis were included in the QA matrix, or if perhaps the data from the QA matrix were used to complete the trend analysis. Further discussion during the next onsite review will be needed. Of these 20, both process and outcome indicators were identified for 15 of the 20 (75%). • Section G did not have any indicators. Sections I, L, N, and S, as noted in the above metric, did not have a sufficient set of indicators.	

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		Of these 20, in 18 (90%), the indicators provided data that could be used to identify the information specified in E1: "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." However, data were not being used in this manner for most of the sections. The exceptions were sections C, D, and V, which looked at many (but not all) of these variables, and sections M, O, P, and R, which looked at one or two of these variables (e.g., across shifts). However, see section D4 of this report regarding the use of the data. • The QA director should describe how each section of the matrix sets the occasion for data to be used to identify the information above, and • How data were being collected and presented to identify trends across the variables described in the wording of this provision E1. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement (or indicate that a self-monitoring tool was not necessary because the collection of the set of data in list covered all aspects of the provision that needed to be monitored). The QA matrix listed self-monitoring tools (or the need for the development of a tool) for 17 of the 20 sections (85%), that is, for all except G, I, and N. All data that QA staff members collected were listed in the matrix. QA staff members collected data using one tool, called the Program Audit. The QA director completed a monthly report in which the data from these audits (and the family survey) were summarized and analyzed. It was a very good report. It appeared within the QA section of the QA matrix. The QAD reported that over the past few months she had modified the tool so that it only contained information that was not included elsewhere in the QA program (i.e., data already being collected and reported within other sections). All satisfaction surveys were not included in the QA matrix. • The statewide family/LAR satisfaction survey continued to be implemented and was included in the QA matrix. The QA director was responsible for managing the survey and results. She did a nice job of summarizing the data and providing graphic and narrative analyses each month. She included a listing of all comments for which action could be taken, and a description of the follow-up that was done. She included a month to month graph, separating the data by content area. Clothing and personal possessions management appeared to be an area with lower satisfaction, so she took some actions with the house managers. In addition, she requested that teams share good/positive comments from	

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		families. • An individual satisfaction survey was not yet developed. Other ways of obtaining individual satisfaction are to review self-advocacy activities, review weekly home meetings, and consult with the HRO. The QA director reported that she reviewed self-advocacy minutes, but could find no pattern or trend of complaints or problems. The monitoring team thought this to be reasonable. Another way is to review the weekly home meeting minutes. The QA director might consider reviewing a sample of these from time to time. The QA director reported that she spoke with the HRO regularly to identify any pattern of allegations or complaints. • There was no staff satisfaction survey. • There was no community business satisfaction survey. The QA matrix was really a subset of the larger data list/inventory. Therefore, all items on the data matrix were also in the data list inventory. The QAD and SAC had created an easy to use database to make this an easy task for them and the section leaders. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Therefore, the QA director should indicate which of the items in the QA matrix were: 1. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). 2. Reviewed or analyzed by the QA department and/or the department section leader. 3. Conducted as per the schedule. All three items can be determined during the facility's monthly QAD-SAC benchmark meetings. The monitoring team had a difficult time determining if the data items listed in the QA matrix were presented to the QA department and reviewed because the data presentations (which occurred regularly in the benchmark and QI Council meetings) were not lined up with the matrix. The data in these presentations does not need to line up with the matrix (often the data in the presentations was above and beyond only what was in the matrix list; this was good to see), but there should be some way that the QA director and SAC are ensuring that all of the data items in the matrix are included. If they're not, then they can determine whether the item should remain on the inventory, but be removed from the matrix (or be added to the inventory and/or matrix if data are being presented that are not already on the inventory/matrix). As noted above, they were planning to begin a process to do so in September 2013. Perhaps their new 15-item criteria list can also include this aspect of data management (i.e., that all items in the QA matrix are presented to the QA department [and QA report/QI Council]).	

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		Self-Monitoring Tools As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that they review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, the QAD should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: 1. Content/validity: A description of how the content of the tools was determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. 4. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement. For those sections for which the QA department, section leader, and QI Council agreed that a self-monitoring tool was not necessary, it should be indicated with a rationale. For example, this had occurred for section C. This section leader instead reported data on all of the indicators for 100% of the restraints. Therefore, there was no need for sampling, and no need for a self-monitoring tool because each of the indicators was reported on individually rather than putting all of the indicators into a tool and giving a percentage for the tool. The QAD and SAC reported that many departments were moving away from self-monitoring tools, as long as they were collecting data, summarizing, and analyzing data (i.e., self-monitoring). For every department, even if there was not a self-monitoring tool, the QAD found some data for which inter-rater agreement could be assessed. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure data list inventory is updated regularly, record the update dates on the inventory itself. The structure for this existed, but the many dates were missing or more than a year old. 2. Ensure the items in the QA matrix represent those process and outcome indicators that are most relevant to the section, and that they track data to identify trends as per the wording of this provision E1. 3. For those sections that maintained a self-monitoring tool, review the self-monitoring tools as per the above four metrics.	

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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.	Continued progress was seen at SGSSLC regarding the gathering, organization, and analysis of data. Data from 19 of the 20 (100%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but section N), but few (2 or 3 of 20 [10-15%]) analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. To make this determination, the monitoring team reviewed the monthly benchmark summaries and attached data, QA reports, and minutes from Admin IDT meetings. <u>Monthly QAD-SAC meeting with discipline departments</u> These monthly meetings, called benchmark meetings at SGSSLC, occurred regularly over the past six months. The meetings had continued to evolve and improve since the last onsite review. The meetings were a good forum for the review of QA-related activities as well as review of process and outcome data for each section of the Settlement Agreement. Some section leaders were becoming more adept at presenting their data and analyses. There were a number of continuing improvements worthy of highlighting below. These activities demonstrated the facility's commitment to the ongoing improvement and development of their QA program. • Many section leaders were now conducting their own QA meetings with their own department staff. This helped the departments to become more comfortable with their own data, made it more likely that the data they were collecting was useful to them, and helped them to prepare for their QAD-SAC meetings, QA report preparation, QI Council presentations (see below). • QA department staff program auditors now attended the QAD-SAC meetings for the departments they audited. • The QAD and SAC were planning to invite/include the section back up leader to attend these meetings. • Unit directors were to be invited to attend. • The QAD and SAC created a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory). This was described in the previous report. At the time of this review, they had expanded the set of criteria and defined each one in much more detail than ever before. There were now 15 items described on four pages. The monitoring team observed two QAD-SAC meetings: for sections K and M. Overall, the topics and goals of the meeting were evident, including presentation and review of data. The K meeting ran for almost two hours, much longer than the scheduled hour and much longer than the M meeting and the length of time reported for the other sections' meetings.	Noncompliance

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		1. Since the last onsite review, a meeting occurred at least twice for 19 of the 20 (95%) sampled sections of the Settlement Agreement (only once for section N). At SGSSLC, a meeting was held every month, except for those months in which a section leader was scheduled to conduct his or her quarterly presentation to QI Council/Administrative IDT (i.e., thus there were eight meetings per year). All five topics below were conducted during 39 of the 39 (100%) meetings that occurred (the monitoring team counted one meeting per quarter in its data calculation for this report even though more than one meeting may have occurred). • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. 2. Since the last onsite review, during 39 of the 39 (100%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during 39 of the 39 (100%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during 39 of the 39 (100%) meetings, action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed. <u>Other QA-Related Meetings</u> Most of the facility departments held departmental QA meetings with their staff. During these meetings, data were discussed and analyzed. This was an excellent addition to what was developing into a comprehensive facility-wide QA program at SGSSLC. The department heads used these meetings to help gather and analyze their data, which they then used when they held their QAD-SAC benchmark meeting, which then were used to prepare for QI Council presentations. Thus, the occurrence of data review and analysis continued to be "pushed down" to the staff who were collecting, and more so now, using the data (e.g., nurses, QDDPs, SAP writers, therapists). The monitoring team observed one of these meetings, for the medical department. Coincidentally, it was the medical department's first departmental QA meeting. Given that this was a new group, a new meeting, and the facility had a new medical director, the content and topics of this meeting were minimal, but likely to improve and expand. This meeting may also help the facility move forward with its medical quality program, as	

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		required by section L3. The monitoring team recommends that the medical director be the lead for this activity. <u>QA Report</u> In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QI Council) was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 19 (95%) appeared in a QA report at least once each quarter in the last six months. Of the 19 sections of the Settlement Agreement that were presented at least once each quarter, one (5%) contained all of the components listed below (section D). That being said, data were presented for self-monitoring data and other key indicators for almost all of the sections (though some were for only seven or eight months because data collection had not been running for 12 months yet). Further, a narrative analysis was present in 100% of the report sections. This was great to see and demonstrated the progress made at the facility regarding data, analysis, and quality assurance. As noted above, the area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Narrative analysis <u>QI Council (Administrative IDT)</u> This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of all QI Council meetings from January 2013 through August 2013. Since the last review, the facility now called the QI Council the Administrative IDT. This group met every Thursday morning. Sometimes, the meeting also included a detailed review of a challenging clinical case. That portion of the meeting was called the Clinical IDT. Although a meeting called QI Council no longer existed, the Administrative IDT adequately met the intention of the original QI Council. Based on observation and review of minutes, the Administrative (and Clinical) IDT provided a forum for good discussion,	

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		decision making, and data review by the senior management of the facility. There was not, however, an adequate description of the QI Council/Administrative IDT in policy. Since the last onsite review, the QI Council/Administrative IDT met at least once each month. Minutes from all (100%) QI Council/Administrative IDT meetings since the last review indicated that the agenda included relevant and appropriate topics, including presentation of Settlement Agreement sections in an organized, scheduled manner. Minutes from all (100%) QI/Administrative IDT Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes (and attachments/handouts) from all (100%) of the QI Council/Administrative IDT meetings since the last review did document or show that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, and (b) the data presented were trended over time. There was indication that (c) comments and interpretation/analysis of data were presented for most of the items (in the QA report and in the minutes). Minutes from all (100%) QI/Administrative IDT Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. During two QI Council/Administrative IDT meetings observed by the monitoring team, there was active participation of participants other than the presenter for all (100%) of the reports/data presented during the meeting. Overall, the Administrative IDT meetings at SGSSLC were running very well. <u>PITs/PETs</u> SGSSLC had three performance improvement teams (healthy campus, active treatment, dental desensitization). These PITs met regularly and their activities were presented to the QI Council/Administrative IDT at least quarterly. Since the last review, the facility had reduced the number of PITs, PETs, and committees by incorporating much of the work of those groups within the activity of the appropriate departments. This appeared to be a sensible way to approach these special activities.	

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		Corrective Actions The QA director continued the system of CAPs management that was in place during the previous review. There were 43 active CAPs for 12 of the 20 sections of the Settlement Agreement. This was about the same as during the last review. This time, however, there was clearer indication that CAPs were considered for all 20 sections, that is, CAPs (or that there was no need for a CAP) were discussed during monthly QAD-SAC meetings, in the QA report, and in the QI Council/Administrative IDT minutes. The 43 CAPs were primarily in nursing (10) and habilitation services (14). It might be that some of these CAPs were merely corrective actions that did not need the formality of the CAPs process. An adequate written description, however, did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. The QAD reported that the this was done in the QA plan narrative, however, the monitoring team was unable to identify an adequate criterion or set of criteria for determining that a CAP should be generated. Therefore, when considering the full set of CAPs and action plans, the monitoring team could not determine if they were developed/chosen following written description, policy, or procedure. Of the 43 CAPs reviewed by the monitoring team (100% of the total), 100% appeared to appropriately address the specific problem for which they were created. This was based on the wording of each CAP, from which the reader could easily determine the problem that was being addressed. Based on these 43 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 43 (100%) included the anticipated outcome of each action step. o However, there were no specific criteria to determine if the CAP was met, or if progress had occurred (0%). • 43 (100%) included the job title of the person(s) responsible, however, none (0%) included the name of the person responsible. • 43 (100%) included the time frame in which each action step must occur. Lastly, the monitoring team recommends that the QA director maintain and graph some simple data on CAPs/action plans. These data can be part of the section E data list inventory (and possibly the QA matrix, too). For example: • Total number of active CAPs/action plans • Number of CAPs/action plans completed and closed out for the month (or	

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		quarter) • Number of CAPs/action plans that are active (i.e., not completed) past their due date To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Analyze data as per the wording of provision E1 when appropriate to do so; or if not, provide a rationale. 2. CAPs program needs criteria for having a CAP. 3. Include criteria for a CAP being met. 4. Consider managing/tracking each of the CAP action plans.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of the 43 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • 0 (0%) included documentation of to whom it was disseminated, including the specific name (0%) and title (100%). Given that the above three bullets were included in the set of metrics submitted to the state since the last onsite review, this provision remains in substantial compliance with the expectation that the above metrics will be addressed by the time of the next review.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The 43 CAPs appeared to have been implemented (100%). Management staff reported on CAPs-related activities at QAD-SAC meetings, in QA reports, and during QI Council/Administrative IDT presentations. The monitoring team, however, could not determine that all aspects of CAPs were implemented fully and in a timely manner. To address this, the monitoring team and QAD and SAC discussed indicating on the tracking spreadsheet, for each CAP, whether it was implemented in a timely manner, done fully, and modified if needed (this last variable is for section E5). This could be done by adding additional columns to the CAPs tracking spreadsheet and/or within the monthly QAD-SAC meeting set of what were at this time 15 different items. There was an adequate system for tracking the status of CAPs. Of the 43 CAPs being tracked by the facility, 40 (93%) indicated the status of the CAP and any action taken if the CAP had not been implemented (though as noted immediately above, the monitoring team could not determine if the actions taken were done in a timely manner and if the actions fully addressed the CAP).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility QA director did maintain summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review. The QA director or section leader did present this information to QI Council/Administrative IDT at least quarterly. The summary data were included in the self-assessment, but not in any QA report.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director reviewed CAPs each month with the responsible person/section leader. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes and timely completion • CAPs are modified when needed • Modifications/results are discussed at QAQI Council • Modifications are implemented as written fully and timely.	Noncompliance

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 DADS Policy #004.1: Individual Support Plan Process o DADS Policy #051: High Risk Determinations o Curriculum used to train staff on the ISP process o SGSSLC Section F Presentation Book o SGSSLC Self-Assessment o The last 10 section F monitoring tools completed by the QIDP Coordinator o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o A list of all individuals at the facility with the most recent ISP meeting date, date of previous ISP meeting, and date ISP was filed. o Draft ISPs and Assessments for Individual #132 and Individual #379. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #104, Individual #151, Individual #52, Individual #375, Individual #277, Individual #166, Individual #362, Individual #388, Individual #345, Individual #76, Individual #53, Individual #379, Individual #268, and Individual #318. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Vicky Hinojos, Section I Lead/Residential Services Director o Jalown McCleery, Incident Management Coordinator o Michael Davila, QIDP Coordinator o Dena Johnston, Rehabilitation Therapies Director o Angela Garner, CNE o Dana Robertson, Section C Compliance Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 8/13/13 and 8/14/13 o Annual IDT Meeting for Individual #132 and Individual #379 o QIDP monthly meeting o Human Rights Committee Restraint Review Meeting

	o Restraint Reduction Committee Meeting o Human Rights Committee Meeting o Pre-ISP Meeting for Individual #76
	Facility Self-Assessment: SGSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 7/8/13 with recent activities and assessment outcomes. The QIDP Director was responsible for the section F self-assessment. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed, as well as other activities for each provision. The facility was also observing ISP meetings, gathering information from the QDDP-Construction Assessment, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1d in regards to the use of assessments in developing the ISP, data were gathered from the Settlement Agreement Monitoring Tools and the ISP monitoring tool. These are the same type of activities that the monitoring team looks at to assess compliance. The facility had developed action steps to address deficiencies noted on the self-assessment. This should ensure that progress will continue to be made on developing an adequate ISP process. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed. Findings for each provision item were similar to findings by the monitoring team.
	Summary of Monitor's Assessment Since the last monitoring visit, SGSSLC IDTs had implemented the newest ISP and risk identification process. Additional action taken to address the requirements of section F included: • Designated three QIDPs without assigned caseloads to facilitate all of the ISP meetings. • Began process to alert department heads of delinquent assessments. • Implemented new ISP monitoring system to capture flow from pre-ISP meeting to annual ISP meeting to documentation review. • Completed additional training with IDT members on developing meaningful objectives in the IHCP and ISP. • Implemented new format for QIDP monthly reviews. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process.

	There was positive progress evident with the new ISP process. At the ISP meetings and one pre-ISP meetings observed by the monitoring team, it was noted that significant progress had been made towards integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was to some degree woven into the discussion regarding the individual's preferences, daily schedule, and support needs. IDTs observed were moving in a positive direction. To move forward towards compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and available to all team members for review. • IDTs should focus on developing action plans that expand on preferences by providing opportunities to learn new skills and explore new activities in the least restrictive setting. • Recommendations from assessments should be integrated into all supports and services. • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised. The new process, thus far, was not resulting in adequate supports and measurable outcomes in many cases. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed three ISP meetings in the new format. The QIDP facilitators facilitated the meetings. IDT meetings observed were good examples of facilitation that ensured that team members participated in the meeting. There were still some areas in the ISP process that teams may need additional training on including discussion around consent and guardianship and the community living discussion. Overall, progress continued to occur and was evident, with regard to the facilitation of meetings. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Five of 15 (33%) QIDPs had been deemed competent in regards to facilitation skills via this tool.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the QIDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QIDPs used this template to draft portions of the ISP prior to the meeting. The QIDPs came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. A sample of IDT attendance sheets was reviewed for presence of the QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. The facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted. Good progress had been made towards developing an ISP that integrated all identified supports and services and focused on the individual's strengths and preferences. As noted throughout many sections of this report, to move forward, the facility needs to focus on monitoring progress/regression and revising supports and services when needed.	
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 QIDP, direct support professionals, and persons identified in the pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. SGSSLC was using the pre-ISP process to identify assessments to be completed prior to the annual ISP meeting and team members that should be present at the annual ISP meeting. The facility was tracking data on attendance at IDT meetings. Data gathered for presentation to the QA/QI council indicated fair presence and participation by relevant team members. Attendance by the physician, dietician, audiologist, and psychiatrist when deemed relevant by the IDT remained low, as did participation by the family members or LARs. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance

Month	Overall attendance by relevant team members
November 2012	70%
December 2012	76%
January 2013	71%
February 2013	87%
March 2013	84%
April 2013	81%

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified in the PSI as relevant participants at six of seven (86%) of the annual meetings in the sample. The sample included Individual #53, Individual #375, Individual #388, Individual #268, Individual #318, Individual #52, and Individual #277. For example,

- At the annual ISP meeting for Individual #53, there was no participation by his nursing staff, dietician, or program developer.
- At the annual ISP meeting for Individual #375, there was no participation by his PCP.
- The LA and vocational staff did not attend the annual ISP meeting for Individual #388.
- At the annual ISP meeting for Individual #52, there was no participation by her psychologist, SLP, audiologist, dietician, PCP, psychiatrist, dental staff, pharmacist, or active treatment staff.
- Individual #318 did not attend his annual ISP meeting. Additionally, his LAR, psychiatrist, PCP, and LA were not present for the meeting.
- Individual #277's advocate, physical therapist, dietician, and active treatment did not attend her annual ISP meeting.

The annual IDT meeting for Individual #379 was held the week of the monitoring team's visit. The individual was ill on the day of his meeting, so did not attend. The IDT did not consider postponing his meeting so that he could participate when feeling better.

Currently, the IDT process was evident in the psychiatry clinic setting. Psychiatry clinic was functioning like an ISPA given the number of staff in attendance and collaboration. However, the facility did not consistently have a full complement of psychiatrists, therefore, there was inadequate involvement in the development of the integrated ISPs for each individual to determine interventions through the IDT, both pharmacological and non pharmacological.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Attendance at ISPs was improved for OT, PT, and SLPs, but still remained low for PCPs and dieticians when recommended.

In an effort to utilize staff resources most effectively, the facility could incorporate some components of the IDT meetings into the psychiatric clinic process (e.g., review of the PBSP during a regularly scheduled psychiatric clinic). Given the interdisciplinary model utilized during the psychiatry clinic the establishment of cohesive diagnostics and evaluation of medication efficacy should occur.

The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td>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.

The facility gathered data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 12/1/12 through 4/30/13 indicated that assessments were not routinely submitted prior to ISP planning meetings.

Data gathered on assessment submission from November 2012 through April 2013 indicated that overall monthly compliance was between 56% and 84%. Detailed data were reviewed on assessment submission for annual ISPs meetings held during April 2013. Data indicated which were submitted at least 10 days prior to the IDT meeting for review by all IDT members. The chart below indicates findings from that review.

<table>
<tr><td>Assessment</td><td>Submission Rate</td></tr>
<tr><td>Medical</td><td>56%</td></tr>
<tr><td>Nursing</td><td>76%</td></tr>
<tr><td>Dental</td><td>67%</td></tr>
<tr><td>OT/PT</td><td>87%</td></tr>
<tr><td>Speech</td><td>77%</td></tr>
<tr><td>Nutrition</td><td>50%</td></tr>
<tr><td>Psychology</td><td>56%</td></tr>
<tr><td>Psychiatry</td><td>18%</td></tr>
<tr><td>PFA</td><td>82%</td></tr>
<tr><td>Vocational</td><td>100%</td></tr>
<tr><td>Rights Assessment</td><td>50%</td></tr>
<tr><td>Audiological</td><td>94%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Newer ISPs supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Zero (0%) of six individuals had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting. • Individual #268 did not have a psychological assessment prior to her annual meeting. Her PSI identified the need for one. • Individual #388 did not have an audiological assessment or a structural and functional behavioral assessment identified as needed at the PSI meeting. His nursing assessment was not submitted 10 days prior to the annual ISP meeting. • For Individual #52, his dental assessment, psychological, and FSA were not completed 10 days prior to his annual ISP meeting. • For Individual #166, her nursing, psychological, speech, FSA, and psychiatric assessment were not completed within 10 days of her annual ISP meeting. • For Individual #318, his medical assessment, nursing assessment, psychological evaluation, psychiatric assessment, dental assessment, FSA, OT/PT assessment, communication assessment, nutritional assessment, and audiological exam were not submitted 10 days prior to his annual ISP meeting for review by the team. • Individual #277's medical, nursing, psychiatric, and nutritional assessments were not submitted 10 days prior to her annual ISP meeting. The facility needs to continue to expand opportunities for individuals to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities. The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. As noted in previous reports and in section S of this report, the FSA was not adequate for capturing this information. The facility was not yet in compliance with this item based on the data available. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months 1. 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. 2. Assessments should result in recommendations for support needs when applicable.	

#	Provision	Assessment of Status	Compliance
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.	As described in F1c, assessments required to develop an appropriate ISP meeting were not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been considerable progress made in integrating assessment recommendations into support plans when available to the team. The monitoring team observed the annual ISP for Individual #132. The IDT was unable to develop a fully integrated ISP because necessary assessments had not been completed prior to his annual IDT meeting. The team agreed that communication and vocational assessments would need to be completed prior to developing outcomes for the upcoming year. The team agreed to meet again when assessments were completed. QIDPs 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. The ISP for Individual #277 included outcomes to review her annual physical and dental assessments once completed. The team was unable to develop necessary supports at the time of her annual ISP because assessments were not available. There was no evidence that the team met when assessments were completed to integrate recommendations into her ISP. Many of the recommendations made by therapy clinicians were not addressed in the ISP and were not included as actions. Most of the direct supports provided were not integrated into the ISP or by ISPA. The descriptions of how individuals communicated were often weak or non-existent and specific strategies for staff use to communicate with individuals were not noted. Skill acquisition plans in the sample of ISPs reviewed did not integrate recommendations from therapy and behavioral assessments into teaching strategies. Examples where assessment results were not incorporated into the supports and services developed by the IDT included: • Individual #318 had a SAP for eating safely. Therapy supports recommended in his mealtime plan were not included in teaching instructions. • Individual #388's PNMP included instructions for using sequenced picture schedules to ensure predictable routines and teach the use of pictures for communication. Teaching instructions in his SAPs did not include the use of sequenced pictures when appropriate. He had a SAP for purchasing items from the vending machine. Recommendations from his mealtime assessment in regards to safe eating were not incorporated into teaching strategies. • Individual #104 had a SAP for safe eating. The teaching instructions did not	Noncompliance

#	Provision	Assessment of Status	Compliance
		include information regarding adaptive equipment needed during mealtime as recommended in his mealtime assessment or communication strategies recommended in his speech evaluation. • The recommendations from Individual #318's vocational assessment were not included in his ISP. He did not have any outcomes related to vocational training or day habilitation. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that all recommendations from assessments are used to develop and revise supports as needed.	
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 mandated that a Living Options discussion would take place during each individual's initial and annual ISP meeting, at minimum. The ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. As part of the new ISP process, each discipline was asked to include as part of the pre-ISP assessment process a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP. At annual ISPs observed for Individual #132 and Individual #379, team members discussed providing supports in a less restrictive environment. • For Individual #132, the QIDP read recommendations from each discipline's assessments regarding community living including supports that would be needed in the community. There were no barriers noted to placement though team agreed that he needed further education on community options. The team stopped short of having an adequate discussion of training that could be offered to facilitate a move to a less restrictive setting. It was agreed that he would go on group home visits, then the team would meet again to discuss his reaction. • For Individual #379, the QIDP asked the team members for input on the most appropriate living option. Team members agreed that there were no barriers to community placement, but the individual had a low level of awareness about	Noncompliance

#	Provision	Assessment of Status	Compliance
		other living options. His team also agreed that group home visits should be arranged for further exposure to other living options. Additional training in the community was not discussed. The team agreed to meet back in six months to discuss his group home visits. In order to capture accurate data and make recommendations based on his response to the visit, the team should have considered meeting immediately after the group home visit. Eight ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #76, Individual #362, Individual #379, Individual #345, Individual #268, Individual #318, Individual #388, and Individual #52. Individual #76, Individual #318, and Individual #345 had no community based outcomes. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #362 had two community based outcomes that stated she "will be provided the opportunity for off-campus outings" and "will take her to purchase and I-tunes card." • Individual #52 had one outcome to be implemented in the community. It stated "will continue to be provided with the opportunity to participate in shopping, church, beauty shops, theaters, and recreational activities at least once a month." When outings are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. There was no focus on providing supported employment or volunteer opportunities for individuals at the facility. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. Meaningful job training was not observed in the vocational program. None of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	

#	Provision	Assessment of Status	Compliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs did not engage in discussion of support needs in relation to preferences. The team reviewed the list of preferences developed during the pre-ISP meeting, but did not use the list to plan for the individual's day. For example, the IDT for Individual #132 determined that he would attend the Suzie Crawford Center and possibly some recreational classes during the day. They did not discuss what specific activities he would be involved in or what training would occur at either site. The IDT for Individual #379 discussed day programming in relation to his preferences, but stated that they were unable to get him enrolled in classes that he was interested in because they were full. They did not consider community based options. For example, they agreed that a retirement program would be appropriate based on his preferences, but the facility-based options were full. The team should have explored the possibility of participation in a community based retirement program. As has been noted in past reviews, attendance in day programming remained very low. The facility needs to explore how to use day habilitation resources to provide training based on individual preferences to ensure that individuals attend day programming and have opportunities to develop new skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Lists of preferences included a much broader range of activities and were individual specific, which was good to see. IDTs, however, were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences. ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer or work opportunities. In a review of eight recent ISPs, none (0%) offered specific training to be provided in the community. While the community was often listed as a possible training site for outcomes, training was not designed specifically for functional training in the community. For many of these individuals, community awareness had been identified as an obstacle to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs. To move in the direction of substantial compliance, the monitoring team recommends that the facility focuses on developing outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	A sample of ISPs, IHCPs, and skill acquisition plans (SAP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. The monitoring team found that there were still many outcomes not written in a way that staff could measure progress towards completion or did not provide enough information to ensure consistent implementation. For example: • Individual #151 had an action step in his IHCP to address his risk for constipation that stated, "encourage him to drink more water fruits, and vegetables." There were no guidelines to ensure that staff knew how much water, fruits, or vegetables should be consumed in a day. Another outcome stated, "weigh at least monthly or as ordered by PCP." An acceptable weight range was not given.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #375 had an action steps that stated "will discuss open classes for Zumba, art, and other classes he might be interested in with Cultural Services." It was not clear what the outcome of this goal should be or what criteria would be used for completion. • Individual #104 had action steps to "increase his use of functional communication" and "increase his social interactions." The plan did not specify what training would occur or how staff would measure successful completion of the outcome. As noted in F1d, recommendations from assessments were not always used to develop training strategies. Additionally, as noted in F2a1, outcomes were not developed based on preferences at the ISP meetings observed by the monitoring team. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Section M and section I also address the writing of measurable strategies to address health care risks. Section T elaborates on the facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. It was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed the individual's array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. The development of action plans that integrated all services and supports was still an area with which the facility struggled. At both annual IDT meetings observed, the team recommended additional assessments. It was not clear how those assessment results would be integrated into the ISP once completed. 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, so that information could be integrated among disciplines. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. The facility had made significant progress in developing comprehensive ISPs that integrated all supports and services. However, as noted throughout section F, assessment information was often not available prior to the ISP meeting. It was not evident that recommendations from assessments obtained after the annual ISP meeting were integrated into the ISP. For example, the IDT for Individual #375 identified the need to discuss the risk/benefits of cataract surgery with his PCP. Recommendations (if any) were not integrated into his ISP. Similarly, Individual #318's physical and dental assessment were not completed prior to his annual ISP meeting. The IDT acknowledged that the assessments would need to be completed prior to developing supports. The team did not document discussion of the assessments and any resulting recommendations once completed. 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. It is expected that progress will continue to be made in developing comprehensive plans as IDT become more familiar with the new ISP process and more adept at developing measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation in some cases. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. IHCP action steps were generally brief statements of action to address the risk. Most did not include methodology or criteria for monitoring effectiveness of intervention. For example: • Individual #76 had action steps to address his risk for weight gain and cardiac disease including "monitor weight weekly" and "abdominal girth checked quarterly." Parameters were not given that would signify a change in risk status or a need for revised supports. • Individual #375 had an action step to monitor his vital signs monthly. The plan	Noncompliance

#	Provision	Assessment of Status	Compliance
		did not include an acceptable range for his blood pressure or pulse or action that should be taken if his blood pressure or pulse did not remain in a safe range (e.g., notify the physician if it was not within a stated range). He had an action step to address his risk for constipation that stated "encourage to drink plenty of fluids daily." The action step did not specify how much fluid he should drink to ensure adequate hydration. <u>Time frame for completion</u> Outcomes in the sample reviewed generally included a completion date. Example where this did not occur included: • The completion dates for outcomes in Individual #318's ISP were left blank. • Completion dates were not stated for action steps in Individual #52's IHCP. • Individual #104's IHCP did not include implementation or completion dates. <u>Staff responsible</u> All SAPs and IHCPs in the sample included designation of which staff would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	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 new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As noted in previous reports, many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence. None of the ISPs in the sample included outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. In the ISPs reviewed, outcomes were not developed to provide training on domestic skills, such as food preparation, housecleaning, or laundry care that would be necessary to live more independently in the community. There was very little measurable training occurring in the day habilitation programs. Vocational skills were often taught in relation to jobs at the facility, but would not necessarily translate well in a community work environment. For example, individuals at the facility had part-time schedules for work or day activities. Lengthy lunch breaks during which individuals went back to their	Noncompliance

#	Provision	Assessment of Status	Compliance
		residences did not allow opportunities for individuals to learn to either bring lunch to eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across 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 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. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. The data to be collected and frequency of implementation was found on the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. SAPs, ISP outcome summaries, and IHCPs now included the person responsible for data collection and the person responsible for review of that data. As noted in other sections of this report, IDTs were still developing general action steps such as "monitor weight" without including criteria that would trigger a review of supports or change in status. Outcomes will need to be measurable in order to permit objective analysis of the individual's progress.	Noncompliance
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	This provision item will 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 G1 regarding the coordination and integration of clinical services. As noted in F1, adequate assessments were often not completed prior to the annual meetings. When assessments were recommended by the team, it was not evident that	Noncompliance

#	Provision	Assessment of Status	Compliance
	ISP.	the ISP was revised to include recommendations once the assessment was completed. To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are integrated throughout the ISP.	
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 11 out of 16 (75%) records reviewed. The facility reported that 127 (58%) of 218 ISPs were filed more than 30 days after the annual ISP meeting over the past year. Supports plans were not always clearly written to ensure consistent implementation or evaluation of progress. For example, at Individual #132's annual ISP meeting, data were presented regarding progress on SAPs, but staff were not able to determine what the data meant or what progress had been made. He had been working on a SAP for two years related to eating skills to address his risk for choking. When the team discussed his risk for choking, they were not sure what supports he needed. Similarly, he had been working on a SAP for toothbrushing for the past two years. Implementation data were available, but staff were not sure what supports he needed to brush his teeth adequately. The team agreed to reassess his skills and then revise his outcomes, if needed. The facility needs to ensure that all plans are comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided and what data should be gathered. 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility needs to ensure that plans are distributed and available to staff implementing the plan within 30 days of development.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s)	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was assigned responsibility for reviewing specific services and supports in the ISP. QIDPs were responsible for reviewing the overall plan. The facility had a QIDP monthly review process to review all supports and services. It was not evident that an adequate review process was in place to ensure that the review	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	of supports and services led to timely implementation of assessments or changes in supports when necessary. An adequate review process was not in place for any of the ISPs in the sample. For example, • Individual #269 had an outcome for vocational staff to check to see if a nut cracking position was available. The outcome was to be implemented by 2/21/13 and completed within five days. The monthly review of services dated 6/24/13 indicated that the outcome had still not been completed. There were no recommendations for follow-up by the QIDP. She had an outcome to purchase a pillow to assist her with her back pain discomfort. Monthly reviews for February 2013 through May 2013 showed no progress. The QIDP did not note any barriers or recommendations for follow-up. Her ISP indicated that her QIDP would check on the availability of painting and embroidery classes for her by 4/12/13. There was no documentation in monthly reviews to indicate that the QIDP ever followed up to see if classes were available. The monthly review did not include a review of all outcomes and services. • Individual #76 had an outcome to attend and participate in Cultural Services classes weekly. His QIDP monthly reviews for April, May, and June 2013 showed "N/A- no classes" in the review of progress grid. The QIDP did not indicate that the IDT had discussed follow-up on the lack of implementation. Another outcome stated that he "will attend and participate in an exercise activity at the gym at least weekly." The QIDP commented "gets regular exercise on the home" for all three months reviewed. Again, there were no comments regarding lack of implementation or the need for revision of the outcome. The monthly review was not a comprehensive review of all outcomes and services. • The monthly reviews for Individual #277 and Individual #388 for February, March, and April 2013 did not include any comments regarding review of supports, or progress made towards outcomes. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QIDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. To move forward towards compliance, 1. Plans should be updated and modified as individuals gain skills or experience regression in any area. 2. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>F2e</td><td>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</td><td>In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document.

The facility had been trained by the state office on developing and implementing the ISP. QIDPs were still learning to use the new statewide ISP format. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at SGSSLC.

The facility was providing staff training on individualized specific plans, but as noted throughout section F, staff instructions for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments.

Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process. As noted in F2f, many current support plans were not available for reference by staff designated to implement supports.

To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.</td><td>Noncompliance</td></tr>
<tr><td>F2f</td><td>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.</td><td>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 ISPs were available in 11 (75%) of 16 individual notebooks in the sample.

Data provided by the facility indicated that 127 of 218 (58%) ISPs developed in the past year were filed more than 30 days after the annual ISP was held.

<table><tr><th>ISPs developed by month</th><th>Implemented within 30 days</th></tr><tr><td>December 2012</td><td>53%</td></tr><tr><td>January 2013</td><td>26%</td></tr><tr><td>February 2013</td><td>44%</td></tr><tr><td>March 2013</td><td>30%</td></tr><tr><td>April 2013</td><td>No data</td></tr></table>
To address timely development of the ISP, the facility had designated three QIDP facilitators to facilitate the annual ISP meeting and then write the ISP. The facility needs</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		to ensure that plans are distributed and available to staff implementing the plan as soon as possible, but no more than 30 days after development.	
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 assurance activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings. Good progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation.	Noncompliance

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: Off Campus Consultation Process, 7/26/12 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC Policy/Procedure: Integrated Clinical Services and Minimum Common Elements of Clinical Care, 9/13/12 o SGSSSLC 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 Medical Provider Meeting Notes o Administrative IDT meeting minutes o Review of records listed in other sections of this report Interviews and Meetings Held: o Stanley Cal, MD, Medical Director o Albert Fierro, RN, Medical Compliance Nurse o Lisa Owens, RN, Quality Enhancement Nurse o David Ann Knight, RN, Quality Enhancement 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 Provider Meetings

	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. For G1, all of the activities reviewed centered around attendance in the various meetings, such as the daily provider meeting, Pharmacy and Therapeutics Committee, and Infection Control Committee meetings. There was no actual metric or surrogate metric to determine if the meetings resulted in the delivery of integrated services. Interestingly, attendance at the fundamental planning meeting, the annual ISP, was not reported in the self-assessment. The activities for G2 were not related to the requirements of the provision. The self-assessment reviewed the internal and external audits related to providers review of consultations. This assessment provided no information on the requirements of the provision item. In moving forward, the monitoring team recommends that the medical director and section G lead review this report. For each provision item in this report, the facility lead should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations. 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 self –assessment indicated that attendance at the clinical integration meeting was not a specified measure of success to ensure clinical integration was occurring. For G2, the facility found it self not in substantial compliance because a system to assess the provision was not successfully implemented. The monitoring team agrees with the facility's self-rating of noncompliance. Noncompliance for G2 was due to the failure to meet the requirements as specified in the Settlement Agreement and state policy.
	Summary of Monitor's Assessment: The facility's medical compliance nurse assumed the role as facility lead for this provision. 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 monitoring team met with the medical director, medical compliance nurse and QA nurse/section H lead to discuss the facility's continued efforts in integrating clinical services. There were no changes to the policy developed in September 2012 and the facility did not have any new initiatives geared at improving integration of clinical services. Most departments were refining processes in a manner that would encourage integration. The medical director described a number of initiatives that

	he believed would promote integration, such as the decision to provide more respiratory services and have weekly meetings with nursing to discuss issues. The facility continued to struggle with how to measure integration of clinical services. For Provision G2, it was reported that there was no change or progress. The facility did not monitor the requirements for this provision item. The monitoring team observed during interviews and discussions that most staff tended to point out a few ways that they integrated with other areas. It was clear that staff had a continued awareness of the importance of integration of clinical services. Throughout the week of the review, the monitoring team learned through committee meetings, but more importantly through discussions and planning for specific individuals, how services were integrated. The facility will need to have each department provide potential metrics for measuring the success of integration in their areas.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The facility implemented an Integrated Clinical Services and Minimum Common Element of Clinical Care Policy in September 2012. The policy primarily addressed Section H. The section on integrated services listed the clinical committees, which promoted integration of clinical services. The clinical service departments were not required to develop a policy that described how the department integrated with other clinical service areas. In attempting to demonstrate compliance with this provision item, the facility focused on attendance at the various clinical committees since that was the focus of the policy. As discussed in previous compliance reports, the attendance at meetings was one, but not the most important surrogate metric for measuring compliance with this provision item. The monitoring team was not looking for the facility to engage in new activities, but to report in a meaningful way, specific and measurable evidence of integration of clinical services. This would likely not be directly measurable, but could be measured through surrogate metrics. The medical compliance nurse explained that the compliance with the requirement to provide integrated clinical services was done by monitoring attendance at the meetings of the clinical committees. As is usually the case, the monitoring team requested examples to demonstrate integration of services. The following were reported by the medical director and medical compliance nurse as evidence of integration: • Daily clinical services meeting • Dental desensitization programs • Hospice services • Collaboration with community pediatrician to provide services to a young individual residing at the facility • Dental modified consistency program	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Pneumonia and infection control • Communication of 24 hour nursing report to medical staff to facilitate appropriate follow-up of individuals who had standard operating procedures implemented Through interviews, observations of activities, review of records and data, the monitoring team noted examples of integration of clinical services. The following are a few examples: • The monitoring team attended several of the daily provider meetings conducted during the week of the review. The meetings continued to discuss the relevant events that occurred over the past 24 hours. Some meetings included in depth discussion of medical issues that required attention. This format allowed for input of the various clinical services. • There continued to be a great deal of collaboration between the dental clinic and psychology with regards to desensitization. However, there were numerous documents and meeting minutes that indicated desensitization efforts at the facility were not going well for many months after the last compliance review. Specifically, it was documented that the plans were ineffective, staff were not trained prior to implementation, and dental clinic was not provided adequate updates on the status of the plans. The issues were addressed, after which the number of needed desensitization plans was reduced from five to zero. It was reported that nine Behavioral Rehearsal Plans were implemented for dental treatment. At the time of the compliance review, it was reported that psychology responded promptly when informed of clinic refusals. • The dental clinic, in conjunction with habilitation services, developed a program to utilize alternative toothpaste for individuals who required thickening of liquids. • The Clinical IDT meeting provided an excellent opportunity to have an in depth review of clinical cases in which members of the IDT could present findings and receive feedback from the clinical leads of each area. The discussion observed by the monitoring team could have been enhanced by the presence of the clinicians that provided direct care. Nonetheless, further management of the individual required appropriate integration of services between medical, psychiatry, nursing, and psychology. • As noted in section J, while information about various topics (i.e., polypharmacy, individuals with epilepsy) were discussed with the IDT, it was not always possible to determine the integration of that information in the treatment plan provided for the individual. The integration with regard to the IDT process evident in psychiatry clinic was better spelled out in the psychiatric quarterly evaluations due to various disciplines providing pertinent information for the	

#	Provision	Assessment of Status	Compliance
		integrated document (i.e., nursing, psychiatry, psychology, and pharmacy). Unfortunately, the psychiatric quarterly evaluations were not always completed in a timely manner. • Integration of psychology and psychiatry was very good. Psychologists and psychiatrists appeared to have meaningful interactions during the psychiatric clinics observed. • The medical and nursing departments leadership met each week to review important topics. • The PNMT worked well together for assessment and follow-up and IDT members (RN, QIDP, and others) attended 100% of the PNMT meetings. The PNMT RN frequently attended IDT meetings when needed. Most of the referrals to the PNMT were generated by the IDTs with only a few being self-generated. There were very clear referral guidelines in place to assist the IDTs in recognizing when referral was indicated. • Attendance at ISPs was improved for OT, PT, and SLPs. Many of the recommendations made by therapy clinicians were not addressed in the ISP and were not included as actions. Most of the direct supports provided were not integrated into the ISP or by ISPA. There was consistent evidence of review of the PNMP with specified changes noted in the ISP in more cases. • During the onsite review, the monitoring team attended the ISP meeting for Individual #132. The meeting was well attended and all relevant clinical services were represented at the meeting. The risk assessment was conducted by the RN Case Manager. The IDT team, responded to the monitoring team's concern regarding the individual's tobacco use by discussing the impact of tobacco use on the health outcomes for the individual. While the IDT team struggled with correlating risk factors with potential health problems, the efforts put forth in the meeting were positive and, notably, team members came away with understanding the rationale for the connection of the individual's risk factor to the individuals corresponding current, and potential health problems. Several areas offered great opportunities for improvement: • Physicians were requested to participate in the annual ISPs based on the risk assessment of the individuals. However, the medical department did not track physician attendance at the annual ISPs or ISPAs. Since the ISP is the fundamental planning meeting that should result in the overarching strategy that assists the individual in achieving goals, identifying barriers to treatment and transitioning, it would be important to include for section G, information on participation of the various clinical services. This is not new data, but is relevant to this provision item. • The facility continued to lack an effective means to integrate psychiatry and	

#	Provision	Assessment of Status	Compliance
		neurology services as required by the Settlement Agreement. • Since February 2013, 44% of the pretreatment sedation forms were not completed by the IDT, thus, indicative that the IDT failed to review details of individuals who received pretreatment sedation. • There was a clear need to have better collaboration between residential services, dental, and other departments with regards to the no show/missed appointments. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should have each clinical service area draft a policy describing how they will achieve integration with other clinical service areas. The policy should define how success will be measured. 2. The center's lead and medical director should address the concerns outlined in the comments above. 3. DADS should develop and implement policy for Provisions G1.	
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 section G lead reported that the medical department secretary was still utilizing a spreadsheet to track off campus appointments. State office conducted training in Austin on use of the new Access database, but it was not being used at the time of the compliance review. The 8/29/13 section G report indicated that the state database was mandatory and was implemented on 6/1/13 and was currently being used. The consultation referral form was revised in July 2012. The front of the form included a section to indicate attachment of the MOSES and DISCUS evaluations, history and physical, labs, seizure records, and other information. The back of the form was utilized by the facility providers to document review of the consult. Information documented on the reverse of the form included: • Acceptance or rejection of recommendations • Explanations or plan of care • Change in status requiring formal IDT review • Signatures of PCP, psychiatrist, RN case manager • Ready to file A total of 50 consults in the record sample that were completed after January 2013 were reviewed: • 10 of 50 (20%) consultations were summarized by the medical providers in the IPN within five working days.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The form was inconsistently utilized during the December 2012 compliance review. The two full time medical providers were informed that the use of the form was acceptable, but could not replace an IPN entry. Record reviews indicated that documentation was found on the consult form and in the IPNs for several months. However, with the arrival of new medical staff, the documentation of consultations became less clear. The consultation referral form was used in addition to completion of IPN entries. Neither form was adequately completed. The summaries on the consultation form were usually limited to a few words. The IPN documentation was not adequate to explain to the IDT the reason for the consult and significance of the findings. While the primary providers were reviewing the consults as required, the appropriate documentation in the IPN was not present in the active records. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The monitoring team recommends that IPN documentation include (a) the required summary statement regarding the reason for the consult and significance of the findings, (b) agreement or disagreement with the recommendations, and (c) the need for IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented. It is further recommended that that the PCPs always notify the IDT when there is a disagreement with the recommendations of the consultant since further discussion may be warranted. The monitoring team also 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., Surgery Consult, 1/1/13). 2. The medical director should ensure that the state database has been appropriately implemented. 3. DADS should develop and implement policy for Provision 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 Lisa Owen, RN, QE Nurse o Stanly Cal, MD, Medical Director o Albert Fierro, 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. For this provision, the self-assessment aligned with the information contained in the July 2013 Minimum Common Elements of Clinical Care Report. For most, but not all, provision items, data were provided on the elements identified by the facility. During the week of the onsite review, the monitoring team met with facility staff to discuss the self-assessment, and the status of each provision item. 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, and the recommendations. The facility found itself in substantial compliance with provision H2. The facility found itself in noncompliance with all other provision items. The monitoring team agreed with the facility's self-ratings.

	Summary of Monitor's Assessment: The facility's QA Nurse continued to serve as the center's lead for section H. Progress continued in this area. The facility had defined many elements that needed to be reviewed and measured. According to facility policy, each discipline was expected to address the requirements of the provision, monitor the services, and provide documentation that this was done. That approach changed and the center's lead was conducting a massive number of record audits to obtain data for multiple provision items. Many of the elements for analysis cited in the facility's policy appeared to have been removed from the audits although the policy was not officially revised. Much of this data should be generated through the quality reviews and quality systems of the departments. Medical audits should be completed within the medical department and data provided to the QA department for inclusion in Section H. In fact, elements that assess the quality and appropriateness of care must be completed as a peer review/quality process. The lack of such review systems limited the amount of progress that was seen since the last compliance review. The center's lead acknowledged that there was no progress to report for some provision items. Notwithstanding the loss of momentum, the audits that were completed provided very good detailed information for the clinical disciplines. Many issues were identified, addressed, and corrected. Progress seen in the completion of assessments in several areas was likely due to the continual auditing and feedback shared with the departments. This report will provide information on the facility's efforts to implement the process outlined in the policy. It will also provide, as usual, the findings of the monitoring team with regards to each provision item.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Facility policy identified three elements for analysis specific to provision item H1 that were captured in the audit tool: • Timelines for completion of scheduled assessments • The appropriateness of interval assessments in response to changes in status • Quality of assessments that will capture compliance with acceptable standards of practice The facility tracked 12 scheduled assessments. Beginning 5/1/13, the center's lead checked the shared drive to ensure compliance was met with the requirement to submit 10 days prior to the ISP. Effective 8/1/13, the QIDP facilitators audited 100% of all ISPs for the 12 required assessments. The center's lead extracted data from that QIDP checklist. Data for annual assessments are summarized in the table below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Scheduled Assessments 2013
Compliance with Timelines for Submission (%)

	Feb	Mar	Apr	May	Jun	July
Number of ISPs	17	20	18	24	16	
Rehabilitation Comprehensive	--	--	--	20	100	75
SPL Annual	100	80	50	0	60	40
Audiology Annual	100	100	0	60	80	80
Nursing Annual	33	60	0	40	40	20
Medical Annual	100	80	80	80	20	80
Psychiatry Annual	0	25	50	0	100	75
Psychology APES	33	60	20	0	20	0
Dental Annual	100	60	80	80	60	60
Nutrition	33	40	0	20	0	100

The data applied to ISP submission dates and did not necessarily reflect the requirements that some disciplines had to complete assessments within 365 days of the previous assessment. The center's lead provided monthly feedback to the clinical disciplines. Additionally, beginning 8/1/13, this information was being brought to the Administrative IDT meetings. While progress was noted in the work done to improve timeliness of assessments, the facility did not present any information related to the quality of assessments.

Six interval assessments were also tracked to determine if assessments occurred in a timely manner in response to a change of status (CoS). The compliance scores are presented in the table below.

Interval Assessment 2013
Compliance with Timelines for Completion (%)

	Feb	Mar	Apr	May	June	Jul
Hab Assessment Post Hospital (CoS)	--	100	100	100	100	33
RN Post Hospital	100	100	80	100	67	33
Nursing Assessment of Serious injury	--	--	75	33	60	100
Medical Post Hospital	100	100	100	100	67	100
Psychiatry –Attachment E	--	--	0	67	33	0
Psychology Post CoS	--	--	75	80	80	60

The audits captured several important assessments that were done in response to hospitalizations, the use of chemical restraints, and serious injury. The audits did not address the physician's response to acute illness that did not require hospitalizations.

In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, and reviewed assessments and facility data. This report contains, in the various sections, information on the required assessments. The results of those activities are summarized here:

#	Provision	Assessment of Status	Compliance
		• Annual Medical Assessments were found in all of the records included in the record sample. As discussed in Section L1, aggregate data for the facility showed that 76% of assessments were completed within 365 days of the previous assessment. Quarterly Medical Assessments were not completed. Medical assessments are discussed in Section L1. • Annual Dental Examinations were complemented in a relatively timely manner. The compliance rate for completion of annual assessments was 84%. This was an improvement from the 80% compliance seen in the December 2012 review. The quality of the documentation also improved. Dental assessments are discussed in Section Q2. • A review sample of the most current quarterly and annual nursing assessments, noted improvement compared to the findings of the December 2012 review. • The PNMT conducted assessments for individuals referred to the team. The assessments were generally completed in a timely manner and resulted in a series of recommendations for the IDT and the PNMT to address collaboratively. • Therapy assessments were completed annually for individuals provided direct and indirect supports and services. A comprehensive assessment was completed at least every five years for all individuals. These were also completed when a change in status was identified by the IDT or a consult assessment was completed and documented in the IPNs. • The OT/PT assessments were generally completed prior to the ISP, but not consistently 10 days prior to the ISP. The average percentage of compliance with essential elements for all 19 assessments reviewed was approximately 92%. This represented a continued improvement in the quality of assessments as well as the timeliness of completion since the previous review. The content aspect of communication assessments reflected progress as 80% of the assessments reviewed contained more than 90% of the 24 essential elements and 100% of the assessments contained 83% or more of the required elements. • The facility did not have data for compliance with the requirement to complete QPMRs within 90 days. • Sixty four percent of the individuals who received psychotropic medications did not have an Appendix B evaluation completed and comprehensive psychiatric assessments were due for 107 individuals at SGSSLC • Initial psychological, annual psychological, and functional assessments were completed for all individuals. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following	

#	Provision	Assessment of Status	Compliance
		recommendations for consideration: 1. SGSLC must have processes in place to determine if assessments are consistent with professional standards of care. 2. SGSSLC should address the issues related to the deficiencies noted above.	
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.	This provision assesses whether medical and psychiatric diagnoses are consistent with the signs and symptoms documented in the records. The facility conducted audits for medical and psychiatric diagnosis. The medical conditions audited were diabetes mellitus, pneumonia, constipation, osteoporosis, and seizures. Records were also reviewed to determine if the diagnoses of depressive disorder and schizoaffective disorder were supported by the documentation in the records. The nursing elements were not included in the audits. The facility's audits showed 100% compliance for all psychiatric criteria for three consecutive months. There was 100% compliance for all, but one medical criterion. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • The monitoring team noticed less consistency in this area compared to the previous compliance review. This may have been the result of the physician turnover. Overall, the medical diagnoses were consistent with ICD nomenclature and fit the reported signs and symptoms of disease. • There was an improvement in the content of the completion of the Appendix B comprehensive evaluations, but a continued deficiency in the completion of such assessments. The facility was in the beginning phase of converting documentation into the new DSM nomenclature that would take some time. Additionally, there was a revised statewide psychiatric policy and procedure that was recently implemented to better guide the facility in addressing the 15 provision items for the delivery of care. • A sample of the most current nursing assessments, and recently implemented IHPs were reviewed. These documents usually did not include a NANDA diagnosis. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. However, the facility will need to take a number of steps to maintain substantial compliance: 1. Audits completed to determine the appropriateness of clinical diagnoses must be completed by a peer reviewer. 2. The IDTs need to develop combined case formulations in order to provide cohesive diagnostics that would result in an applicable treatment plan.	Substantial compliance

#	Provision	Assessment of Status	Compliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The facility identified elements for analysis, including preventive care screenings, immunizations, timeliness of treatment and interventions, clinical outcomes, medical audits, staffing, equipment, death rates, and morbidity. Per policy, the monitoring of treatment and interventions was to be conducted by the discipline lead that would outline the appropriate level of oversight using the monitoring matrix. For this provision item, the July 2013 MCER presented data on the results of the medical management audits completed in May 2013. Audits were completed on diabetes, pneumonia, and osteoporosis. The medical audit process is discussed in detail in section L2. Utilization of the data from the audits conducted on the six conditions identified in the state issued protocols was not sufficient to assess appropriateness and timeliness of the treatments and interventions: • The facility needs to expand the clinical guidelines and include other common conditions. • The medical management audits did not capture several important aspects of care that should be monitored. • The auditing tools used for the nursing review were not standardized as noted in the report and as reported by the facility. • The medical audits did not assess the interventions and care provided by other disciplines, such as habilitation and nutrition services. The minimum common elements of care provision addresses how all of the clinical services impact treatment. The expectations for management of the six selected conditions were outlined in the state issued clinical protocols. The medical compliance nurse provided all medical staff with copies of the clinical guidelines and had documentation that the medical staff reviewed them. The monitoring team offers the following comments on treatments and interventions: • The medical providers responded to changes in health status. It appeared in some instances that they were not working with good information or data were not available. Thus, the interventions implemented in response to a change in status may not have been the most appropriate interventions. The records reviewed did not provide documentation of follow-up assessments that were adequate to determine if the interventions were effective. • Since the last monitoring review, the facility began implementation of the state's integrated health care planning process. There had not been sufficient time to determine outcomes. However, the monitoring team reviewed a number of IRRFs and associated IHPs and found that although the plans were lengthy, they were not individualized, and action steps were not linked to the identified risks.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Changes to the PNMP were made very quickly, usually on the same day or within 24 hours of the ISP. • In the case of direct therapy, the quality of documentation was consistent with generally accepted standards. Measurable objectives for direct therapy provided were always identified these were not consistently integrated into the ISP or ISPA. Initiation of interventions was noted in a timely manner from the date of referral. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The development of clinical guidelines can be an infinite process. Therefore, the facility will need to develop protocols for and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Medical audits, hospital and emergency department data, as well as the sick call roster, have the potential to provide insight on how prioritization should occur. 2. The medical director should refine the post hospital follow-up procedure to ensure that providers are conducting and documenting follow-up appropriately.	
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 planned to monitor the six conditions designated by state issued protocols in addition to metabolic syndrome. The center's lead and a member of the medical staff developed clinical indicator audit tools for diabetes, osteoporosis, and seizure disorder. The tools utilized criteria set by major professional organizations and effectively reviewed the conditions, but had not been implemented at the time of the compliance review. The following observations were made by the monitoring team: • Across all records reviewed, the clinical justifications for baseline information/indicators of the efficacy of interventions and treatments were insufficient. Goals and action steps continued to include statements that were not realistic or measurable. For example, Individual #153 was determined to be a medium risk for choking due to taking large bites and eating too rapidly. The individual was rated as low risk for aspiration. The aspiration of food or fluids can be the antecedent for a choking event. • The therapists were generally consistent with their documentation in the IPNs of	Noncompliance

#	Provision	Assessment of Status	Compliance
		direct therapy and treatment notes that were filed in the Habilitation Therapy tab. Monthly summaries were consistently found in the IPNs. A system for monitoring the effectiveness of all aspects of the PNMP was clearly established and consistently noted at least on a quarterly basis. The annual therapy assessments included a review of the monitoring findings to document the effectiveness of interventions throughout the year. • Collaborative efforts took place between psychiatry and psychology in the psychiatric clinic the week of the review. The clinicians discussed strategies of the two disciplines identifying similar clinical indicators for determination of treatment efficacy. This information must be incorporated into the ISP, PBSP, and other IDT plans. The development of the six state protocols was a good starting point. As discussed in section H3, additional indicators are needed. Once guidelines are established and indicators are identified, the facility will have a more objective means of assessing treatment. Many of these processes should occur within the medical department. The determination of the appropriateness and efficacy of medical care must be made by a physician through the development of audit tools, such as those developed for diabetes, osteoporosis, and seizure disorder. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Per policy, each clinical discipline was responsible for monitoring services and collecting data regarding the health status of individuals. The facility audited three records per month to determine if the risk assessments and plans were appropriate. The audits also reviewed the adequacy of immunizations and current preventive screenings. The audits showed that there was little evidence within the IHCPs that the clinical pathways were appropriately implemented across the disciplines reviewed. The auditing of records provided a retrospective review. The facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both <u>acute changes and chronic long-term disease</u>. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy), • Acute assessments via sick call • Reports of acute changes via the daily medical provider meetings • ISPA Process	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Medical databases (preventive care, cancer screenings, seizure management) • A medical quality program would be the designated quality program and would report certain data elements to the QAQI council. With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team identified a number of concerns related to current processes and systems: • Risk identification and mitigation continued to present challenges for most disciplines. • Medical assessments did not clearly identify risks and therefore frequently lacked an appropriate plan of care. Quarterly assessments were not done. • Deficiencies were noted in the completion of psychiatric assessments and QDRRs. • The medical department had no data related to physician attendance at the ISPAs. • The facility had not developed a program to assess the quality of medical care provided. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The effective monitoring of health status requires proper oversight of risk assessment and provision of medical care. It will be difficult to monitor long-term status without the appropriate medical quality program. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The process for inclusion of the medical providers in the ISPA process should be re-assessed. 2. A medical quality program should be developed.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The facility determined that each clinical discipline would identify when clinical indicator data suggested unacceptable results, the current treatment plan would be altered as evidenced by additional assessments, diagnostics or modified therapeutic regimen. Moreover, each discipline was to document how clinical indicators analyzed structures processes and outcomes. There was no additional work done in this area. At the time of the compliance review, there was the potential to track some changes via the daily provider meetings, ISPAs, responses to the recommendations of the QDRRs and	Noncompliance

#	Provision	Assessment of Status	Compliance
		sick call logs. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and intervention. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of 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.	Facility policy required that clinical committee policies identify the committee chair, participants, meeting schedule, data monitored, and recommendation tracking process. Seven policies were audited for the presence of the required components. The daily provider meeting minutes were also reviewed to determine if integrated discussions occurred. The facility determined that improvement was needed in the development implementation and follow-through of committee policies, recommendations, and integration. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Each of the clinical services departments should develop a policy that outlines how integration will occur with other departments. The metrics for measuring success should be defined within the policy. 2. The facility should develop a process to ensure that the committees are functioning effectively and efficiently. 3. State office should develop a policy for Provisions G and H to provide further guidance to the facility.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of individuals admitted to the infirmary in the past year o List of individuals with serious injuries in the past year o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individuals with GERD o List of individuals at risk for choking 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 skin breakdown o List of individuals at risk for constipation o List of individuals with a pica diagnosis o List of individuals at risk for seizures o List of individuals at risk for osteoporosis 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 who received enteral feeding o List of individuals with chronic and acute pain o List of individuals with challenging behaviors 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 Draft ISPs and IRRF for Individual #132 and Individual #379. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews: • Individual #104, Individual #151, Individual #52, Individual #375, Individual #277, Individual #166, Individual #362, Individual #388, Individual #345, Individual #76, Individual #53, Individual #379, Individual #268, and Individual #318.

	Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Vicky Hinojos, Section I Lead/Residential Services Director o Jalown McCleery, Incident Management Coordinator o Michael Davila, QDDP Coordinator o Dena Johnston, Rehabilitation Therapies Director o Angela Garner, CNE o Dana Robertson, Section C Compliance Coordinator Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 8/13/13 and 8/14/13 o Annual IDT Meeting for Individual #132 and Individual #379 o QIDP Monthly Meeting o Human Rights Committee Restraint Review Meeting o Restraint Reduction Committee Meeting o Human Rights Committee Meeting o Pre-ISP Meeting for Individual #76
	Facility Self-Assessment: SGSSLC submitted its self-assessment. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility planned to engage 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 appeared to have an adequate self-assessment process in place to identify problems and develop action plans for improvement. They were now gathering and compiling data using the section I statewide audit tool. Findings from the audit tool were similar to findings from the monitoring team's review. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed.

	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. While good progress had been made on meeting substantial compliance, through an improved understanding of the risk process by IDTs, the facility was not in compliance with the three provisions in section I. The monitoring team saw some progress in section I in each of the three provision areas, and observed the risk identification process at two ISP meetings. • The facility continued to take an integrated approach to looking at risk. This was evident at both the administrative level and at the individual IDT level. • At both annual IDT meetings observed, the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified. • It was still evident that some important assessment information was not collected and shared prior to the meeting that could have contributed to team's ability to make informed decision regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. • The ISP/Risk identification process was much less fragmented. There was still room to improve this process, but overall, good progress was seen in integrating the risk identification process into the ISP. Teams were also not using the IHCP to track the completion of assessments and document resulting recommendations. 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. Teams were reviewing supports following a change in status, but failing to ensure that assessments were completed and recommendations were implemented. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored for efficacy.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The 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 an integrated health care 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. Integrated Health Care Plans (IHCP) were designed to provide a comprehensive plan that will be completed annually and updated as needed. The facility was using the Section I Audit Tool to gather data and assess compliance with the requirements of section I. Data indicated that IDTs were struggling with having adequate information available in order to make informed decisions and implement plans regarding elements of risks. Overall compliance with the requirements of section I remained around 58% for both July 2013 and August 2013. The monitoring team observed two IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the newly created Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). In both meetings, team members appropriately added information to the discussion regarding rationale for each risk rating. For both individuals, assessment information that was needed to develop adequate supports was not available, so a thorough risk evaluation could not be completed. For example, the team recommended a nutritional evaluation for Individual #132 prior to developing measurable action steps in his IHCP to address his risks. The IDT for Individual #289 reviewed data regarding falls over the past year. He had 14 falls with no significant injuries. At first the team agreed to keep him at a medium risk for falls and continue the same supports because he had not sustained a serious injury due to a fall. After prompted, the IDT ended up having a great discussion regarding his risk for falls. They discussed some very important factors that might contribute to his falls including dementia, poor vision, and medication. The team agreed to further assessments and a change in supports. It was good to see this type of discussion occurring among team members. The state policy required that all relevant assessments be submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun to track submission of assessments by discipline and attendance at IDT meetings. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. The following data were submitted by the facility regarding assessment submission prior to the annual ISP/risk	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>identification meeting between November 2012 and April 2013.

<table><tr><td>Assessment</td><td>Submission Rate</td></tr><tr><td>Medical</td><td>56%</td></tr><tr><td>Nursing</td><td>76%</td></tr><tr><td>Dental</td><td>67%</td></tr><tr><td>OT/PT</td><td>87%</td></tr><tr><td>Speech</td><td>77%</td></tr><tr><td>Nutrition</td><td>50%</td></tr><tr><td>Psychology</td><td>56%</td></tr><tr><td>Psychiatry</td><td>18%</td></tr><tr><td>Audiological</td><td>94%</td></tr></table>
Review of a sample of ISPs for Individual #268, Individual #388, Individual #52, Individual #166, Individual #318, and Individual #277 supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings. None (0%) of six individuals had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks.

While progress had been made in the risk process, additional training was still needed to ensure that team members consider all risk factors when assigning risks. It will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.</td><td></td></tr>
<tr><td>I2</td><td>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</td><td>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. Health risk ratings will need to be consistently implemented, monitored, and revised when significant changes in individuals' health status and needs occurred.

In March 2013, the facility began reviewing hospital and emergency room visits to determine if IDTs were meeting to review supports within five days of a change of status. The facility noted errors in March 2013 and April 2013 data. In May 2013, there were 25 incidents reviewed. Eleven (44%) had documentation of IDT meetings held within five days of the incident to review health status. Compliance in June 2013 dropped to 31% and then dropped slightly in July 2013 to 29%. The facility acknowledged that this was not an acceptable number. A recommendation was made for unit directors for follow-up on this issue.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	identified as at risk.	A sample of records was reviewed to determine if a determination of risk resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. For example, • Individual 277's ISP indicated that she had not had a dental assessment prior to her annual ISP meeting. Her IHCP stated that the IDT would schedule and review her dental assessment by 5/24/13. Her IHCP was not updated with assessment results if the assessment was completed by that date. • Individual #166's ISP dated 2/6/13 indicated that she would be referred to OT/PT for reassessment of her diet texture after wearing her dentures with new adhesive for 90 days. There was no documentation indicating that the assessment had occurred or if it had occurred that assessment results were discussed by the IDT. • Individual #375's IHCP indicated that his PCP had recommended a consultation with a pulmonologist to address his risk for respiratory compromise by 4/30/13. There was no documentation showing that the team met to discuss any resulting recommendations from the consultation. • Individual #388's IDT recommended a chair-side evaluation to assess his choking risk during his annual ISP meeting on 2/22/13. The evaluation was to be completed by 4/20/13. The recommendation for an evaluation was not included in his IHCP and his monthly reviews did not indicate that the assessment was ever completed. The monitoring team reviewed a sample of assessments from each discipline to determine whether or not an adequate assessment process was in place to address identified risk. Findings by discipline are summarized below, <u>Nursing</u> Based on a review of 34 records of which nine had completed nursing assessments, IRRFs and IHCPS, nine of nine (100%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individual's health care	

#	Provision	Assessment of Status	Compliance
		needs. Psychology Generally, psychology functional assessments were found to be very good (as discussed in K5). The quality of PBSPs was much improved (as discussed in K9). There was not, however, sufficient data to ensure that those plans were implemented with integrity (see K10 for more detail). IDTs were not sufficiently documenting that the IDT conducted comprehensive assessments of the conditions associated with a change in status as evidenced by multiple restraints of individuals (see C7 for details). Medical Based on a review of 10 Annual Medical Summaries, 0 of 10 (0%) included comments from the primary providers on risk assessments. This is discussed further in section L1. Integrated Risk Rating forms did not consistently include specific clinical data that should indicate that a change in status review was needed. Thus, the monitoring team was unable to determine if a change in status had occurred for most individuals in the sample unless a significant illness or injury was documented elsewhere in the record. For example, • Individual #277 had an outcome in her IHCP to address her risk for weight gain and diabetes. Action steps included continue diet, continue medications for diabetes, continue exercise classes, and a healthy cooking training objective. There were no instructions for gathering specific clinical data, so it would be difficult to identify a change in status. Similarly, the outcome to address her risk for seizures included one action step to "continue taking medication." The plan should have included documentation of seizure activity and medication monitoring in order to gather data on effectiveness of supports. • Individual #76 had action steps to address his risk for cardiac disease and circulatory disease. His action steps indicated "routine vital sign checks." His IHCP did not include the frequency or acceptable range for vital signs. Without consistent monitoring and acceptable parameters stated, staff could not determine if supports were effective or when a change of status might occur that would signal a need to review supports. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance.	
I3	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	14 working days of completion of the plan, or sooner, if indicated by the risk status. According to data in document VI.2, plans were not in place to address all risks for those individuals designated as high risk or medium risk in specific areas. All ISPs in the sample included general strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was unlikely that risk ratings were based on current data. As noted in I2, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. IDTs were not documenting when plans were implemented. Thus, it was not possible to determine if IDTs implemented all recommendations from assessments within 14 days. For example, • Individual #375's IHCP included an action step to address his risk for weight gain that stated, "consult gym about developing a structured exercise program." Follow-up to that consultation was not documented. It was not evident that a plan had been developed and implemented. • Individual #362's PCP recommended an exercise program to address morbid obesity in his assessment dated 2/5/13. It was not evident that the team incorporated his recommendation for exercise into her ISP or IHCP. 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. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed. Many of the risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an ancillary plan in place or instructions were too general (e.g., follow diet, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: • Develop action plans with measurable criteria for assessing outcomes. • Document the implementation of action plans. • Document that clinical data is gathered and reviewed at least monthly. • Document action taken to revise supports when data indicates that current supports are not effective.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed:</u> 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, notes per nursing, psychiatry notes associated with the incident, documentation of any IDT 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 Examples of desensitization plans or other treatment strategies for dental and 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 (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 PBSP 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: antiepileptic 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: 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 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 has 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 addressed 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, PBSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months <u>Documents Requested Onsite:</u> o Section J presentation book o Draft of PBSP for Individual #50 reviewed in psychiatry clinic 8/15/13 o These following documents for all of these individuals: Individual #395, Individual #175, Individual #266, Individual #52, Individual #182, Individual #37, Individual #372, Individual #99, and Individual #400 • Identifying data sheet (most current) • ISP signature sheet, and ISP addendums/reviews/annual (for the last six months) • Integrated Health Care Plan (IHCP) and change of status IHCP • Social History (most current) • Consent section for psychoactive medications for the past year • Human Rights Committee (HRC) review of psychoactive medications (annual and update) • Dental/Medical Treatment Consent • Desensitization Plan • Psychology Evaluation (most current) • Positive Behavior Support Plan (most current) and addendums for the past six months • Suicide Risk Assessment (for the last six months) • Administration of chemical restraint consult review form (for the last six months) • Safety Plan/Crises Intervention Plan (most current) • Medical and/or Dental Restraint Checklist (for the last six months) • Medical and/or Dental Restraint Plan (most current) • Annual Medical Summary and Physical Exam (most current) • Quarterly Medical Summaries (for the last six months) • Seizures Record Active (for the past year) • Hospital Discharge Summary (for the last six months) • Hospital Emergency Room visits (for the last six months) • Lab reports (for the past year) • Psychiatry section (for the last six months)

	• Psychiatry Assessment Appendix B and all other psychiatry assessments (for the last six months) • Reiss Screen summary (most current) • Psychoactive Medication Review Quarterly (for the past year) • Integrated progress notes (for the last six months) • Observation notes (for the last six months) • Psychiatric Support Plans (most current) • MOSES/DISCUS results (for the past year) • Quarterly Drug Regimen Reviews (for the past year) • EKGs (for the past year) • Cardiology consult (for the past year) • Neurology section (for the past year) • Active Problem List (most current) • Physician's Orders (for the last six months) • Comprehensive Annual Nursing Assessment (most current) • Annual Weight Graph Report (most current) • Quarterly Nursing Assessment (for the last six months) • Vital Signs Record (for the last six months) • Current list of all medications (MAR) • QDDP notes for psychiatry clinic (for the last six months) • Psychologist's notes for psychiatry clinic (for the last six months) • SOTP Treatment Plan (most current) • Pretreatment sedation assessment (for the last six months) • Pharmacy section (for the last six months) • Consent section for pretreatment sedation (for the last six months) • Nurse's notes for psychiatry clinic (for the last six months) <u>Observations Conducted</u>: o Psychiatry clinic conducted by Dr. Victoria Carpenter o Psychiatry clinics conducted by Dr. William Earl Bazzell o Psychiatry clinic conducted by Dr. Min Zhong o Incident Management Review Team (IMRT) meeting o Polypharmacy Committee meeting o Daily Provider meetings o ISPA regarding Individual #395 o Medication Review Committee meeting o Positive Behavior Support Plan Committee meeting

	Interviews and Meetings Held: o Victoria Carpenter, D.O., Psychiatry Department Head o Jennifer Quisenberry, psychiatry assistant and Section J Co-Lead o William Earl Bazzell, M.D., facility psychiatrist o Stanley X. Cal, M.D., Medical Director o Roy Guevara, R.N., facility psychiatry nurse o Rob Weiss, Psy.D., BCBA-D, Psychology Department Head o Dana Robertson, Section C Coordinator o Todd Walker, DDS, Dental Department Head o Kenneth Rees, DMD o Belinda Lendermon, RDH, Dental Section Lead o Janis A. Rizzo, R.Ph., pharmacy director o Isaac Pan, Pharm. D., pharmacist o Justine Aranda, CPhT, Pharm Tech II
	Facility Self-Assessment: SGSSLC submitted documentation regarding section J for the self-assessment dated 7/8/13 that yielded the results of a small sample of the statewide self- monitoring tools. As noted in conversations with the psychiatry department, there were many problems with these tools, therefore, the data collected failed to capture the relevant information required for an accurate self-assessment. The facility had not covered relevant items for all of section J as recommended by the monitoring team. • For example, the facility was not able to provide the percentage of timely psychiatric quarterly assessments completed since the last review for individuals who required psychiatric services. This was pertinent data especially because the facility was deficient in the completion of the Comprehensive Psychiatric Evaluations according to Appendix B, therefore, the quarterly evaluations were used to ensure that no individual received psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner. The psychiatry department included a list of the results of the self-assessment. Further, they were numbered and each result had a corresponding item of the activities engaged in to conduct the self-assessment. In that regard, the psychiatry department attempted to identify activities and outcomes for each provision item. During the onsite review, the monitoring team and the psychiatry department spoke at length about the importance of detailed results of facility wide data being similar to the components monitored by the monitoring team. This task should be accomplished easily by establishing an outline of the items that the monitoring team comments upon in each provision item in order to move in the direction of substantial compliance. The facility described 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 psychiatric assistant, who was designated section J Co-Lead, provided the majority of the update for section J to the monitoring team because the psychiatry department head was

	assigned the role of interim medical director since the last visit. The psychiatry department seemingly put a lot of time into completing the document. There was some improvement in the process because the activities the facility engaged in were beginning to reflect what the monitoring team outlined for the particular provision such as J6. • 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 by May 2013 only 36% of individuals in psychiatric clinic had a comprehensive assessment completed in the Appendix B format. • This provided a clear picture to the facility of the reason this section did not meet substantial compliance. It would be beneficial to additionally cite the actual number of assessments similarly outlined in the report provided by the monitoring team (e.g., given that 166 individuals were deemed to require psychiatric services, comprehensive psychiatric assessments were due for 107 individuals), since the majority of individuals at SGSSLC reportedly required psychiatric services. The conclusion was based on the results of the facility tracking the completion of the Appendix B assessments. • The facility should consider revision of the 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 professional standards of care. Additionally, the facility should choose a representative sample per clinician because the quarterly audits did not specify how many external comprehensive assessment audits were completed as illustrated in the facility summary "February 2013: 96.5%." Overall, the self-assessment did not provide enough detail to the psychiatry department and, thus, limited the awareness concerning the status of section J. For example in J13, the facility noted this provision was not in substantial compliance because regular reviews needed additional improvements in quality and timeliness. The department did not provide the actual number of individuals who did not receive a timely psychiatric assessment and did not complete assessment audit tools in December 2012 and January 2013. The monitoring team had difficulty determining what the facility accomplished in this vital section regarding the mandatory services of the psychiatrist in concert with the IDT. The facility failed to report the data in an adequate manner to portray the level of completion of duties. The facility should receive credit when individuals were reviewed in a timely fashion and this should be quoted with the exact number of evaluations conducted, as such, along with the time period since the last review. 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 progress in a timely method if a set of actions, such as those described in this monitoring report, are set out in their entirety to capture what the facility has implemented pertinent to the items in the Settlement Agreement.

	The start date, projected completion date, and the completion status were determined by the facility. Some items with a start date greater than six months ago had not been initiated as highlighted in the completion status section, "not started," with an example of this provided in J4 regarding pretreatment sedation analysis. J12 was an additional section with a start date actually greater than six months ago, specifically 4/1/12, for the creation of corrective action plans, but had not been initiated as highlighted in the completion status section as "not started." • 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 physician review and completion of the assessment tool, timeliness of the assessment tools, nursing training regarding administration of the assessment tools, physician documentation of the use of the clinical information derived from the assessment tools such as identification of Tardive Dyskinesia, 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. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the psychiatry department (i.e., lead psychiatrist, facility psychiatrists, psychiatry assistant, and psychiatric nursing staff), 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, that is, topics that the monitoring team commented upon, suggestions, and recommendations made within the narrative in order for the facility to reach the goals and requirements to move in the direction of substantial compliance. Even though more work is needed, the monitoring team wants to acknowledge the efforts of the psychiatry department, particularly Ms. Jennifer Quisenberry, for continuing to proceed in the right direction during the time of Dr. Carpenter serving as interim medical director. The psychiatry department head and the psychiatric assistant should design an improved self-assessment to lead to a better set of action plans.

	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 three FTE psychiatrists. As such, the primary goal must be to recruit and retain psychiatrists, such that the psychiatric program can be expanded to provide continuity of clinical services and integrated care with other disciplines. The facility had access to a psychiatrist in the community setting whom had subspecialty training in child and adolescent psychiatry, but experienced delay in obtaining consultation for a child admitted to SGSSLC. This physician reportedly provided care to the youth as requested by the facility. Fortunately, the facility had a lead psychiatrist who worked diligently to secure and coordinate necessary services (i.e., child psychiatry evaluations, neuropsychiatric consultations). The maintenance of any integration beyond what could be accomplished in psychiatry clinic was delegated to the one psychiatric nurse and the psychiatric assistant. These staff provided 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). There was some integration between psychiatry, primary care, and psychology achieved by case reviews in various committee meetings (i.e., polypharmacy and medication review committee). Additionally, the psychiatric clinic included representatives from multiple disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings. The facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration because most provision items in this section rely on collaboration with other disciplines. There were an inadequate number of psychiatric assessments completed and this affected the quality regarding diagnostics and justification for treatment with medication. 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 chemical restraints. The facility must determine the percentage of incomplete evaluations as part of the self-assessment. The different departments must communicate with one another to facilitate timeliness of the evaluations, applicable assessments, and intervention to take place by the IDT. In regards to J4, the facility must collect aggregate data and cite if the ISP for each individual who required pretreatment sedation included treatments or strategies, such as behavioral rehearsals to minimize or eliminate the need for pretreatment sedation. Other information to be reported in the self-assessment should include percentage of compliance with post-sedation monitoring for all individuals who were administered sedating medication, particularly when utilized in combination with other medications prescribed for a psychiatric purpose. The psychiatry department's data collection regarding the Reiss screen did not capture a mechanism for referral and documentation for those individuals requiring a psychiatric evaluation following a positive

	Reiss screen or following a change in psychiatric or behavioral status. The information provided to the monitoring team about the actual completion of the Reiss screen by Ms. Quisenberry was helpful and beneficial to understand the facility progress and problem areas for this section that should help guide the status of the self-assessment for this section and the corrective action plan. 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). SGSSLC informed the monitoring team of the intent to conduct a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy, but this did not occur as planned. A new director of pharmacy was hired and will facilitate addressing this deficiency to set-up a facility-level review system of polypharmacy. The facility was required to develop and implement a system to monitor, detect, report, and respond to side effects of psychotropic medication using standard assessment tools, such as the MOSES and DISCUS. There was lack of timely administration of the standard assessment tools and inadequate utilization 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, reporting of ADRs during clinic process if discovered). Psychiatry must utilize this information to make this process clinically applicable for the health and safety of the individual. 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 facility made progress in the area of informed consent, but remained in noncompliance with J14 due to the lack of completed informed consent practices. The psychiatry department was now 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. There was some exchange of information to coordinate care between the psychiatrist and the community neurologist. The IDT, inclusive of the psychiatrist, however, must 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 primary care physician must be accessible during the time of the selection of medication regimen between the neurologist and psychiatrist to provide pertinent input and continuity of care particularly in regards to the treatment of the seizure disorder. The lead psychiatrist had professional expertise in neuropsychiatry and planned to develop a neuropsychiatric consultation process for the individuals who have a seizure and mental health disorder.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications The psychiatrists who provided services at SGSSLC were either board eligible or board certified in general psychiatry by the American Board of Psychiatry and Neurology. Victoria Carpenter, D.O., was the lead psychiatrist. The facility also had access to a child and adolescent psychiatrist in the community to provide care for youth, particularly under the age of 14 and/or prescribed polypharmacy with complex psychiatric conditions. As such, the professionals were qualified. Experience The psychiatrists who were employed by SGSSLC had experience treating individuals with developmental disabilities. Dr. Bazzell had 16 years of prior experience caring for individuals with developmental disabilities due to the services that he provided to MHMR programs in the state of Texas and to SGSSLC since 12/1/09. Similarly, Dr. Carpenter had 20 years of experience providing care for individuals with developmental disabilities in the MHMR programs in the state of Texas. Dr. Carpenter also treated adolescents and had 18 years experience providing forensic testimony in court proceedings. Monitoring Team's Compliance Rating Based on the qualifications of the psychiatrists, inclusive of locum tenens Board Eligible/Certified 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, 166 of the census of 214 individuals received psychopharmacologic intervention at the time of this onsite review. The psychiatry department tracked reasons for the decrease of 18 individuals who were no longer enrolled in clinic (e.g., community placement, death, transfer to another facility). The facility continued to struggle with the completion of the evaluations completed in Appendix B format (discussed in J6) due primarily to the lack of psychiatric staffing (addressed in J5). Evaluation and Diagnosis Procedures 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., drug regimen review profile, physician's	Noncompliance

#	Provision	Assessment of Status	Compliance
		annual medical review, ISP, PBSP). It was recognized that many of the challenges to providing collaborative care in the facility system-wide were out of the psychiatrists' control. During this review, the psychiatrist and the IDT began to entertain neurology contributants that possibly had an impact on the mental status presentation of the individual, when arriving at a psychiatric diagnosis and for selection of a psychopharmacologic regimen. This was illustrated during the psychiatric clinic observed for Individual #50. Dr. Bazzell and the IDT discussed the occurrence of seizure activity experienced by Individual #50 and the need to obtain a consultation between the neurologist and psychiatrist to review the AED regimen and psychotropic regimen. The psychiatrist, associate psychologist, and the IDT also discussed the revision of the PBSP inclusive of a SAP for deep breathing, delayed gratification, and an edible choice for the replacement behavior. It is important for the facility to obtain a neuropsychiatric consultation when clinically indicated to rule out medical contributants presenting with psychiatric symptomatology (J15). The IDT provided thorough documentation for the quarterly psychiatric evaluation, however, the team continued to focus particularly on aggression instead of both psychiatric symptoms associated with the identified psychiatric disorder and other behaviors. The BPRS was obtained, but rarely discussed in the clinic setting until inquiry by the monitoring team about all data available to the psychiatrist. The IDTs were receptive to feedback. The psychiatry team had not guided the psychologists in identifying specific data to be collected in order to establish if the medication regimen was efficacious. The monitoring team encouraged this type of collaboration and deemed it necessary for psychology and psychiatry to routinely work together to ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner. <u>Clinical Justification</u> Discussions with the facility staff revealed an awareness of the difference in quality regarding clinical documentation. A review of a sample of 20 records revealed varying content in their completeness. The psychiatry department was uncertain of the aggregated data regarding timeliness of the psychiatric evaluations completed since the last review. This information must be calculated in order to determine if individuals who received psychotropic medication had adequate psychiatric treatment via monitoring, as often as necessary, based on the individual's current status, but no less often than quarterly. In several of the psychiatry meetings, the psychiatrist stated that the diagnosis in the record was probably not accurate, and, therefore, requested further review of the case to determine the appropriate diagnosis. If diagnostics are not appropriately addressed in a clinically justifiable manner, the other provisions, such as polypharmacy regimens will not	

#	Provision	Assessment of Status	Compliance
		be successfully addressed. Tracking Diagnoses and Updates 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. Example of delayed care was outlined in the database regarding numerous individuals, including Individual #186 (e.g., quarterly 11/29/12, then annual 5/3/13), Individual #144 (e.g., 11/7/12, then next evaluation 5/1/13), and Individual #279 (e.g., 12/10/12 quarterly, then interim 5/13/13), just to cite a few examples. The facility had not provided self-assessment data to calculate how many individuals received a timely evaluation and the determination of the level of deficiency for this section. The self-assessment noted the total number of individuals receiving medication, but generally summarized that this provision was not in substantial compliance. The information collected by the psychiatry department should guide the IDT in addressing outdated psychiatric assessments facility wide in an organized fashion. Challenges The facility made progress with regard to working on the system of addressing the content of the quarterly psychiatric assessments at the expense of the limited number of completed Appendix B evaluations. The monitoring team explained to the facility that if a quarterly examination was due, the psychiatrist could complete an Appendix B instead, being a more comprehensive document that served the same purpose. As they had managed to complete some psychiatric assessments, it was necessary for this information to be utilized facility wide, specifically highlighting the justification of diagnosis, collaborative case formulations, treatment planning with regard to psychotropic medication, and the identification of non-pharmacological interventions. Monitoring Team's Compliance Rating Due to the lack of completion of timely 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should calculate the percentage and actual number of individuals enrolled in psychiatry clinic who received a quarterly psychiatric assessment. The facility should receive credit when individuals were reviewed in a timely and appropriate manner and this should be quoted with the exact number of	

#	Provision	Assessment of Status	Compliance
		evaluations conducted along with the time period in which the assessments were completed since the last reporting period (e.g., 110/166 (66%) of individuals enrolled in psychiatry clinic received an evaluation at least every 90 days during the time period from 9/1/13- 3/1/14).	
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.	<u>Treatment Program/Psychiatric Diagnosis</u> 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. In the 20 records reviewed, individuals prescribed psychotropic medication had a current PBSP. The details of the content of the PBSPs are discussed in section K. The psychiatry department informed the monitoring team that 100% of all 166 individuals enrolled in psychiatry clinic had a current PBSP. The monitoring team was informed during the medication review committee meeting that Individual #372 was prescribed emergency psychoactive medication, but was not enrolled in psychiatry clinic. There was a debate of whether Individual #372 had an assigned Axis I diagnosis. • 5/1/13 Active Problem List per David. A. Jolivet, M.D. did not cite an Axis I Disorder, however, noted antisocial personality disorder on Axis II. The Drug Regimen Review Profile dated 8/13/13, however, listed diagnostics, such as impulse control disorder (unspecified), adjustment disorder with mixed disturbance of emotions and "c," antisocial personality disorder, observation of other suspected mental condition, and numerous other medical conditions (i.e., "other convulsions," unspecified hypothyroidism, hematuria, etc.). • 5/31/13 Individual #372 was administered Thorazine 100 mg IM due to attacking staff, using objects as weapons against staff, and property destruction. • June 2013: The Reiss screen administered was elevated (14),but Individual #372 did not undergo a psychiatric evaluation and was not enrolled in psychiatry clinic. • 7/25/13 Individual #372 was again administered Thorazine 100 mg stat because he attempted to jump off of the fire escape and fought staff. He was placed on 2:1 LOS. • He also required numerous episodes of physical restraints due to aggression towards staff. • Per record review, he experienced a closed head injury at the age of 17. His father was previously hospitalized due to mental illness and his mother had an intellectual disability. The team members of the medication review committee were receptive to feedback by the monitoring team that case presentations similar to Individual #372 required an interdisciplinary team approach to establish cohesive diagnostics and to ensure that	Noncompliance

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		psychotropic medications shall not be used in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis. This individual had a history of traumatic brain injury, family history of mental illness, and possible familial contributant to intellectual disability that required more clinical attention. During the MRC meeting, the psychiatry department informed the monitoring team that Individual #372 would receive a psychiatric evaluation. 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. It was notable that psychiatry had not consistently participated in the PBSP process whereby determining the least intrusive and most positive interventions to treat the behavioral or psychiatric condition. The information regarding the individual's psychopharmacological regimen was to be outlined in the treatment plan developed by the psychiatrist with the IDT. Additionally, consent for psychotropic medication was turned over to the prescribing physician's responsibility from the psychology department, therefore, the content of the medication information summarized by the psychiatrist was then forwarded to the HRC for approval. A team approach to psychiatry clinic was observed during the review. Psychology representation and other staff disciplines were present in the psychiatric clinic. There were efforts made to justify diagnostics and pharmacological interventions. There was some discussion between team members about non-pharmacological interventions, either occurring or proposed for a specific individual. The IDT was encouraged to consistently review the content of the PBSP with the psychiatrist in the psychiatry clinic especially during times of the revision of the plan. This collaboration in the psychiatry clinic setting would also allow for discussion and subsequent documentation with regard to non-pharmacological interventions in both the IDT plans, such as the PBSP and the psychiatric treatment plan. <u>Emergency use of psychotropic medications</u> The monitoring team was informed that from 12/1/12 to 7/31/13 there was a 26% decrease in the use of emergency medications. There were 105 emergency medications administered to a total of 41 different individuals. As per policy, an IDT meeting should occur for any individual that accrues three or more of any type of restraint within any rolling 30-day period. • Of the 41 individuals there were IDT meetings held for 22 individuals (54%). • The previous review, there were 142 incidents with dates of administration ranging from 4/1/12 to 9/30/12.	

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		The psychiatry staff informed the monitoring team that they discontinued the use of pro re nata (PRN) administration of medication for every individual at SGSSLC, however, Individual #37 occasionally refused the oral form of the psychotropic medication prescribed, therefore, was administered the medication an intramuscular form of Haldol 30 minutes after the refusal. • A physician's order dated 7/23/13 discontinued the order regarding Individual #37 receiving Haldol IM if he refused oral Haldol, but this was not updated on the MAR for the administration period 8/1/13 to 8/31/13. • The facility discovered, and even self-reported, the example highlighted above about Individual #37 at the time of the visit and discussed the most appropriate way to document the content of the medication variance. The monitoring team previously inquired about the intention of this practice pattern regarding other individuals (i.e., was this a stat emergency medication or was this a PRN order). The monitoring team explained to the IDT during the previous onsite visit that an individual had 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. 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 as well as when administered in combination with other medications prescribed for medical purposes and/or pretreatment sedation. Upon interview of several departments regarding the topic of chemical restraints, there was progress in the systematic review and sharing of knowledge about this critical information in a multidisciplinary manner as witnessed in the Medication Review Committee meeting. <u>Monitoring Team's Compliance Rating</u> To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The IDT to consistently review the content of the PBSP with the psychiatrist. This collaboration would also allow for discussion and subsequent documentation with regard to non-pharmacological interventions in both the IDT plans, such as the PBSP and the psychiatric treatment plan with goal of minimizing the use of psychopharmacologic medications, if not clinically indicated. 2. The different departments (i.e., nursing, pharmacy, medical, psychology, psychiatry) must communicate with one another for addressing the utilization of	

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		restrictive measures (i.e., emergency chemical restraints) to allow for appropriate assessment and intervention to take place by the IDT. o Continue the data collection regarding the use of emergency psychotropic medications. o Include PRN medication in the count of psychotropic medication inclusive of medication prescribed for sleep aid.	
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>Policy and Procedure</u> The Pretreatment Sedation Notification and Referral for Assessment Process Procedure dated 7/26/12 included Attachments, such as the Pretreatment Sedation Notification Form and the Dental/Medical Desensitization Assessment Form. The forms outlined sections to allow for the multidisciplinary team input to address this provision that called for coordination of services, including as appropriate, psychiatric, pharmacy, and medical services. For example, the associate psychologist was to address if the individual needed other strategies, such as behavioral rehearsals or desensitization plans. The pharmacy representative was to document if there was any contraindication to using the medication. If the individual was enrolled in psychiatry clinic, the psychiatrist was to review if there was any contraindication to using the proposed pretreatment medication. • Since February 2013 a total of 14 out of 25 pretreatment sedation forms by the IDT were completed. • The facility rated noncompliance for this provision item because review or notification of pretreatment sedation did not consistently occur at SGSSLC. <u>Extent of Pretreatment Sedation</u> The facility reported a total of 31 instances (12/1/12-7/31/13) of pretreatment sedation for medical and dental purposes. There were five administrations of TIVA for dental procedures during this time period. The majority (68%) of pretreatment administrations were for the purpose of medical procedures. Of those individuals who received pretreatment sedation, 79% were also prescribed psychotropic medication. In order to evaluate the extent of pretreatment sedation utilized at SGSSLC, the calculation provided by the facility was one comprehensive list of individuals who received pretreatment sedation medication or TIVA for medical or dental procedures. The list was comprised of the individual's name, whether the individual received psychiatric services, 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. This was an excellent outline of the essential components needed to cite if the ISP for that individual included treatments or strategies to minimize or eliminate the need for pretreatment sedation.	Noncompliance

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		The summary should also include if the psychiatrist participated in the review and completed the psychiatrist's section of the Pretreatment Sedation Notification Form. This would aid the facility in determining the percentage of individuals who received coordination with the psychiatry department for this provision item and the results should be included in the self-assessment summary. The monitoring team requested 10 examples of documentation of psychiatry consultation regarding pretreatment sedation for dental or medical clinic. The facility provided this information and also discussed the incident that occurred regarding Individual #59. • This individual received pretreatment sedation on 4/5/13, 4/26/13, 5/10/13, and 5/31/13. • 4/4/13: Nursing noted the order was obtained for Thorazine 100 mg in order to obtain the CT of the head, consent was completed, and the pretreatment sedation notification form was completed and sent to the psychologist. The nursing documentation was clear and illustrated the process as intended by this provision item. • The IPN dated 4/5/13 summarized that Individual #59 experienced headaches, was referred to the neurosurgeon due to history of a VP shunt placement, and required pretreatment sedation in order to obtain a CT scan of the head. • It was discovered that Individual #59 had bilateral subdural hematomas and was transported to the hospital for further treatment. • The medical director informed the monitoring team that Individual #59 was a good example of the need to monitor drug-drug interactions because this individual also received a PRN sleeping pill (i.e., temazepam) during the same time period of requiring pretreatment sedation that resulted in the further change in mental status (i.e., difficulty with arousal of individual) therefore the PRN sleep aid was discontinued. • For another procedure, the psychiatrist reviewed and signed the pretreatment sedation notification form dated 5/31/13 for the administration of Ativan 2 mg and Benadryl 25 mg po for an eye clinic appointment. There were no reported contraindications to the recommended medication per the pharmacy department. • It would be helpful in such a complex case to briefly summarize that Individual #59 recently underwent a neurosurgical procedure particularly for the benefit of the locum tenens psychiatrist(s) and for other interim and/or new staff, such as the pharmacy staff to understand the clinical applicability of the safeguard review for each individual. Individuals who were prescribed psychotropic medication were subjected to potential drug-drug interactions when they received additional and/or similar medications for procedures, therefore, a concerted effort between disciplines was required. Medications	

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		utilized for pretreatment sedation could result in unwanted challenging behaviors, or in sedation mistaken by psychiatrists as symptoms of a psychiatric condition. Therefore, communication regarding the utilization of pretreatment sedation must take place. <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 required improvement, as evidenced in the lack of documentation. • Since February 2013, 44% of the pretreatment sedation forms by the IDT were not completed. This must be addressed because most of the individuals who received pretreatment sedation were also prescribed psychotropic medication. Different departments were attempting to address this, sometimes in isolation, thus, there was a disjointed approach to this section. Interviews with psychology and psychiatry revealed an improvement in collaboration with the dental department since the hiring of the dental director with the assistance by a full-time dental hygienist. The facility should understand that another goal of this provision item is development of treatments or other strategies (i.e., behavioral rehearsal plans) to minimize or eliminate the need for pretreatment sedation. That is, other treatment strategies may not be necessary for all individuals (though certainly will be necessary for some individuals). 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. • There were 34 individuals who were referred for an assessment to determine if other strategies or dental desensitization plans were clinically necessary. • The facility reported there were 10/10 (100%) of behavioral rehearsal plans implemented in SAP format for dental procedures, but none for medical. • No desensitization plans were "in effect" at the time of the review according to the facility summary provided to the monitoring team. It was unclear if any desensitization plans were deemed necessary and, therefore, not completed via the data presented. <u>Monitoring After Pretreatment Sedation</u> Ten examples were provided to the monitoring team regarding nursing follow-up and monitoring after administration of pretreatment sedation. The facility reported that there was "no cumulative information" gathered for this topic.	

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		Upon review of case examples (e.g., Individual #367, Individual #38, and Individual #201), the nursing staff documented vital signs and mental status findings on the monitoring checklist in the post-restraint assessment. Similar documentation by the nursing staff was also located in the IPNs. The self-assessment regarding monitoring after pretreatment sedation was warranted. Aggregated data to date were not provided for individuals who were 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 medication side effects and potential interactions of pretreatment sedation agents with concurrently prescribed medication. <u>Other Strategies (i.e., Behavioral Rehearsal Plan, Desensitization Plan)</u> In the documents received, there were a total of nine Skill Acquisition Programs (Behavioral Rehearsal Plans) for dental procedures. One of these plans (Individual #222's) was implemented 5/1/13 with the other individuals' plans dated 10/8/12-11/2/12. Requests were sent at a minimum of monthly to the psychologists of those individuals who received pretreatment sedation and did not have treatment in place, in order to be screened for determination of the need for other strategies, as clinically indicated. 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. <u>Monitoring Team's Compliance Rating</u> To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility to collect aggregate data and cite if the ISP for each individual who required pretreatment sedation included treatments or other strategies to minimize or eliminate the need for pretreatment sedation. 2. Continuation of self-assessment concerning the percentage of interdisciplinary coordination via the completion of the pretreatment sedation forms. The summary should include if the psychiatrist completed the psychiatrist's section of the Pretreatment Sedation Notification Form for the review of this section. This would aid the facility in determining the percentage of individuals who received coordination with the psychiatrist and a multidisciplinary review for each individual administered a pretreatment medication. 3. Aggregated data regarding compliance with post-sedation monitoring for side effects, to be provided for individuals who were administered sedating medications, particularly when utilized in combination with other medications prescribed for medical and/or psychiatric conditions.	

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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.	<u>Psychiatry Staffing</u> Approximately 77% of the census received psychopharmacological intervention at SGSSLC as of 8/12/13, which was a five percent decrease since last review. Of these, two individuals were younger than 18 years of age (Individual #395 was 10 years of age). • The facility tracked the reasons for the decrease in utilization of psychotropic medications and informed the monitoring team that 16 individuals no longer resided at SGSSLC. • There were 12 new admissions in the past seven months and the medication regimen for 92% of these individuals consisted of psychotropic medications upon admission to SGSSLC. The psychiatry department had a full time lead psychiatrist, Dr. Carpenter, who was the department head. During the last visit, this psychiatrist suitably outlined a summary of the requirements of the chief position with notation that the assignment called for at least a one-half time position that would allow for sufficient hours to initiate, evaluate, and coordinate integration across disciplines regarding the requirements of the psychiatry section of the Settlement Agreement. Only a few individuals received psychiatric services by Dr. Carpenter at the time of the review because she also served the role of interim medical director until the recent hire of Dr. Cal. She had intended to dedicate 50% of her time to the psychiatric care of individuals at SGSSLC, but was not able to accomplish this goal due to providing necessary duties for the medical department. Dr. Bazzell conducted psychiatric care for 61% of the individuals enrolled in the psychiatry clinic, Dr. Zhong (locum tenens psychiatrist) had a caseload of 38% of the individuals who required psychiatric treatment, and the community psychiatrist managed 1% and focused on the minors deemed in need of such services (i.e., children). The facility had one vacant position for a psychiatrist that had not been filled since 1/31/13, therefore, utilized the services of locum tenens psychiatrists. In summary, at the time of the review, the facility had three FTE psychiatric staff consisting of two full-time, board eligible or certified general psychiatrists, a board eligible locum tenens psychiatrist, and a community child and adolescent psychiatrist available for the treatment of minors. The full time employed psychiatrists (not locum tenens staff) had an alternating psychiatric call coverage schedule every month that involved telephone consultation after hours, weekends, and holidays. Otherwise, each of these psychiatrists worked five days per week, a minimum of eight hours each day. The psychiatry department consistently indicated that a minimum of three FTE psychiatrists would be required in order to allow the psychiatrist to provide care for the individuals at SGGSLC. The three FTE psychiatrists would include enough time for the completion of the Appendix B comprehensive assessments, quarterly reviews, attendance	Noncompliance

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		at meetings (e.g., polypharmacy committee, IDT meetings, physician's meetings, positive behavior support planning), other clinical activity, such as collaboration with primary care, nursing, neurology inclusive of neuropsychiatric clinics and/or consultation, 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. One registered nurse was designated to work full-time in the psychiatry clinic, and joined the team in October 2011 to assist the psychiatrists with making rounds and gathering pertinent information for quarterly reviews and Appendix B comprehensive evaluations. <u>Administrative Support</u> The psychiatric assistant, Jennifer Quisenberry, was the Section J Co-Lead. Ms. Quisenberry was comfortable in numerous areas regarding this position and was receptive to working with the psychiatrists, medical staff, and other disciplines. She was a valuable asset to the psychiatry department and provided information for section J during this visit because the designated department head had predominantly served as the interim medical director. Ms. Quisenberry previously worked in the psychology department and gained knowledge of completing various assessments, such as the Reiss, desensitization programs, and other vital information related to the psychiatry clinic. She collaborated with the other departments to address section J and persistently gathered requested documentation. Other duties included administrative support to the psychiatrists for scheduling evaluations, obtaining records and contact information, collection of pertinent data, and the completion of Reiss screens. During the monitoring visit, she was informative, understood the elements of the Settlement Agreement for provision J, such as the necessity of integration of clinical services between disciplines, and was instrumental to the psychiatry team. <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 management of the psychiatry clinic was developed to take into account not only clinical responsibility, but also documentation of delivered care such as quarterly reviews, neuropsychiatric consultations, 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, participation in pharmacy and therapeutics committee, medication review committee, polypharmacy meetings). <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of noncompliance in the self-assessment for this item	

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		because of the inadequate number of continuous FTE psychiatrists. SGSSLC had not yet demonstrated a consistent ability to employ or contract with a sufficient number of psychiatrists to provide the services required. The facility should begin to make progress because of the efforts of the lead psychiatrist to organize and guide the psychiatry team in the delivery of psychiatric services.	
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.	<u>Appendix B Evaluations Completed</u> The facility struggled with the completion of psychiatric assessments as described in Appendix B as determined by the calculation that 64% of the individuals who received psychotropic medication did not have a CPE. These comprehensive assessments were due for 107 individuals at SGSSLC who required psychiatric services. Therefore, this provision remained in noncompliance. <u>Review of Completed Evaluations</u> Upon review of the requested 10 Appendix B style evaluations performed in the previous six months, there was noticeable improvement in the content and format in how the documents were completed. A sample of the Appendix B style evaluations performed in the previous six months was submitted and reviewed for the following individuals: Individual #322, Individual #57, Individual #349, Individual #323, Individual #34, Individual #170, Individual #103, Individual #134, Individual #266, and Individual #254. The psychiatrist sufficiently completed the assessments with some exceeding the intent of the section. The format was followed for the Appendix B outline and reflected an improvement in documentation since the last review. The psychiatrist outlined all of the current medications inclusive of dosage. Medical data, such as status of labs (e.g., lipids, thyroid function test, urine drug screen if applicable) were included in the comprehensive evaluations, however, previous and current orthostatic vital signs were noted as "not available." 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, change in pulse, etc. The Appendix B evaluation for Individual #34 dated 4/1/13 consisted of 28 pages that exceeded the requirements of J6. The purpose of the comprehensive assessment per the Settlement Agreement is to capture the pertinent features and develop a treatment regimen applicable to the individual's symptom presentation and diagnosis. While it was positive to see that the psychiatrist developed a comprehensive document, the facility should consider a streamline of the lengthiness of these evaluations that already required a lot of time to complete.	Noncompliance

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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 remained 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 Reiss screen should also be administered to those individuals with a change in psychiatric and/or behavioral status. The psychiatry department had taken over the responsibility of administration of Reiss screens under the direction of Ms. Jennifer Quisenberry. The psychiatry and psychology departments must share this vital information as part of the functional assessment process, have similar data, and work together to address this section in order to establish a facility-wide system for identification of individuals in need of psychiatric care. Psychiatry should be aware of the findings of the Reiss screen in order to determine if the individual warranted psychiatric intervention. During the onsite visit, it was revealed that some of the screens had elevated scores, but there was not a system in place to review the individual's case to determine the next step of action. If a Reiss screen was elevated and the individual did not require intervention by a psychiatrist, the psychiatrist should document this information for easy access by the IDT and others (i.e., comprehensive functional assessment, ISP document). The monitoring team was informed there were 12 new facility admissions from 12/1/12-7/31/13 and 10 individuals were administered the Reiss screen. • Individual #103 did not require a Reiss screen because of the following reasons: she had a CPE completed at SGSSLC, and she was transferred from another SSLC where she was given a Reiss screen and had a CPE. • The facility reported that Individual #246 was admitted to SGSSLC, but was not due for the completion of the Reiss screen. In order to calculate the percentage, in regards to the timeliness of the completion of the Reiss screens, the list provided via the document request outlined the name of the individual, date of admission, and date of the completed Reiss. The information provided to the monitoring team was helpful and beneficial for understanding the facility progress and problem areas for this section. This should help guide the self-assessment.	Noncompliance

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		The cumulative data summary from August 2013 provided by the facility did not provide the overview of the results of the screens and, therefore, it was difficult to determine how many individuals were determined to be in need of a psychiatric assessment. Similar information was calculated indicating that 100% of individuals had a completed Reiss screen. This accomplishment was excellent, but this did not reveal how the facility utilized this information in a clinical manner. • For example, 100% of the seven individuals who required a Reiss screen were administered the screen and two of these individuals had a completed psychiatric assessment. • This calculation must include how many individuals were in need of receiving a psychiatric assessment due to Reiss findings and because of other relevant presenting symptoms, as illustrated in the example for Individual #372. • In the facility self-assessment, it was cited that this provision remained deficient because referrals to psychiatry clinic were not being made based on the results of the completed Reiss screen. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The psychiatry and psychology departments struggled with the intent for the administration of the screen. Previously, if there was a current psychiatric assessment, the psychology department may have also obtained a Reiss screen for those residing at the facility. The reason for completing such screens was not clear to the monitoring team because it was not attributed to a change in the individual's status. This process placed undue burden on the staff administering the screen. Fortunately, there was improvement in this since the last review. The psychiatry department's data collection regarding the Reiss screen included, but was not limited to, a numbered, alphabetized list with the date of the screen, whether the individual was referred to psychiatry due to a high result of the screen or change in status, and a category for comments to indicate if the individual was reviewed in the psychiatry clinic. For example, Individual #42 had a positive Reiss screen 5/30/13, but the date scheduled in psychiatry clinic noted "not completed" and did not provide any further comments regarding 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. This topic was summarized in J6. <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	

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		comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) was to then be attained in a clinically justifiable manner. Five individuals required a Reiss screen for change in status and the facility completed these screens. There was one completed psychiatric assessment due to the change in status, but again it was not clear how many other individuals required a psychiatric assessment. This type of collaboration was essential to the health and well being of individuals requiring psychiatric intervention. There was no specific process, however, for determining when a change in status should result in a Reiss screen being implemented. Consideration should be given to reasonable timelines (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>Monitoring Team's Compliance Rating</u> To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. 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 or behavioral status. The facility to clarify timelines within which the Reiss screen and Appendix B evaluations will be completed.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	<u>Policy and Procedure</u> The SGSSLC facility-specific policy and procedure dated 10/8/12 regarding psychiatric services addressed how the combined assessment and case formulation occurred (i.e., integrated care via clinically appropriate assessments, and obtaining interdisciplinary information of essential elements in a biopsychosocial and spiritual formulation that affects the individual's condition, functional abilities, and quality of life). <u>Interdisciplinary Collaborative Efforts</u> The monitoring team observed several separate psychiatric clinics held with 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 support professional, and the individual). Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 30 minutes) observations/interactions with the individuals, as well as the review of information provided during the clinic. The psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress, and reviewed if any medication changes were	Noncompliance

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		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. The integration between psychiatry and psychology services was also apparent in the interviews with the psychiatrists, as well as the interview with the psychologists. These interactions were visible in the observation of the psychiatric clinics conducted during the onsite visit. There was analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. There was also a discussion of interpersonal and environmental factors that might be affecting the individual's presentation. Where appropriate, a member of the nursing staff would comment on any recent medical issues that might be having an effect on the individual's presentation. There was an attempt to review the efficacy of the prescribed medications that focused on the impact of challenging behaviors. A deficit in terms of case formulation had been the co-identification of the same behaviors as being both a target of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The psychiatry department, working in conjunction with the psychology department, had not consistently developed a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision. This subject is also relevant to section J.9, where it is discussed in more detail. <u>Combined Assessment and Case Formulation</u> The facility self-assessment noted that this section was not in substantial compliance because integration between psychology and psychiatry needed additional documentation to illustrate combined case formulation and case assessment. 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 with design of habilitation and interdisciplinary treatment processes to meet the individual's needs. Psychology and psychiatry need to cohesively formulate diagnoses, the reason the medication was prescribed, and plans for the treatment of all individuals as a team. There was participation in the discussion and collaboration, but the team did not consistently ask for, or provide, data of the essential target <u>symptoms</u> that were deemed necessary for monitoring of the current psychiatric diagnosis. One area of progress was the availability of the results of the BPRS, but unfortunately the scale was not always reviewed in psychiatric	

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		clinic. 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 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. 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 continuity of care together because of the staff turnover and lack of completion of evaluations. 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 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> The facility continued to struggle in addressing this provision item, therefore, 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	As noted above with regard to Section J.8, the integration of psychiatric and psychological behavioral services was evident in the psychiatric clinics, but lacked in portions of the documentation found in the sample of 20 records of individuals who were prescribed psychotropic medication. When making decisions about potential changes in an individual's psychotropic medication, the psychiatrist relied heavily upon the data related to the frequency of those behaviors identified as challenging behaviors. The monitoring team identified a deficiency in this process related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified as being present on a learned/behavior basis and/or as being related to environmental factors, as outlined in J8. The dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were potentially being used to suppress environmentally-determined behaviors, and/or that the psychiatric treatment plans and the corresponding psychology behavioral treatment plans were developed through parallel processes that were not fully integrated.	Noncompliance

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	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.	The review of the sample of records for 20 individuals prescribed psychotropic medication indicated the facility had not rectified the issue of insufficient IDT collaboration before a proposed PBSP for individuals receiving psychiatric care and services is implemented. The psychiatrists had not consistently outlined the derivation of the monitored behaviors in the psychiatric section of the record, which primarily linked specific behaviors to the symptoms or manifestation of the underlying psychiatric diagnosis. Psychiatry must work with psychology to discuss the effects of the individuals' psychiatric disorders on their behavior, and then differentiate this from those behaviors maintained by environment/operant factors. In general, please consider the following: the differentiation of the maladaptive behaviors with which the individual presents is related directly to the concluding requirement in this provision, which addresses "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors that are (in reality) related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk the individual would be prescribed unnecessary psychotropic medication. In addition, the individual might not receive the behavioral supports appropriate to address the problem. Alternately, the goal of the appropriate identification and differentiation of these factors decreases (if not eliminates) the risk a psychotropic medication being inappropriately utilized to suppress learned behavior. In a corollary manner, it also assists in ensuring the least intrusive and most positive interventions are used to address the individual's challenging behaviors. The psychiatry department should not place the burden of summarizing this complex clinical information upon the staff members who prepare the final ISP documentation. <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. 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 lack of psychiatric participation in the PBSP and ISP process negatively affected the decision-making process in regards to recommendations of other less intrusive measures, diagnostics, and indications for utilization of psychotropic medication. The monitoring team was provided information that psychiatry failed to attend any of the Behavior Support Plan Committee meetings for the time period since the last review. The facility noted that psychiatry attended 22% of the ISPs since the last monitoring visit and provided a self-rating of noncompliance because documentation regarding integration to address this provision item was not consistent.	

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		It would be best for the facility to calculate the number of cases that met the requirement for J9 for the facility to understand what work was unfinished. The psychiatrists stated a willingness to become more involved. Furthermore, there had been change of staff (locum tenens psychiatry) resulting in lack of knowledge about the individual's history and response to psychiatric treatment. The Appendix B evaluations documented non-pharmacological intervention recommendations, with some evaluations completed shortly after the admission to the facility, before the proposed PBSP had been completed. This type of information should be utilized in the proposed PBSP. <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. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed in the psychiatry clinic, during the already regularly scheduled 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 the last report encouraging the psychiatrist to meet with the IDT <u>before</u> a proposed PBSP is implemented 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 some discussion of non-pharmacological interventions provided to the individuals (e.g., participation in anger management classes). It was positive to witness the IDT's efforts in utilizing non-pharmacologic treatment. The ISP documentation for the member's signature lines that were typed made it easier to determine the various disciplines that were in attendance. <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item therefore remained in noncompliance.	

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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.	Policy and Procedure The SSLC statewide policy and procedure for psychiatric services updated 5/1/13 and implemented by each state center on or before 7/1/13 included the exact language as from the Settlement Agreement for this item. The SGSSLC facility-specific policy, Psychiatric Services dated 10/8/12, revealed similar content. This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The monitoring team's initial reviews of the records regarding this section indicated that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were usually described as a reduction in the behaviors. Previously, the discussion of these factors primarily occurred in the PBSP with the content authored by the psychology department. The facility self-assessment noted that this provision is in noncompliance because documentation of the IDT, psychiatrist, PCP, and nurse prior to the administration of psychotropic medications did not occur consistently. The psychiatry department assumed initial responsibility for obtaining informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications on 2/1/13 (J14). This transition was completed on 3/10/13 for all of the new psychotropic medications prescribed. Quality of Risk-Benefit Analysis There were reportedly 502 consents for psychotropic medications with 37% completed by the psychiatrist. The informed consent explanation for the use of psychoactive medication had a section to outline the expected risks of medication vs. illness. The records reviewed noted the following summary: the "risk of illness is thought to be greater than the risk of medication" with one brief additional sentence cited in this section. The key element that was missing was a statement actually outlining a risk-benefit analysis specific to the each individual, such as someone with multiple medical problems (e.g., tardive dyskinesia, morbid obesity, sleep apnea, hypothyroidism, abnormal EKG findings with QTc prolongation) to determine if the possible harmful effects of the psychotropic medications that the individual received (e.g., Divalproex, Zyprexa, Seroquel, and Hydroxyzine), which had the potential to cause, contribute and exacerbate further side effects (e.g., weight gain, diabetes, dyslipidemia, exacerbation of abnormal motor movements, neuroleptic malignant syndrome, extrapyramidal symptoms) were clearly indicated for the evidence-based approach in line with the psychiatric condition or if simplification (e.g., one dose reduction) of at least one medication was necessary.	Noncompliance

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		Example of risk-benefit analysis: Individual #201: • The consent for Individual #201 did not reflect that Individual #201 had Tardive Dyskinesia and was not listed in the document request regarding individuals diagnosed with TD (J12). The consent must be applicable for each individual particularly when prescribed a new neuroleptic that may result in increased motor movements due to a difference in the binding/effect on the neurotransmitter site. This information would alert staff of the potential signs and symptoms experienced by the individual in the risk-benefit analysis. Some agents may actually mask TD symptomatology, but when discontinued result in increased abnormal motor movements upon discontinuation and possibly on long-term basis. • Individual #201 was prescribed Seroquel and the consent appeared to be a copy and paste template instead of relevant to the individual's condition. For example it was noted that Seroquel "has been prescribed for you…an antipsychotic medication used to treat the symptoms of psychotic conditions such as schizophrenia." This individual did not have a psychotic diagnosis, but the target symptoms to be monitored included psychosis on the consent. • Individual #201 had a "question of depression" noted in the psychiatric consultation dated 5/17/13, but the consent did not list this diagnosis. The facility later reported that this individual did not ultimately meet criteria for the diagnosis. In the consent process, the explanation of the medication, its class, dosage, and purpose should be specific for the individual. The facility had gathered important clinical information, but did not summarize the case material in an applicable manner for the care of the individual once the findings were discovered. The psychiatry department must also utilize the findings in the quarterly drug regimen reviews (QDRRs) to enhance clinical care of the individual when available. They were implemented for systematic review for those individuals receiving medication, such as psychotropics (section N). Unfortunately, the QDRRs were deficient due to the staff turnover in the pharmacy department. The monitoring team's review did not consistently find an adequate discussion of the risk-benefit analysis in the records contained in the review sample. A key factor in determining if the use of psychotropic medication represented the most effective and least intrusive intervention relates directly to the derivation of the target behavior from biologically determined factors, behavioral sources, or a combination of both. The monitoring team recommended for the facility to ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication was appropriate. • Utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with	

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		behavioral intervention. • 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., identified antecedents, graph format, with medication adjustments, and specific stressors identified). • 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. 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, psychologist, and nurse. It will also require that appropriate data regarding the individual's updated medical status and target symptom monitoring are provided, 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. 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 and the psychiatry department worked diligently in changing this process. This was a large accomplishment. The monitoring team previously 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. <u>Observation of Psychiatric Clinic</u> The development of the risk-benefit analysis could be undertaken during psychiatry clinic. The analysis must be specific to the individual's care and not reflect a cut and paste content of specific side effects for a medication. For example, if an individual had problems with being overweight, was diabetic, hypertensive, s/p cerebrovascular accident, was elderly, and had hyperlipidemia, the psychiatrist would have to factor in the medical conditions before considering the administration of psychotropic agents that may further worsen the individual's health status. 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.	

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		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 data provided. 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. <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). The descriptors of the consent were authored by the prescribing physician and then provided to the HRC for review. The appropriate risk-benefit analysis with information relevant to the assigned diagnosis and specific to the individual's health status must be included for the HRC determination. <u>Monitoring Team's Compliance Rating</u> To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Make the content and quality of the risk-benefit analysis individualized for each person who was prescribed psychotropic medication. 2. Update the informed consent for each individual who does not have an adequate consent in place instead of waiting to amend the consent when it is due annually.	
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	<u>Facility-Level Review System</u> SGSSLC informed the monitoring team of the intent to conduct a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy. The facility self-assessment summarized that this section was not in compliance because monthly reviews pertaining to individuals on polypharmacy did not occur consistently. Last review period, the polypharmacy committee inappropriately summarized the psychotropic aggregate data because medications solely utilized for the management of a seizure disorder were included in the psychoactive count. Information about individuals not enrolled in psychiatry clinic was included in the psychotropic polypharmacy facility-level review and this skewed the data. The monitoring team met with the new pharmacy team who recently started at SGSSLC. The monitoring team attended the polypharmacy meeting. The meeting was well attended by numerous staff (i.e., pharmacy director, lead psychiatrist, psychiatric assistant, medical	Noncompliance

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	that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	director, psychology representative, facility psychiatrist, primary care physicians, and psychiatric nursing staff). The monitoring team was provided a list regarding which individuals were prescribed a polypharmacy regimen, including the number of psychotropic medications. The facility-level data included how many individuals were prescribed psychotropic polypharmacy on a monthly basis, but did not include the total number of individuals who received psychotropic medication each month. This process resulted in the facility and the monitoring team being incapable of reviewing trends of the percentage of individuals prescribed this type of regimen. Data nicely outlined the names of individuals who received three medications, four medications, five medications, and so on. The polypharmacy committee composed of key staff charged with the development of a facility-level review system were in the beginning stage of setting-up the pertinent data/information collection reflective of the facility wide review. In fact, during the week of the visit, the P&T committee did not occur because of the recent hire of the director of pharmacy. The monitoring team extensively met with the pharmacy staff to orient their team on the components of the Settlement Agreement and the required integrated system of care that must be developed between the multiple disciplines. The monitoring team explained that numerous medications prescribed by the medical staff, such as beta blockers and calcium channel blockers for hypertension and AEDs for seizure disorder, may affect the individual's psychiatric symptomatology and behavioral presentation, but if the medication was not given for the purpose of a psychiatric indication, then the medication should not be counted in the polypharmacy count regarding psychoactive medications. The list of medications affecting the brain and behavior prescribed for other purposes are endless, thus, the reason why there is an importance for the IDT to be monitoring all of the medications together. The facility provided updated data, upon request by the monitoring team, during the onsite visit that 82 out of 166 individuals who were enrolled in psychiatry clinic received psychotropic polypharmacy. • Last review it was noted that 56 individuals were prescribed polypharmacy in May 2012. • The number of individuals tripled to 167 in August 2012 when the new procedure to report polypharmacy was implemented. • Last review period a pharmacy staff member of the polypharmacy committee reported to the monitoring team that it was best to "over report" hence the inclusion of all of the additional medications, but this is not the purpose of this section.	

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		It was imperative for the facility to have detailed data of an applicable facility-level review system to address the prescription of intraclass and interclass polypharmacy. 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 because the record and the details of the cases reviewed were not present (e.g., medical record usually not brought for review in the committee) or utilized until prompted by the monitoring team to obtain. The pharmacy department should be knowledgeable about the information that is collected in the psychiatry department and vice versa in regards to this provision. <u>Review of Polypharmacy Data</u> For onsite review weeks, the monitoring team has requested that the facility polypharmacy review and Pharmacy and Therapeutics Committee (P&T) meeting always take place at the beginning of the week so that the monitoring team can provide feedback throughout the remainder of the week. The facility arranged for the polypharmacy committee to be held the first day of the visit and this was beneficial for understanding the facility-level approach regarding ensuring that the use of such medications was clinically justified, and that medications that were not clinically justified were eliminated. Regarding polypharmacy, two individuals received six psychotropic medications (Individual #186, Individual #142), nine received five, 28 received four, and 35 received three. The names of the individuals were provided. The facility should consider a psychiatric peer review system regarding polypharmacy in order to provide feedback to one another and to address this 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. Numerous individuals had agitation and/or aggression listed as the indication for the medication without identification of a specific diagnosis for which the medication was prescribed. This pervasive practice pattern of unjustified polypharmacy regimens will continue without establishing an evidence-based practice by the psychiatric team.	

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		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 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 findings of the QDRRs remained very important. <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item therefore remained in noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure a multidisciplinary, facility level review to monitor at least monthly, the polypharmacy trends, aggregate data, prescribing practices, and justification for the psychotropic medication regimens prescribed.	
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.	<u>Policy and Procedure</u> The requirements of this section required at least the quarterly administration of a standard assessment tool and more often when necessary based on the individual's current status. • The facility policy and procedure regarding psychiatric services dated 10/8/12 outlined that the MOSES must be completed at least every six months. The administration of the DISCUS was to occur at least every three months. <u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> The MOSES and/or DISCUS were not being completed in a timely manner. These tools for monitoring side effects of psychotropic medication were not obtained, not only according to schedule, and per data presented it was difficult to determine if the MOSES and/or DISCUS was obtained when there was a change in status. The monitoring team's function, of course, is not to diagnose or conclude if individuals were experiencing side effects, but has the responsibility to inquire about the applicability of the findings of the psychiatrist and the IDT in regards to the delivery of psychiatric services. For example, if an individual had a prior DISCUS score less than five and then had presenting symptoms of numerous abnormal motor movements, the IDT was required to intervene and reassess. The completion of an adverse drug reaction form should also occur during the psychiatric clinic when an ADR was discovered.	Noncompliance

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		The facility provided a completion ratio of individuals who had been evaluated with the MOSES and DISCUS in graph format from February 2013-July 2013. • February 69%/69%; • March 78%/81%; • April 90%/60%; • May 79%/43%; • June 100%/100%; • July 100%/100% Psychiatry must utilize this information and work together with nursing to obtain the updated information in a timely and clinically-based approach. Four individuals were prescribed Reglan (Metoclopramide). Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. These four individuals did not have a diagnosis of TD. During December 2012 to May 2013: • Individual #60 received Reglan, but had only one DISCUS administered on 2/6/13. • Individual #85 received Reglan, but had only one DISCUS administered on 3/25/13. • Individual #217 received Reglan, but had only one DISCUS administered on 4/25/13. <u>Training</u> Documentation per NOO, Regina Haight, RN, supported that 100% of all current RN case managers and all newly hired RN case managers attended MOSES and DISCUS training. The facility should include training of ADR reporting, preferably in the same time frame with the MOSES and DISCUS education, in order for staff to associate the purpose of the monitoring/detecting with the reporting requirement. Once any 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 12 individuals were provided to the monitoring team who had the diagnosis of some type of dyskinesia due to medication, such as tardive dyskinesia, and "subacute dyskinesia." The facility failed to include Individual #201 who was noted to have TD in the record review. The facility did not provide adequate history about prior neuroleptic history in the	

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		completion of the rating scales or in the records of most of the individuals reviewed this visit. It is important to document this because the knowledge about the history of exposure to prescribed medications, such as neuroleptics and metoclopramide, is an important factor when assessing 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, due to medication noncompliance, medication error, 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 Attention-Deficit/ Hyperactivity Disorder, Bipolar Disorder, etc. Therefore, all diagnoses, inclusive of TD, must be routinely reviewed, considered, and documented. <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item, therefore, it remained in noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The timely administration of the standard assessment tools and appropriate utilization of this information in clinical decision-making; 2. It is recommended that the psychiatry 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	<u>Policy and Procedure</u> SGSSLC facility-specific policy and procedure dated 10/8/12 was provided in the document request and noted a comprehensive process cohesive with the content of the Settlement Agreement. Attachments were part of the policy, such as Quarterly Psychiatric Medication Review (QPMR) and Interim Psychiatric Evaluation that focused on addressing the content of this section. The attachments were measures to prompt the psychiatrist and the IDT to safeguard that the evaluation identified a clinically justifiable diagnosis, the expected timeline for the therapeutic effects of the medication to occur along with target symptoms to be monitored, and other pertinent features relevant to this section. <u>Treatment Plan for the Psychotropic Medication</u> The treatment plan for the psychotropic medication would have to be designed with the IDT to establish cohesive diagnostics across disciplines. 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 for the IDT to change the treatment plan accordingly. Per record reviews	Noncompliance

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	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.	for 20 individuals, some of the information required to meet the requirements of this provision item were included in the psychiatric assessment, but not necessarily in a timely or reliable manner. The monitoring team was informed that Individual #395 was a child who received a polypharmacy regimen of three psychoactive medications and was initially evaluated by the general psychiatrist at SGGSLC (who was not comfortable with evaluating children). • The individual had been at the facility 12 days prior to the monitoring team's review, had not been evaluated by a child psychiatrist, and was housed with adults 18-21 years of age. • The lead psychiatrist, who was also a general psychiatrist, later took over the care of Individual #395 and attempted to coordinate her subspecialty care with a community child psychiatrist, but there was a delay in securing this evaluation. • The lead psychiatrist documented the name of a member of the monitoring team twice in Individual #395's clinical record. This was an inappropriate way to cite feedback from the monitoring team regarding the review of system issues at SGSSLC. • On a positive note, the lead psychiatrist effectively orchestrated an outlined plan with the IDT and the facility administration to expedite Individual #395's forensic, child psychiatry assessment, medical work-up inclusive of EKG due to the medications prescribed upon admit, and requested further discussions regarding housing and options as outlined in the extensive psychiatric summary. The monitoring team gave feedback to the facility that if SGSSLC was deemed the facility for females of all ages involved in the legal system, then the system must provide appropriate treatment interventions for these individuals. If the facility was not able to provide adequate assessment, intervention, and appropriate housing (i.e., out of sight and sound from adults in the treatment milieu), then the facility must review options with the state and the court in order to keep the youth safe and implement the content of this provision item. The facility reported that 96% of individuals enrolled in psychiatry clinic had a treatment plan. The monitoring team reviewed the records for 20 individuals and discovered there had not been timely psychiatric consultations (J2). This was unacceptable because the facility must provide psychiatric treatment identified in the treatment plan, no less often than quarterly, and based on the current status of the individual. Polypharmacy utilized must be coordinated with other disciplines with the indication summarized for each medication and including additional information about the ineffectiveness of the prior monotherapy regime, thereby, justifying additional medication.	

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		The details of an individual's treatment plan, such as the case formulation, arrival at diagnostics, and reasons that a medication may have exacerbated versus ameliorated symptoms of a psychiatric disorder (e.g., an antidepressant may worsen the condition of the bipolar disorder without the use of a mood-stabilizing agent) should be clearly noted, along with what symptoms to monitor and how the individual could benefit from other less restrictive interventions. Documentation outlining all individuals with a current psychotropic medication regimen, their diagnoses, and the date of their psychiatric clinic visit was provided, but the facility did not calculate the number and percentage of individuals who did not meet the standard of monitoring frequency by the psychiatrist and IDT. • The facility provided a self-rating of noncompliance because reviews and assessments needed additional improvements in quality and timeliness. 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. This was the case for Individual #186 who received a large number of psychoactive medications (six) as outlined in the polypharmacy committee data. Based on the psychiatry database, Individual #186 failed to receive timely care. Similarly, Individual #279 was administered four psychotropic medications, but did not receive timely psychiatric assessments based on the individual's current status and/or changing needs. It should be noted that while multiple individuals were out of compliance with regards to receiving quarterly clinic reviews, there were also some individuals that were, in fact, seen in clinic more frequently than quarterly inclusive of an initial, interim, and quarterly assessment. The monitoring team encouraged the facility to calculate the necessary type of information in order to self-assess each section of this provision and to identify areas in need of further attention. <u>Psychiatry Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was a low percentage of psychiatry participation in the ISP process (addressed in J9). The schedules and turnover of psychiatric staff did not allow their attendance at the majority of ISP meetings. 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	

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		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 records for the individuals scheduled for evaluations throughout the week in clinic were available to the psychiatrist and IDT. This was an improvement since last visit and allowed staff to review the details of the case history and chart findings in the record, when clinical necessary, that were mandatory duties of the multidisciplinary team. The clinics were run efficiently. The teams did not rush, 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, and 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. The data presented to the psychiatrist predominantly focused on behavioral presentation (e.g., agitation, SIB, aggression towards others) and did not consistently include relevant psychiatric target symptoms of the assigned diagnostics to determine medication efficacy. <u>Medication Management and Changes</u> 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 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. The problem remained that when the psychiatrist inquired if the individual was doing "better," the psychiatrist and the IDT had not outlined what would constitute if an individual had improved (e.g., reduction of psychotic symptoms for someone who had Schizophrenia). <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item therefore remained in noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The 90-day reviews of psychotropic medication must occur within the timeframe, 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 medication.	

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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 5/1/13, the state center must provide information about the psychotropic medications to individuals, their families, and LAR. The policy further noted that the information must address characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, and standard alternative treatments, legal rights, and any questions the individual, the family, and/or LAR may have. The facility-specific policy Psychiatric Services dated 10/8/12 outlined the psychiatrist's role in obtaining consent for psychotropic medications. Per this policy, SGSSLC "must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications (or other restrictive procedures)." At SGSSLC, the lead psychiatrist informed the monitoring team that since the last visit, psychiatry obtained consents for psychotropic medications, not the psychology department. Both the medical and psychology departments were receptive to the prescribing physician being responsible for obtaining consent for the psychotropic medication. The monitoring team is in agreement with this plan. The monitoring team recommended that the prescribing practitioner for the medication regimen was the party responsible for establishing the content of the consent to ensure the designated representative for the individual (i.e., LAR/Guardian) understood the risk versus benefit analysis. The facility should handle this medical consent consistent with other medical policy and procedures for obtaining consent. Current Practices The psychiatrists informed the monitoring team of efforts to obtain some of the consents, particularly for the new prescription of a psychotropic medication, but this was not yet implemented facility wide unless the medication consent renewal was due. The monitoring team encouraged the psychiatrists to oversee the medical content required for consent. There were no families/LARs who refused to authorize psychiatric treatments and/or medication recommendations. The monitoring team requested 10 examples of consent for those who were prescribed new psychotropic medications. Individual #337 was prescribed Zyprexa for symptoms associated with schizophrenia. Target symptoms established (i.e., psychosis) were consistent with the diagnosis. The consent for the use of the psychoactive medication adequately noted the description of the expected benefit of the antipsychotic medication being to target symptoms of psychosis. This example illustrated progress in the consent format. In regards to the side effects section, consent should be relevant to the individual, therefore, for Individual #337 the side effects of the Zyprexa should not include adverse	Noncompliance

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		reactions in the elderly because this individual was not in that age group. The consent documents included the name and discipline of the person giving explanation of the content of the consent. Individuals have the right to refuse treatment, therefore, detailed information in regards to their capacity must be documented on the consent form. The example provided for Individual #188 noted that the individual refused to sign the consent form in order to receive Thorazine, but the consent form did not outline if Individual #188 had the capacity to give consent. This posed a problem because the consent for medication signed by the HRC representative and the director of the facility did not clarify this information. It would be best in those cases, especially for individuals who do not have the capacity to consent for the use of the psychotropic medication, to alert the reader of the purpose of the signature by the individual. This form must clarify who actually gave consent for the individual. Further, staff must review the estimated duration of the validity of consent for the medication, consistent with established state consent guidelines and whether this should be less for specific measures (i.e., pretreatment sedation). A consent form, once completed, was presented to the Human Rights committee for review before a non-emergency medication was given. • The consent form included the following language: if clinically necessary, any listed medication may be held, and then restarted within the one year effective date *without obtaining a new consent* for that medication. • The wording noted above concerned the monitoring team. It was observed that if a medication was used for a particular disorder, but then the diagnosis was changed, it was problematic when the consent was not revised to indicate the new purpose for the same medication. • In summary unless the medication was temporarily held due to review of possible side effects and/or a potential adverse reaction, the consent process must be relevant to the situation and obtained again for the new indication assigned. This would reflect the risk-benefit analysis in regards to the medication selected for the psychiatric symptoms/diagnosis experienced by the individual. <u>Monitoring Team's Compliance Rating</u> The facility made progress in addressing this provision item, but remained in noncompliance due to the lack of completed informed consent practices at SGSSLC.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure	<u>Policy and Procedure</u> Per DADS policy, Psychiatry Services dated 5/1/13, the neurologist and psychiatrist must coordinate the use of medications through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder. Facility wide policy and	Noncompliance

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	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.	procedure Psychiatric Services dated 10/8/12 listed this section in the integrated care portion and outlined the necessity of the coordination between the psychiatrist and the neurologist regarding the use of medications, but did not list the IDT as a necessary participant of the process. The policy, however, highlighted that findings would be presented in the quarterly review forum that included members of the IDT. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> The monitoring team was informed that 66 individuals participating in psychiatry clinic had a diagnosis of a seizure disorder. Last visit there were 48 individuals who required neuropsychiatric intervention. The psychiatry department made progress sustaining a roster of individuals who would require the coordination of care by a neurologist and a psychiatrist to treat both seizures and a mental health disorder. These data would facilitate determination of the necessity of neuropsychiatric services. The psychiatry department provided data that psychiatry, however, did not attend any IDT meetings specifically pertaining to neurology care for individuals enrolled in psychiatry clinic since the last review. <u>Adequacy of Current Neurology Resources</u> There had been efforts to coordinate care with neurology by the lead psychiatrist. While this collaboration was a movement in the right direction, to date, there had been no reference that a neuropsychiatric clinic was ever scheduled. However, the psychiatry staff stated that there had been telephone contact between the psychiatrist and the neurologist, but this information was not captured to date. The lead psychiatrist had professional expertise in neuropsychiatry, traumatic brain injury, and psychiatric aspects of seizure disorder. She had a goal of developing, implementing, and monitoring the efficacy of treatment delivered via a formal neuropsychiatric clinic for the individuals who had a seizure and mental health disorder. Because the components of this section had not been adequately addressed by the facility, Dr. Carpenter, will lead this particularly important section due to her expertise in this area. The facility previously calculated this section would require up to eight hours per week on the part of the psychiatrist to outline accurate case history that would be presented to the neurologist. The calculation of FTE for the department was addressed in J5. Neuropsychiatric consultation requires the neurologist and a psychiatrist's coordination of the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. The treating psychiatrists did not physically meet with the neurologist because individuals requiring neurological consultation were evaluated in the community setting. The schedule of Dr. Chris Vanderzant, one of the community neurologists, indicated that neurology consults occurred on average two to three times per month. He knew many of the individuals because he had provided	

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		neurology care for them for many years. Three additional neurologists were listed as providing services for a total of four clinics since last review. 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 the necessary medication regimen and indications for the all of the medications. 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. There was a pervasive pattern noted throughout the record review that numerous individuals received an AED medication, yet the IDT did not team consistently cite the purpose of the medication. 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 may also reduce seizures. Thus, the psychiatrist should obtain consultation with the neurologist through the IDT process, prior to discontinuation of an anti-epileptic agent, particularly for individuals with a seizure disorder. Similarly, the neurologist choosing an agent without the psychiatrist's 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. Dr. Bazzell illustrated the need to entertain neurology contributants in the example outlined for Individual #50 (J2). <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. 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.	

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 #186 (5/17/13), Individual #29 (3/15/13), Individual #379 (3/25/13), Individual #237 (6/14/13), Individual #78 (5/31/13), Individual #100 (6/7/13), Individual #277 (3/29/13), Individual #314 (6/11/13), Individual #45 (6/10/13), Individual #321 (2/8/13), Individual #349 (8/9/13, Individual #145 (4/19/13), Individual #196 (6/6/13), Individual #129 (1/14/13) o Functional Assessments for: • Individual #186 (1/15/13), Individual #29 (3/20/13), Individual #379 (2/28/13), Individual #237 (5/15/13), Individual #78 (5/8/13), Individual #100 (5/22/13), Individual #277 (2/15/13), Individual #314 (5/29/13), Individual #45 (5/22/13), Individual #321 (1/15/13), Individual #196 (8/16/12), Individual #145 (3/8/13), Individual #294 (2/13/13) o Six months of progress notes for: • Individual #186, Individual #29, Individual #379, Individual #237, Individual #78, Individual #100, Individual #277, Individual #314, Individual #45, Individual #321 o Full Psychological Assessments for: • Individual #162 (2/15/13), Individual #125 (2/28/13), o Annual Psychological updates for: • Individual #186 (5/8/13), Individual #29 (3/4/13), Individual #379 (4/9/13), Individual #237 (5/15/13), Individual #78 (4/29/13), Individual #100 (5/14/13), Individual #277 (3/20/13), Individual #314 (3/18/13), Individual #45 (2/27/13), Individual #321 (3/5/13), Individual #353 (1/13/13) o Psychological and Behavioral Services policy and procedures, revised 5/24/13 o Behavioral Support Monitoring Tool, 1/25/13 o PBSP readability scores for: • Individual #186, Individual #29, Individual #379, Individual #237, Individual #78, Individual #100, Individual #277, Individual #314, Individual #45, Individual #321 o Sessions treatment plans and progress summaries for: • Individual #316, Individual #29, Individual #267, Individual #200, Individual #382, Individual #163, Individual #142, Individual #362, Individual #117, Individual #46 o A list of all individuals who are receiving counseling/psychotherapy, undated o Session Psychology attendance tracking, 4/13, 5/13 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 SGSSLC Self-Assessment, dated 7/8/13 o SGSSLC Action Plan, dated 7/8/13 o Graph of data collection reliability from 5/12-5/13 o Graph of IOA from 8/12-5/13 o Psychological and Behavioral Services policy and procedure, revised 5/24/13 o Behavioral Support Monitoring tool, 1/25/13 o Section K presentation book, undated o Departmental QA meetings minutes, 12/3/12, 1/7/13, 2/4/13, 4/8/13, 5/13/13 o Behavioral Support Monitoring Instructions, 1/3/13 o List of the most recent revision of all individuals annual psychological evaluation, undated o List of the most recent revision of all individuals full psychological evaluation, undated o List of all individuals who have PBSPs and date of most recent revision, undated o List of all individuals who have a functional assessment and date of the most recent revision, undated o List of all treatment integrity and IOA checks completed in the last six months <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., BCBA-D, Chief Psychologist o Erick Ybarra, BCBA, Associate Psychologist o Robb Weiss, Psy.D., BCBA-D and Lynn Zaruba, BCBA, Clinical Supervisor o Dana Robertson, Section C Lead o Lynn Zaruba, BCBA, Clinical Supervisor o Simukayi Nyakunika, Associate Psychologist o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors <u>Observations Conducted</u>: o Psychology Department Meeting o PBSP training • Instructor: Adriana Henderson, Associate Psychologist • PBSP trained: Individual #349 o Psychiatry Clinic Rounds • Individual Presented: Individual #266 o Psychology Internal Peer Review Committee • Individual presented: Individual #353 o Behavior Support Plan Committee (BSPC) Meeting o Functional Assessment review meeting o Benchmark Meeting for Psychology o Relationship Skills Therapy session • Staff facilitators: Becky Flygare and Maggie Smith • Individuals participating: Individual #169, Individual #265, and Individual #190 o ISPA meeting

	• Individual reviewed: Individual #395 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: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared based directly on the monitoring team's report. SGSSLC's self-assessment included a review for each provision item, a list of the activities engaged in by the monitoring team, and the topics that the monitoring team commented upon both positively and negatively. This allowed the psychology department and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team acknowledges the efforts of the psychology department in completing the self-assessment, and believes that the facility continued to proceed in the right direction. SGSSLC's self-assessment indicated compliance for items K2, K3, and K8. The monitoring team's review of this provision, as detailed in this report, found K2, K3, K5, K7, K8, and K11 to be in substantial compliance and noncompliance for all other provision items. The reasons for this discrepancy are discussed below. Finally, 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 continues to recommend 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: SGSSLC made many improvements since the last onsite review. These improvements resulted in substantial compliance in three new items (K5, K7, and K11). Additionally, the facility maintained substantial compliance on the three items (K2, K3, and K8) that were in substantial compliance prior to this review. A summary of these improvements are listed below and described in detail in the following report: • Increase in the percentage of associate psychologists who are board certified behavior analysts (BCBAs) (K1) • Improvements in IOA collection procedures (K4, K10) • Improvements in the timeliness and quality of functional assessments (K5) • Improvements in the timeliness of the annual psychological assessments (K7) • Improvements in the timeliness and quality of PBSPs (K9)

	• Improvement in DSPs reports that they understood PBSPs (K11) The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that all associate psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Ensure that replacement/alternative behaviors are collected for all individuals with PBSPs (K4) • Ensure that data collection reliability data are collected across both first and second shifts (K4) • Demonstrate that established minimal frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved (K4, K10) • Ensure that when individuals are not making expected progress, that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4) • Ensure that PBSPs are consistently implemented within 14 days of receiving consent (K9) • Ensure that replacement behaviors are functional (when possible and practical) (K9) • Ensure that PBSP procedures are consistent with the hypothesized function of the target behaviors (K9) • Expand the collection of PBSP treatment integrity to antecedent and consequence procedures (K10) • Document that every staff assigned to work with an individual, including float/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter (K12)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all associate psychologists at SGSSLC who wrote Positive Behavior Support Plans (PBSPs) were board certified behavior analysts (BCBAs). At the time of the onsite review, one associate psychologist was a BCBA. This represented an improvement over the last review when no associate psychologists were BCBAs. Ten of 13 associate psychologists who wrote PBSPs (77%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. This was a decrease from the last review when 92% of the associate psychologists that wrote PBSPs, either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. The facility provided supervision of associate psychologists enrolled in the BCBA program by an on-staff BCBA. SGSSLC and DADS are to be commended for their continued efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each associate psychologist's BCBA training and credentials.	Noncompliance

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	restraint.	To achieve substantial compliance with this provision item, it is recommended that LSSLC ensure that all associate psychologists who write PBSPs attain BCBA certification.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility 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. Since the last review, Dr. Weiss became a board certified behavior analyst. Additionally, Dr. Weiss was a member of the Psychological Association of Greater West Texas, and had over 15 years of experience working with individuals with intellectual disabilities. 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 continued to be in substantial compliance with this item. SGSSLC continued its weekly internal, and monthly external, peer review meetings. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Support Plan Committee), the internal peer review meetings provided an opportunity for associate psychologists to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #353's PBSP. The peer review meeting included active participation from the majority of the department's associate psychologists, and appeared to result in a clearer understanding of the environmental variables affecting her individual target behaviors. Review of minutes from internal peer review meetings indicated that the majority of associate psychologists in the department regularly attended peer review meetings. Additionally, meeting minutes from December 2012 to May 2013 indicated that internal peer review meetings occurred weekly, and that once a month, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, SGSSLC needs to provide documentation that internal peer review consistently occurred weekly, external peer review consistently occurred at least monthly, and evidence of follow-up/implementation of recommendations made in peer review.	Substantial Compliance

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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 improvements in this area. More work, however, is necessary before this provision item can be judged to be in substantial compliance. 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 support professionals (DSPs) used to record target behaviors. The cards could then be scanned and used to produce graphs of the data. As reported in the last review, however, not all individuals' replacement behaviors were being collected at the time of the onsite review. None of the nine data cards reviewed by the monitoring team had replacement data. Additionally, although all 10 of the progress notes reviewed contained replacement behavior graphs, six of the graphs were blank (i.e., did not contain replacement data). It is recommended that the occurrence of replacement/alternative behaviors be collected for all individuals with PBSPs. The ease of implementation and the simple process from data collection to graphing were clear advantages of this scan card system of data collection. Additionally, the data system required DSPs 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 DSPs were recording data at the intervals specified (i.e., data collection reliability) when the observations by associate psychologists or management occurred mid-shift. The monitoring team did its own data collection reliability by sampling individual scan cards across several treatment sites, and noting if data were recorded up to the previous hour. The target behaviors sampled for four of nine scan cards reviewed (44%) were completed within the previous 60 minutes. This was similar to the last review when 43% of the scan cards were completed within 60 minutes of the behavior occurring. At the time of the onsite review, the facility was conducting data collection reliability. Their data, however, was substantially higher than that found by the monitoring team. May 2013's data collection reliability data, for example, indicated that 93% of the scan cards were filled out within the previous interval of the observation time. It is not entirely clear why the facility's and the monitoring team's data collection reliability scores were so discrepant. The monitoring team reviewed the data collection reliability procedures with several associate psychologists and the methodology they reported appeared to be the same as that used by the monitoring team. One possible reason for the discrepancy is that the majority of data collection reliability collected by the psychology department was during the first shift whereas the monitoring team's sample	Noncompliance

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		occurred during both first and second shifts. As suggested in the last report, the psychology department had established minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and minimum data collection reliability levels (i.e., what are acceptable data collection reliability scores). The facility determined that each associate psychologist will conduct two data collection reliability sessions per month. The goal level for data collection reliability was established as 80%. It is recommended that data collection reliability data attempt to equally represent both first and second shifts, and that SGSSLC develop a tracking system so that it can document that data collection reliability is collected twice a month for each associate psychologist, and that the average level is at least 80%. While data collection reliability assesses whether data are recorded in a timely fashion, inter-observer agreement (IOA) assesses if multiple people agree that a target or replacement behavior occurred. At the time of the onsite review, the facility had recently modified the IOA procedure and expanded the collection of IOA data across the entire facility. Since the last review, the facility established that IOA would be collected twice a month for each associate psychologist, and 80% was the goal level. The self-assessment indicated that IOA averaged 94% in the month of May 2013. At this point, it is recommended that the facility establish a tracking system to ensure that IOA is collected twice a month for each associate psychologist, and that the average level is at least 80%. All the graphs reviewed by the monitoring team were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events. The routine use of data to make treatment decisions also continued to improve. For example, in Individual #266's psychiatric review, the associate psychologist presented simplified graphs that represented data up to the previous month. Additionally, the associate psychologist brought data to the meeting that was current to the previous day. The clear and current graphs contributed to a productive discussion by Individual #266's team, and resulted in data based decisions concerning the use of his medications. In reviewing PBSP data in 10 individuals' progress notes, five (50%) indicated a lack of progress in at least one severe target behavior. This was similar to the last review when 43% of PBSPs reviewed indicated a lack of progress. An area of improvement for the facility is the documentation of action taken to address the lack of progress. In four of the five individuals (Individual #314 was the exception) for whom there was no obvious progress in severe target behaviors (80%), the progress notes clearly documented specific staff actions to address the absence of target behavior change. This represented an increase from the last review when 67% of the progress notes reviewed documented actions to address the absence of progress. It is recommended that in those instances	

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		when an individual is not making expected progress, that the progress note or PBSP consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. Over the next six months, it is recommended that SGSSLC ensure that replacement behaviors are consistently collected and graphed. Additionally, the facility needs to have documentation that data collection reliability and interobserver agreement (IOA) have been collected at least twice a month by each associate psychologist, and that IOA and data collection reliability levels of at least 80% have been achieved. Finally, the facility needs to ensure that when individuals are not making expected progress, that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred.	
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.	Since the last review, SGSSLC increased the percentage of individuals with full psychological assessments to 99% of individuals, and increased the percentage of individuals with current (i.e., reviewed/revised at least every 12 months) functional assessments to 100%. Additionally, the full psychological assessments and functional assessments reviewed consistently were complete and clear. Therefore, this item is now rated as being in substantial compliance. <u>Psychological Assessments</u> A spreadsheet of full psychological assessments indicated that 213 of the 214 (99%) individuals at SGSSLC at the time of the onsite review had a full psychological assessment. This represented an improvement from the last review when 83% of individuals had a full psychological assessment. The spreadsheet indicated that five full psychological assessments were completed in the last six months, and two of those (40%) were reviewed to evaluate their comprehensiveness. As found in the last review, both (100%) full psychological assessments reviewed were complete and included 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> A spreadsheet provided to the monitoring team indicated that 191 individuals at SGSSLC had PBSPs. All 191 of those individuals had functional assessments (100%) that were current (i.e., revised/reviewed within one year). This represented a dramatic improvement over the last review when 21% of the individuals with PBSPs had current functional assessments. The spreadsheet indicated that 130 functional assessments were completed in the last six months. Thirteen of these functional assessments (10%) were reviewed to assess compliance with this provision item.	Substantial Compliance

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		All functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and/or specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. As found in the last report, all of the functional assessments reviewed included acceptable indirect assessment procedures. Twelve of the 13 functional assessments reviewed (92%) were judged to contain adequate direct assessment procedures. This represented another improvement from the last review when 60% of direct observation procedures were judged to be acceptable. An example of a complete direct assessment procedure was: • Individual #294's functional assessment included a description of a direct observation of how reaching across him resulted in physical aggression, suggesting that reaching across him was an antecedent to his target behavior. In the one direct assessment procedure rated as unacceptable (i.e., Individual #314) a direct observation was conducted, but it did not include an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent and/or consequent events affecting the target behavior. Twelve of the 13 functional assessments reviewed (92%) identified potential antecedents and consequences of the undesired behavior. This represented a slight decrease from the last review when all functional assessments included potential antecedents and consequences. The unacceptable functional assessment (i.e., Individual #277) identified antecedents that actually appeared to be precursors to the target behavior (e.g., Individual #277raises her voice, or starts pacing). The functional assessment should only include environmental antecedents to the target behavior (e.g., noisy environments, placing demands, absence of staff attention). All 13 of the functional assessments reviewed (100%) were judged to have a clear summary statement. This represented another improvement from last review when 70% of the functional assessments reviewed were found to have a clear summary statement. Overall, 11 of the 13 functional assessments reviewed (85%) were evaluated to be comprehensive and clear (Individual #314 and Individual #277 were the exceptions). This was consistent with the last review when 85% of the functional assessments reviewed were evaluated as acceptable.	

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		The psychology department is to be commended for their efforts to achieve substantial compliance on this provision item. In order to maintain substantial compliance with this provision item SGSSLC needs to ensure that at least 90% of individuals have a full psychological assessment, and that at least 85% of those reviewed contain all of the above components. Additionally, the facility needs to ensure that every individual with a PBSP has a functional assessment, and at least 90% of the functional assessments are current (reviewed/revised at least every 12 months), and that at least 85% of the functional assessments contain all of the above components.	
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 24 of the 213 individuals with full psychological assessments (11%) were conducted in the last five years. This represented a slight improvement from the last review when 4% of the full psychological reviews were conducted within 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.	This provision is now rated as substantial compliance due to improvements in the timeliness of the annual psychological updates (assessments). In addition to the full psychological assessment, SGSSLC completed annual psychological updates. A spreadsheet provided the monitoring team indicated that current (i.e., reviewed/revised at least every 12 months) annual psychological updates were completed for all individuals at SGSSLC. This represented another dramatic improvement from the last review when 46% of individuals had current annual psychological updates. A spreadsheet indicated that 163 annual psychological updates were completed in the last six months, and 11 (7%) of these were reviewed by monitoring team to assess their comprehensiveness. Ten of 11 annual psychological updates reviewed (91%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status. The other annual assessment (i.e., Individual #277) was missing the review of history and medical status. This represented a slight decrease from the last review when 100% of the annual assessments reviewed were rated as comprehensive. Psychological assessments should be conducted within 30 days for newly admitted	Substantial Compliance

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		individuals. A review of recent admissions to the facility indicated that seven of the eight individuals admitted to the facility in the last six months (88%) had psychological updates within 30 days of admission. In order to maintain compliance with this item of the Settlement Agreement, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have a psychological assessment completed within 30 days of admission.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	The facility continued to be in substantial compliance with this item. As discussed in the last review, multiple therapies, 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 a group therapy session. All treatment plans reviewed were found to be goal directed, with measurable objectives, specific treatment expectations, and appeared to be derived from evidence-based practices. They also contained an objective review of progress, and each treatment plan reviewed included a "fail criterion" and a plan for the generalization of acquired skills. Observations of a group therapy session indicated that there were clear objectives for the observed session, measurable progress toward those goals were recorded, and the therapy reflected evidence-based practices. Staff who provided therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or who supervised homework or milieu activities, received training and monitoring from qualified therapists. Finally, the facility developed a referral procedure that documented the need for services. In order to maintain substantial compliance, the facility will need to demonstrate that all non-PBSP therapies continue to be goal directed, with measurable objectives, specific treatment expectations, objective measures of progress, a fail criterion, and a plan for generalization of skills learned during therapy. Additionally, the facility will need to demonstrate that their therapies are evidence based and steps have been taken (e.g., attended conferences, workshops, modified curriculums) to ensure that all therapies represent current best practices.	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.	Although there were improvements in the overall quality and timeless of PBSPs at SGSSLC, this item was rated as being in noncompliance because PBSPs were not documented to be consistently implemented within 14 days of receiving consent, and at least 85% of the PBSPs were not complete. A list of individuals with PBSPs indicated that 191 individuals at SGSSLC had PBSPs and all of these (100%) were current (i.e., reviewed/revised at least every 12 months). This represented a dramatic improvement from the last review when only 43% of PBSPs were current. As reported in the last review, all PBSPs had the necessary consent and approvals. There was, however, no documentation that PBSPs were implemented within 14 days of receiving consent. SGSSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. One hundred and thirty-one PBSPs were completed in the last six months, and 14 (11%) of these were reviewed to evaluate compliance with this provision item. As found in the last review, all PBSPs reviewed (100%) included operational definitions of target and replacement behaviors. Twelve of the 14 (86%) of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the stated function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This is represented another substantial improvement from the last review when only 40% of the PBSPs reviewed were judged to be consistent 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) and pain attenuation. The antecedent procedure was consistent with his hypothesized function and included teaching him how to ask for a break or tell staff that he was in pain. The consequent interventions in Individual #145's PBSP, however, included removing him from the environment following an episode of physical aggression (relocation). If avoiding undesired situations were 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	Noncompliance

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		maintain him in the activity or situation, 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 activity should be avoided following the target behaviors, 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 #29s' PBSP hypothesized that the function of her aggressive behavior was to gain others' attention. Antecedent interventions included providing her with staff attention for the absence of target behaviors, and encouraging/reinforcing her for engaging in her replacement behavior (i.e., asking staff if she could talk to them) before she was aggressive. Her intervention following aggression included ensuring safety, but minimizing attention to Individual #29. Additionally, her PBSP specified that staff should not counsel her following an aggressive episode, and provide attention after she calmed down. Replacement behaviors were included in all of the 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. The monitoring team found that 12 of the 14 (86%) replacement behaviors that could be functional were functional. This represented a slight decrease from the last report when 90% of all replacement behaviors that could be functional were functional. An example of a replacement behavior that was not functional was: • Individual #186's PBSP hypothesized that her physical aggression was maintained by escaping undesired activities and access to preferred items. Her replacement behavior was practicing deep breathing exercises, and practicing thought stopping. These activities appear to be incompatible with physical aggression, however, they do not appear to be functional. Examples of a functional replacement behavior could be teaching her alternative ways to avoid undesired activities (e.g., requesting a break) and/or alternative ways to attain preferred items. When the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire (as appeared to be the case in the	

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		majority of PBSPs reviewed), the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. As found in the last review, all 14 PBSPs reviewed (100%) included the reinforcement of replacement/alternative behaviors. Overall, 11 of the 14 PBSPs reviewed (79%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented another considerable improvement from the last review when 40% of the PBSPs reviewed were judged to be acceptable. The psychology department should be commended for their improvements in the timeless and quality of PBSPS. In order to achieve substantial compliance with this provision item, the facility now needs to document that PBSPs are consistently implemented within 14 days of receiving consent, and ensure that at least 85% of the PBSPs reviewed have functional replacement behaviors (when practical and possible) and that antecedent and consequent procedures are clearly based on the hypothesized function of the target behaviors.	
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.	This item was rated as being in noncompliance because, at the time of the onsite review, not all associate psychologists were collecting treatment integrity. Additionally, IOA and treatment integrity minimal frequencies and levels were not demonstrated to be achieved. As discussed in K4, at the time of the onsite review, all associate psychologists were collecting IOA, and minimal acceptable frequencies and levels were established. It is now recommended that the facility demonstrate that these frequencies and levels are attained. All of the DSPs asked about PBSPs indicated that they understood them (see K11). The most direct method, however, to ensure that PBSPs are implemented as written is to regularly collect treatment integrity data. SGSSLC was assessing PBSP treatment integrity, however not all associate psychologists were consistently collecting it at the time of the onsite review. Additionally, the facility was only scoring treatment integrity for replacement behaviors. It is recommended that the facility ensure that each associate psychologist collects treatment integrity, and that the treatment integrity measures include integrity of both the implementation of replacement behaviors and interventions for decreasing undesired behaviors. Finally, it is recommended that established minimal acceptable	Noncompliance

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		frequencies of treatment integrity collection and levels of treatment integrity are attained. Target and replacement behaviors were consistently graphed monthly at SGSSLC. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. In order to achieve substantial compliance with this provision item it is recommended that treatment integrity (including a measure of the implementation of procedures to decrease undesired behaviors) be expanded to all PBSPs. Additionally, it is recommended that SGSSLC demonstrate that minimal established frequencies and levels of IOA and treatment integrity are achieved.	
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.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DSPs interviewed indicated that they understood the PBSPs. Therefore, this provision item was rated to be in substantial compliance. The psychology department reviewed all PBSPs that were presented in peer review and the Behavior Support Plan Committee to ensure that they were simple, clear, and written in a style that would promote staff understanding. The monitoring team reviewed 14 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed, for example, were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 3.4 target behaviors per PBSP reviewed), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, SGSSLC monitored the reading level (using the Flesch-Kincaid Readability score) of a sample of PBSPs written in the last six months and determined that they averaged an 8.0 reading level. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs indicated that the plans were simple, clear, and easy to understand.	Substantial Compliance
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	This item was rated as being in noncompliance because, at the time of the onsite review, SGSSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Associate psychologists and psychology assistants conducted the trainings prior to PBSP	Noncompliance

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	overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	implementation and whenever plans changed. The monitoring team observed the training of DSPs on Individual #239's PBSP. The training included a review of the PBSP by the associate psychologist that wrote the PBSP, an opportunity for DSPs to ask questions, and written questions pertinent to Individual #239's PBSP. The monitoring team found the training to be comprehensive. The facility indicated that they maintained inservice logs on all staff training. They reported, however, that float staff were inserviced by the residential charge staff and they did not know the method used to train these staff. 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, including float/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	
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 214 individuals and employed 13 associate psychologists responsible for writing PBSPs. Additionally, the facility employed three psychology technicians and four psychology assistants to assist those associate psychologists. As discussed in K1, the facility had one associate psychologist with a BCBA. In order to achieve substantial compliance with this provision item, the facility must have at least eight associate psychologists with BCBAs.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/13 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 DADS Clinical Guidelines o SSLC Medical Services Policy, 4/26/12 o SGSSLC Policy/Procedure Pneumonia Review, 5/30/13 o SGSSLC Policy/Procedure Medical Consultation, 4/8/11 o SGSSLC Routine Laboratory and Tests Screenings, 11/18/10 o Clinical Daily Provider Meeting Minutes, May 2013 o Administrative IDT Meeting Minutes, 2012 - 2013 o QA/QI Reports o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Mortality Review Documents o Clinic Tracking Spreadsheets o Reports for Internal and External Medical Reviews 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 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department 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 #77, Individual #202, Individual #188, Individual #112, Individual #182 Individual #369 Individual #180 Individual #38, Individual #179, Individual #246

	o Annual Medical Assessments the following individuals: • Individual #165, Individual #216, Individual #39, Individual #77, Individual #340, Individual #40, Individual #186, Individual #371, Individual #71, Individual #112, Individual #370, Individual #63, Individual #275, Individual #58 o Neurology Notes for the following individuals: • Individual #95 Individual #398, Individual #218, Individual #145 Individual #210, Individual #116, Individual #241, Individual #277, Individual #229 Individual #85 <u>Interviews and Meetings Held</u>: o Stanley Cal, MD, Medical Director o David Jolivet, MD, Primary Care Physician o Albert Fierro, RN, Medical Compliance Nurse o Victoria Carpenter, DO, Lead Psychiatrist o William Bazzell, MD, Psychiatrist o Angela Gardner, RN, Chief Nurse Executive o Lisa Owens, RN, Quality Enhancement Nurse o David Ann Knight, RN, Quality Enhancement Nurse o Angela Kissko, QA Director <u>Observations Conducted</u>: o Daily Medical Provider Meetings o Pneumonia Review Meeting o Clinical and Administrative IDT Meetings o Clinical Death Review Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Review Meeting o Observations of homes
	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. The center's medical compliance nurse served as the lead for this provision. For each provision item, he provided a series of activities engaged in to conduct the self-assessment. For provision L1, he looked at compliance with annual assessments, ER/hospital audits, Quarterly Medical Summary tracking, meeting agendas, and data from the preventive care databases. In some instances, the center's lead utilized criteria that differed from that of the monitoring team. For example, Annual Medical Assessments were reported as compliant if submitted 10 days prior to the ISP. Utilization of this criterion alone did not take into consideration the fundamental requirement of also completing the Annual Medical Assessment within 365 days of the prior assessment. This resulted in

	compliance rating higher than that determined by the monitoring team. For provision L3, the self-assessment documented compliance with corrective actions for the external medical provider audits. The assessment reported that 100% of CAPs were completed. It appeared that this was not Round 7 data since many of those CAPs remained incomplete. Similar activities were completed for the other two provision items. In moving forward, the medical director, as center lead, should review this report noting the recommendations and comments included in the body of the report. The next self-assessment should include some measure of assessment for every item reviewed by the monitoring team. It should also include other activities believed to be important in the self-assessment process, too. This type of an assessment will help to determine the status of the facility relative to compliance. It will also provide a clearer picture of what actions need to occur to move towards substantial compliance. The facility rated itself in noncompliance with all four provisions. The monitoring team concurred with the facility's self-ratings.
	Summary of Monitor's Assessment: The medical department continued to face challenges with staffing. During the first half of the year, medical care was primarily provided by a series of locum tenens physicians. The flux of providers did not settle until June 2013 with the hiring of a full time medical director. The monitoring team had numerous interviews with the medical director and medical compliance nurse, attended several meetings, and conducted observations in home areas. Many records and documents were also reviewed. These series of activities were instrumental in understanding the current status of services provided, changes that were implemented, and the impact of the changes. The monitoring team found improvement in some areas, no change in other areas, and regression in a few areas. This was not unexpected given the recent staffing challenges in both the medical and pharmacy departments. The new director, along with a full time locum tenens primary provider, was beginning to set the tone for a series of changes within the medical department. They both expressed the desire to work collaboratively with other departments so that the agency could move forward. Discussions with facility staff affirmed that there was change developing in how the primary medical providers interacted with other staff. Facility staff reported that the medical staff were more visible in the homes and were more accessible. While the medical department did not have data related to ISP attendance for the primary providers, it was anecdotally reported that due to staffing instability, it would probably be low. The medical director did attend ISP meetings during the week of the compliance review. Improvement was seen in the provision of preventive care. There were modest increases in the compliance rates for most cancer screenings. The monitoring team also found that all individuals in the record sample had received the core vaccinations.

	Overall, documentation continued to improve, but legibility remained a problem for some providers. Annual Medical Assessments were not always timely and additional work was needed to improve the content. Quarterly Medical Summaries were not being completed. Documentation in the IPN was usually in the proper format, but was inconsistently done. The documentation of consultations in the IPN also needed to improve. The management of pneumonia at SGSSLC remained problematic. The reported pneumonia data did not appear to represent the true incidence of the condition. A pneumonia review policy and guidelines were developed, but this did not occur until the very end of May 2013. Documentation by the medical providers did not present a clear plan for management of pneumonia, nor did it reflect that the pneumonia guidelines were actually being considered. Moreover, the review of pneumonia cases was not standardized and important data were not presented during the review meeting. This was a significant problem because most of the deaths in 2013 were associated with the diagnosis of pneumonia. External medical audits were completed and corrective action plans developed. The corrective actions for the audits were not completed. The mortality reviews were not all completed at the time of the compliance review. The monitoring team will need to review the final reports during the next compliance review. The need for a medical quality program or review process had not been addressed. The facility had several data elements, such as hospitalization rates and seizure management data that could have been useful, but these data were not analyzed or trended to help determine the quality of care provided. No additional clinical guidelines, apart from the pneumonia protocol, were developed at the time of the review.

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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** Several staffing changes occurred in the medical department since the last compliance review. The lead psychiatrist served as the acting medical director for several months. A new medical director joined the staff on 6/17/13. A series of locum tenens physicians provided services. In March 2013, a full time locum tenens primary care physician started to work at the facility and continued to work at the time of the compliance review. The medical director had a caseload of 121 and the locum tenens physician had a caseload of 90. A second full time locums physician began working on 8/12/13 and had	Noncompliance

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		not been assigned a caseload. The long-term part time locum tenens physician continued to work, but had been on leave since June 2013. **Physician Participation In Team Process** The medical staff conducted medical rounds throughout the day and participated in a various meetings. The facility continued the 4:30 pm daily medical meetings. The full time locums provider facilitated these meetings during the week of the compliance review. Attendees included the medical staff, medical compliance nurse, nursing representatives, pharmacy director, hospital liaison nurse, psychology, dental director, dietary representative, and residential services. The monitoring team attended several of these meetings and observed discussions related to hospitalizations, consultations, medication refusals, and specific clinical cases. While all disciplines were represented in the meetings observed by the monitoring team, attendance records and other documents revealed that attendance by many disciplines was not consistent. Minutes were taken daily and made available to staff. Unfortunately, the minutes for this meeting were simply transcriptions that included all commentary of the participants. This format was not optimal for the structure of the meeting because the minutes did not summarize the information/issues, provide necessary action steps, or indicate which items required follow-up. The medical department did not maintain data on physician attendance at annual ISP meetings. The medical compliance nurse reported that physician attendance was based on the risk ratings and physician participation would probably be low. The medical providers' ISP attendance should be addressed, particularly for those individuals with significant medical issues. The primary provider plays an important role in the planning process in terms of determining how the individual's health will impact goals, barriers, transitioning, etc. **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 clinic 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 Shannon Medical Center. In order to foster cooperative efforts between the facility and Shannon Medical Center, the facility staff continued to have quarterly meetings with the medical center staff. SGSSLC participants included the medical director, medical and psychiatry providers, medical compliance nurse, and hospital liaison. The medical center was	

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		represented by that facility's medical director, nursing director, hospitalist, and ER director. There were a number of topics documented for the 7/31/13 meeting, including care of specific individuals and laboratory issues. During this meeting, the availability of access to the medical center's labs was also explored. According the SGSSLC medical director, some facility staff had already been granted access. Labs were drawn at the facility and sent to Shannon Medical Center. Results for routine labs returned the next day while the results for stat labs were available in about two hours. A mobile x-ray company completed roentgenograms and reports were received the same day. After hours, roentgenograms were completed through emergency department assessment at the local hospital. Overall, individuals received basic medical care including the required screenings, immunizations, and preventive care. The medical staff was involved in all aspects of care. They interacted with facility staff, contacted hospital providers, and encouraged discussions with family members. The medical director visited the hospital in order to learn of the status of one individual whose care had been challenging. It was clear that there were efforts to implement new systems and ideas that could benefit the individuals. In meetings, there was also a more open approach to discussion of the issues, identification of problems, and problem resolution. Clinical curiosity was manifested in discussions of complex medical cases. The monitoring team heard more discussion about what could be done to improve both the facility's delivery of health care and the health status of individuals rather than accept barriers as the status quo. For example, although the facility did not employ respiratory therapists, a plan was developed for the use of peak flowmeters and incentive spirometry. This was all good to see and encouraging. However, the numerous staff changes and use of multiple rotating physicians resulted in a loss of continuity of care. This was manifested in a number of ways. The monitoring team found examples of inadequate medical follow-up, and instances in which individuals had significant problems, but were not assessed or transferred in a timely manner. Hospital follow-up was particularly troubling. Individuals with serious health issues did not have documentation of adequate follow-up. Moreover, several individuals with recurrent pneumonia/aspiration did not have adequate documentation by the primary provider of a plan to minimize the risk of recurrence of aspiration. This was problematic considering the number of deaths that were associated with the diagnosis of pneumonia. The presence of a full time medical director and stable primary provider should provide	

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		the medical staff stability that is needed to see improvement in the continuity of care. An additional full time provider will be needed in order to have manageable caseloads. 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: • 10 of 10 (100%) AMAs were current • 7 of 10 (70%) AMAs included comments on family history • 10 of 10 (100%) 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 Annual Medical Assessments along with a copy of the previous year's assessment. For three individuals, the 2011/2012 AMAs were submitted. For three other individuals, no previous assessment was submitted. For the sample of Annual Medical Assessments submitted by the facility: • 9 of 15 (60%) AMAs were completed in a timely manner • 11 of 15 (73%) AMAs included comments on family history • 13 of 15 (87%)AMAs included information about smoking and/or substance abuse history • 14 of 15 (93%) AMAs included information regarding the potential to transition The AMA was considered timely if it was completed within 365 days of the previous summary. The medical compliance nurse tracked the timeliness of the assessments. He reported that all individuals had a current assessment. Assessments were considered timely when submitted 10 days prior to the ISP date. While this was the facility's requirement for submission, timeliness did not take into consideration the requirements to complete	

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		an assessment within 365 days of the previous assessment. The facility submitted the current census listing the dates of current and previous assessments. Based on this information, all individuals had current assessments. However, only 160 of 210 (76%) assessments were completed within 365 days of the previous assessment. In most instances, the deficiencies were limited to several days, but there were examples of assessments that were several weeks to many months late. Most of the assessments reviewed did an adequate job of presenting historical information, such as immunizations and preventive care. The presentation of consultation data and the interval history, however, were not effective in providing a snapshot of the individual's health status. For example, Individual #38 had multiple hospitalizations, many of which were for pneumonia. The individual was reported to have several MBSSs, which showed signs of aspiration. The AMA, completed on 4/16/13, did not provide any plan of care related to aspiration. The findings of the MBSS done on 12/18/12 were documented under x-rays, but there was no reference to the MBSS done during the March 2013 hospitalization. That study was reported to show silent aspiration. The outcome was an AMA that made no reference to a history of aspiration. Thus, there was no discussion of risk, risk mitigation, or a plan of care related to aspiration. A chronological presentation of interval care, organized by problems, would have presented the opportunity to link many of the data elements found in the AMA. A review of the March 2013 hospitalization had the ability to surface the issues of aspiration, dysphagia, GERD, and pneumonia. The monitoring team has recommended in the past and continues to recommend that interval care be presented chronologically, but organized by problems. Organizing an AMA in this manner would encourage a more through exploration of each problem by documenting all of the relevant care. For this individual, once aspiration pneumonia was identified, the AMA would provide information related to all relevant care and events, such as GI evaluation, pulmonary evaluation, hospitalizations, and diagnostics in a cogent manner that allowed for analysis of risk and formulation of an appropriate medical plan of care. Problem oriented discussion essentially mandates that the medical provider review each problem and ensure that the appropriate care was provided in accordance with clinical guidelines. The monitoring team also found that the physical exams documented in the evaluations frequently reported a set of routine and normal findings. Individual #38 had advanced rheumatoid arthritis, but the AMA did not document any of the hallmark findings of the condition. Documentation of the extremities was essentially normal. The rheumatologist noted in an assessment on 7/29/13 and during other visits that the individual had severely contracted metacarpal phalangeal joints and 30 degree flexion	

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		contractures of the wrists. Another example of the lack of critical information in the AMAs is that of Individual #188. This individual had a history of status epilepticus on 5/1/12. The AMA, dated 5/9/13, documented that the date of the last seizure was 5/1/12. The assessment failed to acknowledge that this was the first seizure that the individual experienced. Moreover, there was no documentation that this was an occurrence of status epilepticus that was believed to be associated with lithium toxicity and/or withdrawal of clozapine. Thus, there was no discussion of continued risk of status epilepticus. There was also no documentation of a history of lithium toxicity in the AMA. Many of the issues related to the problems with the AMAs are likely the result of turnover. The medical staff was frequently conducting annual assessments for individuals that they had known for a very brief period. Medical staff stability and reorganization of the interval history should help to minimize these occurrences. <u>Quarterly Medical Summaries</u> A template was developed, but had not been implemented at the time of the December 2012 review. During that review, it was reported that due to staffing, the plan was to begin with semi-annual summaries and progress towards the requirement of quarterly completion when staffing was increased. This had not occurred at the time of the compliance review and the medical staff was not doing quarterly assessments as required by the Health Care Guidelines. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL There was improvement in the updating of the APLs. Even so, several of the APLs reviewed did not include important active diagnoses. Some had not been re-typed in two years and were, therefore, difficult to read because of handwritten addendums. The Health Care Guidelines require that the APL be updated as problems change. The frequency of re-typing the documents is facility specific, but this should be done no less than annually. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. The content of the IPN entries varied among providers. Legibility continued to be a problem with the entries for some providers. Many of the notes did not include the appropriate positive and negative findings. Most providers did not include vital signs and wrote that vital signs were stable or as documented in the	

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		nursing assessment. The most significant problem was the overall lack of IPN documentation. The monitoring team found some examples in which, based on nursing documentation, a physician appeared to have conducted some sort of assessment, but did not provide documentation in the records. Physician Orders Physician orders were usually signed, dated, and timed. Overall, there were less verbal orders and standard operating procedures for administration of treatments and both were generally signed by the medical providers. This was an improvement in comparison to the last compliance review. Consultation Referrals A total of 50 consults in the record sample that were completed after January 2013 were reviewed: • 10 of 50 (20%) consultations were summarized by the medical providers in the IPN within five working days. The facility continued to use the back page of the consult to document acceptance of recommendations, plan of care, the need to review on rounds, and referral to the IDT. This form was implemented just prior to the last compliance review. During the last review, the medical staff was informed that the Health Care Guidelines required that an entry be made in the IPN. Those providers, who no longer worked at the facility, began to make appropriate entries in the IPN. However, the new providers were not providing adequate documentation in the IPNs. The consultation documentation was a hybrid of comments on the form and entries in the IPN. The providers usually wrote one line on the form regarding the recommendations and commented on acceptance/rejection and IDT referral. Many also made minimal IPN entries. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. There was evidence that the primary providers reviewed most consults. However, there was inadequate documentation of the consult findings in the IPNs. The requirements for consultation review and documentation were discussed with the medical director. Consultation referrals are discussed in section G2.	

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		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. The medical compliance nurse maintained the databases related to the provision of preventive care services. Data from the 10 record reviews listed above and the facility's preventive care reports (databases) are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 9 of 10 (90%) records included PCFSs • 5 of 9 (56%) forms were signed and dated Most flow sheets were being updated, but it was difficult to determine who completed the updating. Many were not signed or dated and several had no entries since 2011. It may be practical for the primary provider to review the flow sheet as part of the quarterly review process and update at that time. <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status Two of the individuals who received vaccination against hepatitis B did not have an appropriate antibody response. This should be clearly identified in the annual assessment and problem list. <u>Screenings</u> • 10 of 10 (100%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 4 of 6 males met criteria for PSA testing • 3 of 4 (75%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The total for both lists was 41 males: • 36 of 41 (88%) males had current PSA results	

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		• 5 of 41 (12%) males did not have current PSA results documented <u>Breast Cancer Screening</u> • 2 of 4 females met criteria for breast cancer screening • 2 of 2 females (100%) had current screenings A list of females age 40 and older was provided. The list included the names of 34 females, the date of the last mammogram, and explanations for any lack of testing: • 17 of 34 (50%) females had current breast cancer screenings • 17 of 34 (50%) females did not have current breast cancer screening o 5 of 34 (15%) females had screening discontinued due to age o 4 of 43 (12 %) females did not complete screening due to risk o 3 of 34 (9%) females were not able to cooperate o 4 of 34 (12%) females were scheduled or had no reason listed o 1 of 34 (3%) female refused testing <u>Cervical Cancer Screening</u> • 4 of 4 females met criteria for cervical cancer screening • 2 of 4 (50%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 80 females, the date of the last pap smear, and explanations for lack of testing: • 48 of 80 (60%) females had documentation of cervical cancer screening within the past three years. • 32 of 80 did not have current screenings documented o 13 of 80 (16%) females did not have documentation for lack of screening o 4 of 80 (5%) females had screening discontinued due to risk o 4 of 80 (5%) females had screening discontinued due to age o 4 of 80 (5%) females had undergone hysterectomies o 4 of 80 (5%) females were not able to cooperate o 3 of 80 (4%) females refused testing <u>Colorectal Cancer Screening</u> • 6 of 10 individuals met criteria for colorectal cancer screening • 5 of 6 (83%) individuals completed colonoscopies for colorectal cancer screening	

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		A list of individuals age 50 and older was provided. The list contained 84 individuals: • 45 of 84 (54%) individuals had completed colonoscopies • 39 of 84 (46%) individuals had not completed colonoscopies o 13 of 84 (15%) individuals were considered at risk due to sedation o 7 of 84 (8%) individuals refused colonoscopy o 12 of 84 (14%) individuals had no explanation for lack of colonoscopy o 7 of 84 (8%) individuals had issues related to guardian refusal, age, and ability to complete prep <u>Additional Discussion</u> The compliance rates documented by the monitoring team were lower than those reported by the facility. It appeared that the facility excluded many individuals stating that they did not meet criteria. In many instances, the documentation for exclusion was inadequate. Explanations included "IDT determined risk greater than benefit," "precluded by need for sedation," and "D/Ced, see IPN." The records should document the <u>clinical justification</u> for the decision. For individuals that refuse, there should be documentation that the individual/LAR has been thoroughly informed of the risk of refusal. Overall, compliance rates for completion of colorectal and cervical cancer screening were continuing to improve and compliance with PSA screening remained high. **Disease Management** The facility had access to numerous clinical guidelines issued by state office. 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) LDL<100, (3) BP <140/80 (general goal), (4) monitoring for diabetic nephropathy (5) annual eye examinations, and (6) administration of yearly influenza, hepatitis B and pneumococcal vaccinations: • 3 of 3 (100%) individuals had adequate glycemic control • 2 of 3 (67%) individuals had LDLs < 100 • 3 of 3 (100%) individuals had adequate BP control (<140/80) • 2 of 3 (67%) individuals had urine protein (albumin/creatine ratio or spot microalbumin) documented • 3 of 3 (100%) individuals had annual eye examinations • 3 of 3 (100%) individuals received the yearly influenza, hepatitis B, and	

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		pneumococcal vaccinations The diagnosis for Individual #77 was not clear. The AMA listed Type 1 diabetes. Other documentation reported a diagnosis of Type 2 diabetes. The primary provider should clarify the diagnosis because the differentiation is important for some aspects of management. Individual #246 did not meet the target LDL of <100 and was appropriately started on a statin agent. The medical director should ensure that primary providers are utilizing the most recent guidelines for management of diabetes as set forth in the American Diabetes Association's Standards of Medical Care in Diabetes - 2013. These guidelines are updated on a yearly basis. <u>Osteoporosis</u> The facility submitted several documents related to osteoporosis. The prevalence of the disease was understated in the listing because individuals who had bone mineral densities (BMD) discontinued were omitted even though the diagnosis was correct. The monitoring team did not use these data. Three individuals included in the record sample had the diagnosis of osteoporosis. For those three individuals: • 3 of 3 (100%) individuals received calcium and vitamin D supplementation • 1 of 3 (33%) individuals received additional pharmacologic therapy • 2 of 3 (67%) individuals had current BMD studies <u>Pneumonia</u> The facility tracked the number of cases of pneumonia that occurred each month and categorized each as bacterial or aspiration. The number of cases of pneumonia is summarized in the table below.	

Pneumonia 2012 - 2013							
	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of Incidents	1	3	3	1	1	4	1

The facility documented a total of 14 episodes of pneumonia for the reporting period. This data did not appear accurate when compared to information found in the AVATAR reports submitted. There were other individuals who had recurrent pneumonia several months apart that were also not listed.

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		The monitoring team attended the pneumonia review meeting. Three individuals were discussed. Individual #38 had recurrent pneumonia and an abnormal MBSS. There was extensive discussion related to the results of the swallow studies, but none of the staff provided a definitive answer regarding the results of the independent MBSS obtained by SGSSLC. It appeared that the individual was allowed a modified texture diet, but there was continued evidence of aspiration. The process of review was not standardized. Utilization of a checklist would standardize the review, expedite the process, and ensure that the necessary data were available for the meeting. As a result of the meeting, it was decided that several steps would be taken including a change in the influenza protocol, and implementation of the use of peak flow meters, and incentive spirometry. **Case Examples** <u>Individual #179</u> This individual was evaluated by a primary medical provider on 12/4/12 around 9:45 am due to reports of coughing. A CXR was obtained. The individual developed a fever later that day and was transferred to the local hospital around 5:00 pm for evaluation. The individual was hospitalized until 12/11/12 for treatment of community acquired pneumonia. Upon return to the facility, a post-hospitalization note was written by the primary medical provider. The records did not provide any additional medical documentation until noon on 1/8/13 when the individual was evaluated due to respiratory issues. Nebulizer treatments were provided. Vital signs included a BP of 103/55 and HR of 91. On 1/9/13, around 3:00 pm, the individual was transferred to the Emergency Department due to a new pulmonary infiltrate and deterioration in kidney function. The individual returned to the facility on 1/14/13 and was seen by the primary medical provider who noted that the hospital diagnoses were pulmonary embolism and pneumonia. The plan was limited to two lines: (1) continue amoxicillin and (2) Lovenox 75 q 12. The next medical IPN entry was on 1/19/13 at 2:50 pm when the provider noted vomiting of questionable etiology. The timing of this entry did not appear accurate. The individual did not tolerate oral promethazine, so intramuscular prochlorperazine was ordered. Emesis was documented again at 5:30 pm. On 1/19/13 at 12:45 am, the individual was found in extremis. Based on the records submitted and reviewed, this individual did not have adequate documentation of medical follow-up. It was also noted that the nephrologist recommended discontinuation of the lisinopril on 7/30/12. The PCP continued the medication stating that it was part of the lab matrix. No other explanation was provided for the decision to reject the recommendation of the consultant. Additionally, on	

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		11/15/12, nursing documented that during the annual ISP, the IDT questioned why the individual walked "bent over at the waist." Nursing documented that this information was relayed to the PCP who indicated that he did not know the reason for the individual's gait, but did not believe further evaluation was warranted. The PNMT assessment completed following hospitalization noted that this posture affected positioning. <u>Individual #188</u> On 6/23/13, nursing documented at 4:45 pm that the individual vomited. At 8:30 pm, the individual vomited again and the abdomen was noted to be distended and firm. The individual had no bowel movement for three days, so a suppository was given. The RN assessment at 10:30 pm documented that the individual's skin was cool, but pale, and the abdomen was distended with hypoactive bowel sounds. The PCP on call was notified, ordered a fleets enema and requested a KUB in the morning to rule out bowel obstruction. It was documented that vital signs were refused. At 11:25 pm, nursing documented that the individual was found unresponsive. This individual had a history of status epilepticus that was associated with lithium toxicity and/or withdrawal of clozapine. The lithium level was noted to slowly increase with the last level on 6/5/13 being 1.04. The monitoring team was concerned about a few issues related to the management. First, the inability to tolerate oral intake placed the individual at risk for lithium toxicity. Second, consideration of the diagnosis of bowel obstruction in an individual with nausea and vomiting required an immediate medical assessment. This individual was scheduled to have a KUB done the following morning. That was more than eight hours from the point at which the order was given. <u>Individual #38</u> This individual had multiple hospitalizations during the past year, several of which were related to pneumonia and aspiration syndrome. The individual was discussed during the pneumonia review meeting and it was clear that staff remained confused about the results of the MBSS. The facility referred the individual for a MBSS at another facility since three were already done at Shannon Medical Center. The medical director reported during the pneumonia review meeting that the studies "showed serious signs of aspiration." According to the SLP consult done on 8/11/13 while the individual was hospitalized, prior dysphagiagrams were conducted, the most recent being in March 2013. It was recommended at that time that the individual be NPO and have placement of a PEG tube. The recommendations also stated that if feeding continued, in spite of the aspiration risks, thickener should not be utilized due to the consistent results of silent aspiration	

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		on thickened liquids during the past two dysphagiagrams. The hospital consult documented that the SLP pathologist contacted the SGSSLC SLP staff who informed her that the SGSSLC referred the individual to another facility for a MBSS and the facility was more comfortable with those results. The results of the MBSS were not provided to Shannon Medical Center, however, the medical center cancelled the order for the repeat MBSS. The individual was NPO during this hospitalization and all intake was via a nasogastric tube, which was discontinued prior to discharge to SGSSLC on 8/14/13. The medical documentation in the IPN by the medical provider documented that the individual was hungry. There was no documentation of the results of the MBSS, which would indicate that it was safe for the individual to have oral intake. This was important because the Shannon staff documented silent aspiration. Even more important, the monitoring team could not identify in the medical IPN documentation, what interventions, other than "aspiration orders," were being implemented to help minimize the recurrence of aspiration. Hospital notes documented chronic aspiration, but the medical provider IPN entry documented a diagnosis of left lower lobe pneumonia without any indication that aspiration was involved. The plan listed daily weights, antibiotics, continue GERD treatment, and "aspiration orders." The physician orders included a request to add "history of aspiration pneumonia" to the APL. Suction toothbrushing, dental, and PNMT consults were requested. However, the individual's previous orders were resumed including oral medications and nutrition. The physician's hospital return note should adequately summarize the hospital diagnosis and treatment and provide the plan that is being implemented upon return to the facility. <u>Individual #180</u> This individual had several documented elevated blood glucose levels in recent months. The serum glucose was noted to be as high as 185 on 7/3/13, but there was no documentation in the IPN that addressed these abnormal findings. The most recent glucose on 8/7/13 was 114. There was also no documentation of an HbA1c to assess overall blood glucose levels. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 59 individuals. The following data regarding AED use were summarized from the list provided: • 3 of 59 (5%) individuals received 0 AEDs • 38 of 59 (64%) individuals received 1 AED • 15 of 59 (25%) individuals received 2 AEDs	

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		• 3 of 59 (5%) individuals received 3 AEDs The number of individuals seen by the neurologist is summarized in the table. Neurology Clinics 2012 - 2013 Appointments December 8 January 9 February 5 March 10 April 5 May 12 A total of 49 appointments were completed over six months. There was an average of 8 clinic appointments over the six-month period. Overall, compared to the previous reporting period, fewer individuals were having neurological evaluations. The average for the prior review was 11 appointments per month. The facility reported that three individuals had refractory seizure disorder. Two of the individuals had undergone VNS implantation. Seven individuals were transferred to the ER due to uncontrolled/prolonged seizure disorder. No individuals experienced status epilepticus. 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 the diagnosis of seizure disorder. The following is a summary of the review of the 10 records in addition to the records included in the record sample: • 7 of 10 (100%) individuals were seen at least twice over the past 12 months • 10 of 10 (100%) individuals had documentation of the seizure description • 10 of 10 (100%) individuals had documentation of current medications for seizures and dosages • 6 of 10 (60%) individuals had documentation of recent blood levels of antiepileptic medications • 7 of 10 (70%) individuals had documentation of the presence or absence of side effects • 10 of 10 (100%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc.	

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		Overall, the monitoring team did not identify any major issues with the care provided by the consultant. The neurologist provided detailed documentation of the evaluations, including seizure history, medications, and available lab results. In most notes, there was a clear description of the physical examination, the demeanor of the individuals, and any changes that were observed. The absence or presence of clinical signs of toxicity was usually documented. Attention was also given to the psychiatric diagnoses and comments of the psychiatrists. For example, the consult for Individual #229 indicated that there was a question regarding the ability to decrease the dose of psychotropic medications in order to improve a movement disorder. The facility, however, did not have an adequate means of ensuring integration of psychiatry and neurology. This example demonstrated the need for improvement in that area. Many of the consults reviewed did not state explicitly, but implied that labs for review were not available. Comments such "if not already done, please obtain" were noted in several consults in which the pertinent lab values were not documented. The following are some examples of concerns related to neurological care: • Individual #95 was seen on 12/7/12 and the neurologist noted full seizure control on Trileptal. However, the individual described a frequently occurring myoclonus. EEGs showed activity consistent with generalized seizures. Therefore, Trileptal was not the most appropriate medication for seizure control. The recommendation was made to obtain a 24 hour ambulatory EEG after which the individual would be evaluated for change to a more appropriate medication. The EEG, obtained on 3/11/13, was consistent with generalized seizure disorder. The individual was seen by the neurologist on 4/5/13. Staff reported that the individual experienced a two minute generalized seizure en route to another medical appointment. The recommendation was made to start Keppra. Two weeks following the clinic evaluation, the individual sustained a serious injury during a generalized seizure. o The monitoring team was concerned about the three month delay in obtaining the 24 hour EEG because the study was needed to make decisions about appropriate medical management. • Individual #398 was seen on 9/6/11 and was noted to have no seizures for more than five years. The individual had a major seizure on 10/3/12 and was seen by the neurologist for follow-up on 10/19/12. A review of the MAR revealed that the Tegretol dose was given on a TID schedule rather than an 8-hour schedule. The neurologist noted that an 8-hour dosing schedule (not TID) was needed to achieve optimal blood levels. The dose of medication was increased and schedule changed. During the 5/3/13 appointment, it was noted that the individual had not had any further seizures. o It was not clear if the TID schedule was intentional or the result of conforming to medication administration times. The monitoring team	

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		recommends that the administration of AEDs be reviewed to ensure that the administration times are appropriate. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included the names of 17 individuals who had active DNRs. Failure to thrive was frequently cited as the reason for the DNR. Other reasons included DNR per guardian, dementia/DNR per IDT, and DNR per Guardian/IDT agrees. The ages of the individuals spanned from 26 years to 81 years. The facility did not submit justification for the DNRs that were in place and there was no evidence that the DNRs were reviewed by an ethics committee. 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. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical director should continue recruitment efforts for permanent primary care providers. 2. The facility should review the current process of requesting medical participation in the ISPs to ensure that there is medical representation when necessary. The medical department should track attendance of physician participation in the annual ISPs. This information should already be available. 3. The medical department should maintain minutes for the daily provider meeting in a format that ensures issues receive adequate follow-up. 4. The medical staff must complete Quarterly Medical Summaries as required. 5. The medical director should address the issues included in the body of the report related to documentation in the Annual Medical Assessments, Quarterly Medical Summaries, Active Problem Lists, IPN entries and consultation referrals. 6. The medical providers should thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. The medical providers should ensure that the proper risk categorization is applied to determine the appropriate frequency of cancer screenings. 7. The medical director should review the current pneumonia data for accuracy. 8. The medical director should ensure that primary providers are appropriately	

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<tr><td></td><td></td><td>implementing pneumonia guidelines.
9. The medical director should continue to pursue mechanisms of improving neurology-psychiatry integration.</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>
An external medical reviewer conducted Round 7 of the medical audits in May 2013. State guidelines required that a sample of records be 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. A five percent sample of records was audited for three medical providers. The facility submitted data for the internal and external audits. Those data are summarized in the table below:
<table><tr><td colspan="3">External Medical Reviews 2012 - 2013</td></tr><tr><td></td><td>Essential</td><td>Nonessential</td></tr><tr><td>Round 5</td><td>92.5</td><td>84</td></tr><tr><td>Round 6</td><td>96.5 (79.5)</td><td>92 (68)</td></tr><tr><td>Round 7</td><td>93 (98)</td><td>85 (87)</td></tr></table>*( ) Internal reviews
<table><tr><td colspan="3">Medical Management Audits 2013</td></tr><tr><td>Diabetes Mellitus</td><td>Osteoporosis</td><td>Pneumonia</td></tr><tr><td>100 (100)</td><td>87 (82)</td><td>52 (96)</td></tr></table>The marked variation in the results of the internal and external reviews for pneumonia should be further examined. The training provided for reviewers as well as the tools utilized should be evaluated.

During the last compliance review, no data were provided on the status of corrective action plans for Round 5, but it was reported that many were incomplete at the time of the review. Similar problems were noted during this review. Initial discussions with staff indicated that the status of the corrective actions for Round 7 was unknown. This was clarified later during the visit when the QA nursing staff reported that 15 of 16 (94%) action plans for the external audits remained incomplete. Compliance by question graphs were not submitted for review. Therefore, the monitoring team could not compare the audit's findings for compliance with specific requirements to compliance rates determined by the monitoring team. The monitoring team also requested a copy of the external reviewer's exit comments, but was told that it was not</td><td>Noncompliance</td></tr>
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		available. The monitoring team identified several significant issues with the external audit process. First, there was a failure to ensure that the deficiencies identified in the audits were remediated. The second problem, which has been highlighted in previous reports, was the lack of measurement of clinical outcomes. The audits continued to focus on processes. In the case of the diabetes audits, the following six questions were used to assess the management of diabetes mellitus: 1. Is diabetes listed on the APL? 2. Did the provider prescribe the appropriate follow-up lab? 3. Did the provider order appropriate diagnostics and consults if warranted? 4. Did the provider order a consult for diabetes control if indicated? 5. Did the provider order appropriate diabetic diet or consult with the dietician for needed change to the diet? 6. Did the provider evaluate and assess the individuals for other risk factors such as smoking, hypertension, and obesity? While these were all appropriate questions, the audit failed to address many of the widely accepted guidelines set forth by the American Diabetes Association. The 2013 Standards of Care in Diabetes provided numerous guidelines with metrics suitable for measuring processes and clinical outcomes. Most leading professional organizations emphasize the measurement of clinical outcomes, such as glycemic control, lipids, and blood pressure. While the selection of metrics is a challenging one, assessment of quality must not exclude measurement of the intermediate outcomes. Section L1 provides several of the ADA metrics, including targets for LDL, blood pressure, and HbA1c. These data often provide the opportunity to implement changes that impact care and minimize adverse outcomes as well as identify inappropriate processes that result in poor outcomes. Finally, the facility conducted medical management audits for six conditions on a rotating basis. The monitoring team agrees that this was a good starting point, however, there is an obvious need to assess the medical management of a number of disease conditions, such as hypertension and chronic hepatitis. The facility should draft additional management guidelines to ensure that the medical staff provides the appropriate care. These guidelines could then be utilized to develop brief audit tools to ensure that the care provided is in accordance with generally acceptable standards. This could also translate into a medical management flow sheet that would be included in the records with the preventive care flow sheets.	

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		Mortality Management There were six deaths in 2013 at the time of the compliance review. Information from the three death certificates included in the document request is summarized below: • The average age of death was 71 years with an age range of 45 to 90 years. • The causes of death were: (1) pneumonia (2) aspiration pneumonia (3) cardiopulmonary arrest of unknown origin. The individual whose death was attributed to cardiopulmonary arrest was admitted with pneumonia and hypotension one month prior to death. The medical director reported that the most recent death that occurred in July 2013 was also related to aspiration pneumonia. As part of the minimum common elements of care, the facility was tracking some basic death statistics, such as age at death and causes of death.	

Mortality					
Year	2009	2010	2011	2012	2013
#Deaths	4	8	5	3	6
Age at Death (Mean)	70.75	76.75	80.8	72	62.5
Age at Death (Median)	67	78.5	78	92	64.5

Summary documents for section H presented some benchmark data related to mortality in the United States. It was good to see that there was some evaluation of the mortality data for the facility. However, the causes of death in persons with developmental disabilities differ from that of the general population. Additionally, there was no evidence that this information was being reviewed critically within the medical department for the purpose of performance improvement.

At the time of the compliance review, the facility had not completed all death reviews. The monitoring team observed the facility's Clinical Death Review Committee meeting. Participants included the medical staff, QA nurse, other clinical staff, and the medical director of Hospice of San Angelo. There was a frank discussion of the issues surrounding the death and some recommendations were made at the conclusion of the meeting. The monitoring team will review the finalized clinical and administrative death reviews during the next compliance review.

The monitoring team also met with the QA director, medical director, and QA nurses to discuss mortality management at the facility. It was reported that recommendations

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		from mortality reviews were now followed up in the Administrative IDT meetings. The monitoring team did find documentation in meeting minutes, beginning in April 2013, on the status of the corrective actions. The mortality review process at SGSSLC continued to lack an objective review completed within the SSLC system to assess the quality of medical care provided. The mortality review process relied on the physician's discharge summary, QA nursing review, incident reports, and hospital information. The monitoring team noted that recommendations continued to focus on issues related to nursing care. The lack of an objective medical review resulted in the loss of opportunities to evaluate the provision of medical care. However, it appeared based on the observation of the clinical death review that the medical director encouraged a more objective and critical review of the facts. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The external/internal medical audits should include greater assessment of clinical outcomes. 2. The medical management audits will need to address clinical outcomes in addition to processes. The six conditions were a starting point, however, there needs to be assessment of other medical problems that are common in the population being supported. 3. The medical director should ensure that the outstanding corrective actions for Round 7 are completed. 4. Mortality reviews should be completed in a timely manner, with corrective actions generated and followed through to completion. 5. A comprehensive and objective review of the medical care should be completed by a physician, preferably one not associated with the facility. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review.	
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;	The medical director was aware of the need to move forward with this provision item. He had been employed at the facility only two months at the time of the compliance review. He had not had the opportunity to address this provision item. The facility completed external and internal audits, but as already noted, there were several problems with the use of those audits as measurements of quality. The facility had not developed a comprehensive set of indicators to be used in developing quality measures. However, the Section H lead along with one of the primary medical providers	Noncompliance

#	Provision	Assessment of Status	Compliance
	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	developed clinical indicator audit tools for pneumonia, osteoporosis, and diabetes mellitus. The tools did a good job of assessing the processes and outcomes associated with management of the conditions. For example, the diabetes tool monitored the frequency that HbA1c levels were done, but it also assessed glycemic control by noting if the Hba1c <7. It assessed timely completion of urine microalbumin as well as the results of the study. Similarly, it reviewed the use of ACE/ARBs in medical management, completion of eye exams, and development of diabetic retinopathy. The appropriateness of dietary interventions was also assessed. In doing this, the facility was using very specific, widely recognized, and accepted criteria to determine the quality of care provided to individuals with the diagnosis of diabetes mellitus. These are all quality metrics for diabetes care and the results of the audits should be reported as part of the medical quality data. The use of the tools had not been implemented at the time of the compliance review. SGSSLC also maintained a number of data elements related to preventive care. A limited amount of this information was presented in the self-assessment. Other data related to hospitalizations, seizure management, pneumonia, and mortality were collected, but there was no evidence that the medical department had a process to review, analyze, and trend this data for the purpose of performance improvement. The monitoring team met with the medical director, medical compliance nurse, and QA nurses to discuss the development of a medical quality program. The Agency for Healthcare Research and Quality defines quality "as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results." With this in mind, the facility must develop a comprehensive set of indicators that includes a mix of process and outcome indicators. The actual metrics must be well defined and measurable. The frequency for review should also be specified. Development of a good set of indicators/metrics will result in data that help to determine the quality of care, highlight what areas need improvement, and provide an objective means of measuring the success of the interventions. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical director should proceed with the development of the medical quality program. 2. The audit tools should be implemented. The audit process should be outlined and include identification of the auditors as well as frequency of the audits. 3. A comprehensive, but reasonable set of indicators should be selected and tools developed as necessary.	

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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 several diseases and medical conditions. Several of the state issued clinical guidelines were multidisciplinary and provided guidance to physicians, nurses, and direct support professionals. The medical department localized the general health care policies. A policy related to the pneumonia review process and guidelines for management of aspiration pneumonia was approved on 5/30/13. No other policies, procedures or guidelines were developed or provided to the monitoring team. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Local policies and procedures should be developed based on state issued protocols and guidelines. 2. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions, such as hypertension, hyperlipidemia, chronic hepatitis, and other identified conditions.	Noncompliance

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Section M Self-Assessment, updated: 7/8/13 o SGSSLC Section M Action Plan, updated: 7/22/13 o SGSSLC Section Presentation Book o Active Record Order and Guideline o Map of Facility o SGSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o SGSSLC Nursing staffing reports last six months o SGSSLC Vacant Positions by Number of Days Vacant, dated: 8/7/13 o SGSSLC Number of Budgeted Positions by RN and LVN o SGSSLC Nursing Administration Meeting Minutes with Assistant Director of Operations (ADOP), December 12, 2012 through May 29,2013 o SGSSLC Shannon Partners Meeting Minutes, dated: 7/31/13 o SGSSLC 24 Hour Report Sheets, 7/14/13 through 8/14/13 o SGSSLC Medical and Nursing Meeting Minutes, dated: 7/13/13, 8/7/13 and 8/14/13 o SGSSLC RN Case Management Meeting Agenda, 1/30/13 through 8/14/13 o SGSSLC LVN Meeting Agenda, December 2012 through 5/31/13 o SGGSLC Listing of New Active Record Order and Guidelines RN Responsibilities, dated: 1/29/13 o SGSSLC Infirmary Admissions for the last year o SGSSLC Admission from Hospital to Infirmary Policy and Procedure revised: 1/3/06 o SGSSLC Listing of Emergency Bags/Automatic External Defibrillator (AEDs) Locations o SGSSLC Emergency Drill Checklists, January 1, 2013 through May 31, 2013 o SGSSLC CPR Course Due/Delinquent Report by Employee, run date: 6/27/13 o SSGSLC Emergency Response Policy and Procedure, revised: November, 2012 o SSGSLC Emergency Equipment Walk Through Check List, revised: 11/29/12 o SSGSLC Skin Integrity (SIT) meeting minutes February13, 2013 through July 16, 2013 o SSGSLC SIT August 14, 2013 Meeting Agenda, and associated document Pressure Ulcer Management Guideline, revised 2/2/13 o SSGSLC Infection Control Committee Policy and Procedure, revised: 11/29/12 o SSGSLC Quarterly Infection Control Meeting Minutes and associated documents, dated: 4/16/13 and 7/2/13 o SGSSLC Administrative Communication Document "Bed Bug Precautions following off campus stays", dated: 8/7/13 o A list of individuals currently with a gastrostomy tube, colostomy, tracheostomy, and Foley catheter o A list of individuals ever diagnosed with human immunodeficiency virus (HIV), dated: 6/25/13 o A list of individuals diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA), Hepatitis,

	A, B, and C, positive Purified Protein Derivative (PPD), converts, HINI, Clostridium Difficle (C-Diff) and/or sexually transmitted disease (STD's) including name, unit and date of diagnosis, dated: 6/25/13 o SGSSLC Infection Control Report of Infections, data, and summaries, Fiscal Year (FY) 2013 o SGSSLC Nursing Protocol: Enternal Nutrition, revised: May 2013 o SGSSLC Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse, dated: June 2013 o SGSSLC Nursing Services Policy #010.3, effective: 6/17/13 o SGSSLC Administration of Oral Medications, revised: 6/8/11 o SGSSLC Transcription of Orders/MARs, revised: 3/19/12 o SGSSLC Medication Room Audit Inspections, raw data, dated: March 20, 2013 through July 26, 2013 o SGSSLC Refrigerator Temperature Logs, raw data, dated: January 2013 through August 14 2013 o SGSSLC Medication Administration Observation form, dated: 10/31/12 o SGSSLC Medication Observation Raw Data 12/4/12 through 3/28/13 o SGSSLC Medication Observation Form, dated: 01/31/12 o SGSSLC Medication Observation Guidelines, dated: October 2012 o SGSSLC Pharmacy and Therapeutics Committee Meeting Minutes 12/4/12 and1/23/13 o SGSSLC Last six months Hospitalizations and ER visits o SGSSLC Nursing Policies and Procedures o SSLC Medication Variances Policy, #053, effective: 9/23/11 o SGSSLC Medication Variance Report Form, dated: 10/31/12 o SGSSLC Last six months 20 Medication Variances and Corrective Action Plans (CAP) o SGSSLC Medication Error Trend Report; December 2012 through May 2013 o SGSSLC Medication Variance Committee Meeting Minutes, December 2012 through May 2013 o SGSSLC Last six months, nursing audits, data, analysis, reports, sample size, staff completing the audits, plans of correction for head injury, vomiting, seizure activity, antibiotic therapy urinary tract infections, acute illness an injury, urgent care/emergency room and hospitalizations, nursing infection control, respiratory compromise, chronic respiratory distress, prevention, skin integrity, annual nursing care plans, documentation, pain management; and random monitoring verification o SGSSLC Mortality Death Review Recommendations o SGSSLC Mortality Clinical Death Review Committee Meeting and Recommendations for the last six months o A List of Individuals at Risks 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 Medication Administration Record (MAR) Treatment Administration Record (TAR) Signature Sheet, and Integrated Progress Note (IPN), as applicable for conducted medication passes for: • Individual #109, Individual #146, Individual #241, Individual #388, Individual #189, Individual #283, Individual #178, Individual #217, Individual #85, Individual #218, Individual #73, Individual #400, Individual #233, Individual #137, Individual #77, Individual #268

	o Medical Records for: • Individual #132, Individual #23, Individual #38, Individual #76, Individual #180, Individual #59, Individual #140, Individual #180, Individual #59, Individual #140, Individual #85, Individual #162, Individual #153, Individual, #145, Individual #241, Individual #132, Individual #23, Individual #400, Individual #34, Individual #103, Individual #58, Individual #218, Individual #3, Individual, #370, Individual #275, Individual #244, Individual, #117, Individual #337, Individual #37, Individual #85, Individual #164, Individual #153, Individual #145 <u>Interviews and Meetings Held</u>: o Angela Garner, RN, BSN, Chief Executive Officer (CNE) o Regina Haight, RN, Nurse Operations Officer (NOO) o April Watson RN, Program Compliance Nurse o Courtney Daniels RN, Infection Control Nurse (ICN) o Karen Breast RN, Assistant Infection Control Nurse o Rachael Wittich, RN, Nurse Educator o Leslie Nixon, RN, Hospital Nurse Liaison o Virginia Dooley, RN, Clinic Nurse o Anna Pittman, RN, BSN, RN Case Manager Supervisor o David Anne Knight RN, MSN, Quality Assurance Nurse o Melinda Gentry, Assistant Director of Operations (A.D.O.P.) o Nurse Managers o Staff RN's and LVNs o Interdisciplinary Team Meeting, for Individual #1613, 8/12/13 o Daily Provider Meeting 8/12/13, 8/13/13 and 8/15/13 o Nursing Bench Mark Meeting, 8 /13/13 o Pneumonia Committee Meeting 8/13/13 o Medication Variance Committee Meeting, 8/13/13 o RN Case Management Meeting, 8/14/13 o Nursing Administration Meeting, 8/14/13 o Medical/Nursing Meeting, 8/14/13 o Clinical Death Review Meeting, 8/14/13 o Clinical IDT Meeting, 8/14/13 o SIT Committee Meeting, 8/14/13 o At Risk Individuals Meeting 8/15/13 <u>Observations Conducted</u>: o Medication Observation Passes were conducted in units 508A, 508B, 509A, 509B, 510A, 510B, and 516 during various times of the day, and evening o Medication Room Observations with focused inspection of external, internal stock drugs, glucose monitoring devices and testing strips o Medication Administration Observations Passes:

	• Individual #109, Individual #146, Individual #241, Individual #388, Individual #189, Individual #283, Individual #178,Individual #217, Individual #85, Individual #218, Individual #73, Individual #400, Individual #233, Individual #137, Individual #77, Individual #268 o Residential areas during various times of the day and evening o Inspection of Emergency Equipment various units
	Facility Self-Assessment: The facility submitted its self-assessment for section M, updated 7/8/13, and provided comments/status for section M, provisions M1 through M6 of the Settlement Agreement. The facility rated itself as being in noncompliance with five of the six provisions of section M (all but M4). The monitoring team found all six provisions to be in noncompliance, however, much progress was noted. The format for both the Facility Self-Assessment and Action plan as recommended in the previous monitoring report had improved, such as by documenting the results of the facility's review under the applicable corresponding provisions, as exampled in the submission of M.5. The Action Plan updated 7/22/13 provided the monitoring team with a status of the action steps taken for each provision, including those steps completed, not started, or ongoing, with the projected date of completion.
	Summary of Monitor's Assessment: Across section M, the facility had made progress in all provisions with the exception of M.6. During the monitoring team's meetings with the CNE and other members of the nursing leadership team, which included the specialty nurses and Assistant Director of Operations (ADOP), it was evident that they were enthusiast and motivated, especially given the most recent positive staffing changes occurring within nursing administration and new facility medical director. The monitoring team during the onsite visit, observed interactions between nursing and medical across all ranks in various units, various times of the day, and evening; addressing individual's requests and/or direct support professional requests, triaging multiple health problems, making referrals to sick call for treatment, by a physician or nurse practitioner. Provision M.1: This provision was not found in compliance. The monitoring team noted little improvement in the recruitment and retention of nursing staff. Since the last monitoring visit, several Nursing Administration positions that were vacant were filled, as recent as 5/1/13. The facility continued to use overtime, agency staffing, and mandatory staffing by Administration Nurses (including the CNE) in order to provide sufficient staffing. Notwithstanding the augmented staffing, the facility continued to report its failure to meet minimum staffing requirements. The facility reported 20 vacancies at the time of the onsite review.

	Other requirements for Provision M.1. included infection control, emergency response systems, availability of relevant medical records, assessment and documentation of acute changes in health care status, quality enhancement, and staffing. The facility must meet all of these components in order be found in compliance. Information addressing assessment and documentation of restraint use is included in Section C, and death review information is reported in Section L. Much work is needed here. Provision M.2: This provision was not found in compliance. The RN Case Manager Supervisor recently promoted from RN Case Manager, was enthusiastic and focused on making improvements through the advancement of a more organized case management system, beginning with timely annual and quarterly nursing assessments, identifying risk, and strengthening the development of acute care and integrated health care plans. Provision M.3: This provision was not found in compliance. The RN Case Manager Supervisor at the time of the monitoring visit had only been in the new role a little over a month. The RN Case Manager Supervisor had success in the development of systems to prompt RN Case Managers, via implementation of tracking logs, for more timely quarterly and annual assessments, MOSES, and DISCUS. The data from the Clinical IDT meeting reported a 17% increase in the number of nursing assessments from May 2013 to July 2013. Provision M.4. This provision was not found in compliance. The Nurse Educator had been the most stable position, and continually developing learning opportunities when implementing nursing protocol cards to promote critical thinking. There had been significant change in documenting individual's illness and injury when following nursing protocols. For this provision to be in compliance there must be demonstration of an understanding of the policies and procedures, documentation of training, and evidence of clinical practices. Provision M.5. This provision was not found in compliance. In order to obtain compliance for this provision requires a process to accurately identify risk and to develop an Integrated Health Care Plan, by the relevant disciplines. To the credit of the CNE, the RN Case Manager Supervisor was recently assigned as a co-chair to the At Risk Individuals Team Section I Meeting, to further promote the interdisciplinary process of integration of the risk identification processes. Provision M.6. This provision M.6., had not progressed from the previous monitoring team's review: • Omissions of accepted standard of care practices when administering medications • Absence of an integrated interdisciplinary team approach to prevention and root cause analysis of medication variances • A much needed overhaul is essential here.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The facility section M self-assessment stated additional monitoring activities were needed to address all requirements of this provision in order to meet compliance. The monitoring team conducted its own independent review of this provision and found justification through interviews, observations, and record reviews that were similar to the facility's self-assessment activities, reported data, and findings. This provision addresses the areas of staffing, medical records, hospital liaison activities, wound and skin integrity, infection control, emergency response, quality enhancement efforts, and assessment and documentation of acute changes in status. <u>Staffing, Structure, and Supervision</u> At the time of the monitoring review, there were 214 individuals residing at SGSSLC. The nursing department data submission for having met minimum staffing, for the last six months (181 days) December 2012 through May 2013, were 95 days (52%). The nursing department had conducted a month-to-month review for trends, and found that minimum staffing shortages occurred on the 6-2 pm shift, and that an increase in the number of nursing employees call-ins for illness occurred during January 2013, with 84 call-ins. The facility was budgeted for 86 positions of which the facility nursing department reported a vacancy of 20 nurses (23%). The CNE position and other nursing administration positions had requirements of mandatory shift-to-shift staffing, three per month. The Nursing Director should investigate if the continuation of having nurses float were attributed to nursing dissatisfaction and or high turnover rates. The CNE should consider a "no float" policy. The last monitoring visit noted the facility was in awes of "critical staffing" and at this visit the term "critical staffing was not suggested, the continued use of nursing management staff, failure to meet minimum standards is impeding and or stalling progress toward having sufficient systems in place, for example auditing processes, infection control and medication variances and committees; and further contributes to action steps not started as noted in the facilities own report. The ADOP made changes since the last monitoring visit to shorten the time between when a vacancy occurred and when hiring could occur. Even so, sufficient staffing continued to plague the nursing department. The monitoring team met with the CNE and ADOP and provided technical assistance related to staffing suggestions, such as nursing acuity to more effectively utilize nursing resources. In March 2013, the department filled three vacancies: the NOO, RN Case Manager Supervisor, and Hospital Liaison. They also hired an RN as assistant to the Infection Control Nurse Position. Most all positions were promoted within or were lateral transfers, which was fortunate for the facility, because of the continuity of care and services that this provided. Prior to these hires, the CNE in addition to covering shifts, was the back-up for Hospital Liaison Nurse, too. Even so, many of these nurses continued to support the units	Noncompliance

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		as they did in their previous roles. For example, the new Hospital Nurse Liaison continued to provide RN Case Management activities. The ADOP held monthly meetings with the CNE and Nursing leadership. Evident in the minutes reviewed was support and guidance from the ADOP for nursing recruitment and retainment activities, addressing equipment/supply needs, and other improvement activities, such as re-doing the 24- hour log for form and function to include a more thorough report of occurrences (e.g., incidents of acute illness/injury hospitalizations, new orders). <u>Availability of Pertinent Medical Records</u> The facility made improvements toward having an accurate and complete record for each individual as noted below. • The facility in January 2013 put in place a New Active Record Order that required code status and advance directives be placed in each of record. • Pertinent historical information had a documented record disposition. For example, surgical reports were to be maintained in the record for 10 years. • Development of RN Case Management Responsibilities related to the new Active Record Order were placed in the record by the RN Case Manager. These included ensuring that annual and quarterly assessments, labs/x-rays, Consults, MOSES/DISCUS, ER Hospital packets, HMPs, ACPs, MARs/TARs, and Enteral feeding Logs were filed timely in the record by nursing. • Nursing completed in May 2013 a review of individual records for documentation of current PPDs. PPDs for all individuals were reported at 100% compliance. • Nursing completed its review of the presence of aspiration trigger sheets, and intake and output sheets, and continued to monitor quarterly. <u>Hospitalization and Hospital Liaison Activities</u> The Hospital Liaison Nurse most recently transferred from a RN Case Manager to this position. In an interview with both the CNE and Hospital Liaison Nurse, they reported that orientation was conducted on the job because a formal orientation for the position did not exist. The CNE should consider more formalized orientation for new hires in administration roles to ensure continuity and to allow for opportunities for improvement of existing processes. The CNE continued to serve as the back-up for the Hospital Liaison Nurse, for example, for Individual #180 Hospital Liaison Report, dated 6/26/13. The Hospital Liaison Nurse reported the hospital contacts were face-to-face, records were accessible at the hospital, and a planned agreement between certain hospitals were being put in place for nursing and physicians to be able to review "real time records" on line at the facility. Notably, and to the credit of the Hospital Liaison, this process was a positive	

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		step forward for the facility in the promotion of continuity of care between the hospital and the facility. At the next monitoring visit, the monitoring team will review the progress and status of the Hospital Liaison's activities, as the Hospital Liaison Nurse was in orientation at the time of this visit. From 5/15/13 through 8/12/13, five of the most recent Hospital Liaison Reports, associated applicable IPNs, and Observations Notes for Individual #38, Individual #76, Individual #180, Individual #59, and Individual #140 were reviewed by the monitoring team. The findings were as follows: • Four of five (80%) contained the date and time of the Hospital Liaison Visit. • Two of five (40%) contained the signature and date by the Hospital Liaison RN. • Three of five (60%) contained documentation about the individual; Do Not Resuscitate (DNR) status; health as applicable to Neurology, Cardiac, Respiratory, Skin Integrity, and Gastrointestinal, Labs; and Discharge Planning • One of five (20%) contained documented information of communication between the direct support professional and the Hospital Liaison Nurse related to the individual's response to care and services provided in the hospital setting. • None of the five (0%) contained a corresponding IPN note in the record regarding the individual's hospital stay. Nursing Department should further obtain input from other team members as to how useful the information (or lack of information) contained in the Hospital Liaison Reports were actually utilized to make decisions regarding hospital care, treatment, and discharge planning. <u>Infirmary</u> The facility continued to have an operational infirmary, primarily used for individuals returning from a hospital stay. From October 2012 through 6/2/13, there were a total of eight admissions with an average stay of 3.75 days for the beds as identified as infirmary beds. The facility had made no changes to its current policies or procedures as noted in this and the previous monitoring visit. The facility had not addressed baseline criteria for admissions and discharge back to their residential setting, and what supports must be in place to ensure continuity of care. The monitoring team strongly suggests the nursing department collaborate with the medical director regarding infirmary baseline criteria for admission and discharge. The monitoring team conducted an in-depth record review of recent admissions to the infirmary for Individual #38, Individual #76, Individual #180, Individual #59, and Individual #140.	

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		Individual #38 was hospitalized on 5/18/13, a hospital physician admission assessment and plan provided the following diagnosis: septic knee, ileus, protein malnutrition, and osteoporosis. During the hospitalization, the individual required surgical intervention for treatment of the septic knee and after a somewhat lengthy hospital stay, was discharged and received to the San Angelo Infirmary on 6/12/13 at 3:35 pm. The individual returned from the hospital with a Dobbhoff nasogastric feeding tube in place and written physician orders to administer medications. Further review of the record, showed these negative findings: • Blanks on the fluid intake and output records. • Omissions on the Post Hospital/ER/LTAC Nursing for the following: time of the assessment, a discharge summary, medication changes review/reconciliation, and RN Case Manager Assessment review as indicated on the form. • Omission of documentation of referral to physician for an abnormal finding of green drainage for eyes, indicated on both the 6/12/13 at 3:45 pm Post Hospital /ER/LTAC Nursing Assessment and IPN of 6/12/13 5:05 pm. • Omission of follow-up using protocol card for antibiotic therapy related to antibiotic ointment prescribed for the eye drainage . There were some positive findings: • Evidence of Interdisciplinary team meeting to discuss reason for the naso-gastric tube. • Evidence of appropriate referral to Physical Nutritional Management Team related to naso gastric tube/aspiration precautions. • Documented communication, identification, discussion, and staff education for aspiration risks. • Aspiration Trigger Data Sheets were present in the record. • Acute Care Plan document for conjunctivitis (eye infection) dated 6/13/13. Notwithstanding the above positives, the monitoring team was concerned by the lack of sufficient pre- and post-discharge planning for the provision of alternate routes for medications, especially given the need for pain medication, the individual's problems with oral intake, and the absence of prompt reporting for abnormal findings of the eye drainage. <u>Wound and Skin Integrity</u> The Nursing Department, effective in April 2013, combined the Skin Integrity Committee with the existing SIT Committee meeting. The meeting was chaired by the Unit Nurse Manager, previously the Skin Integrity Committee chair. The monitoring team attended the meeting where much discussion occurred as to new information processes, reconciling discrepancies in nursing PNMT data elements, referrals, organizational processes, and	

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		data collection with regard to identifying and tracking skin issues. In addition, Pressure Ulcer Management Guidelines were shared at the meeting. During the meeting, there was much discussion regarding Individual #132, identified with a significant skin integrity change of status, Stage II wound dated 8/13/13, upgraded to Stage III wound with tunneling, and diagnosis of cellulitis 8/14/13. The individual was evaluated by the physician on 8/14/13, placed on antibiotics, and referred for a wound consult. Although the merging of the Skin Integrity Meeting and SIT process were still evolving, the monitoring team was pleased to see an excellent example of team discussion regarding the development of action plans related to the individuals' immediate health needs. The Skin Integrity/SIT meeting notes/minutes, however, were problematic. In addition to being scribbled, illegible, and handwritten, they contained no substantive assessment of issues/problems or identified ongoing issues or actions steps. The status of the committee meetings and data collection, will be reviewed again at the next monitoring team visit because the recent merger of the Skin Integrity Meeting and SIT committee had really not had enough time to put in place organizational process and decisions for action planning, data collections, and trending of data. The facility should support the committee to ensure the organizational process, data collection, and trends move swiftly, given the monitoring team's finding of 24 hour Reports that contained numerous individuals identified with alterations in skin integrity. <u>Infection Control</u> The monitoring team interviewed the Infection Control Nurse with the CNE present. The ICN provided a report on the facility's current environmental issues of bed bugs during the monitoring team's onsite visit. These updates were provided daily (or more often as needed) and provided information on residential infestation, activities to prevent to transmission, and any residents and staff requiring treatment for bed bug bites. The ICN provided educational information on bed bugs to the monitoring team. The ICN continued to research information on the internet in order to make decisions regarding surveillance of infections, suggested treatments, and isolation procedures because the facility did not have a formal method to receive continuing infection control education. Even so, see comments below. The monitoring reviewed the previous six months of infection control meetings and associated data. Infection control meetings were held quarterly, though no minutes were available for January 2013. The available data provided to the monitoring team contained numbers of infections by diagnosis and by home over the last three quarters of fiscal year 2013. The Infection Control Quarterly Reports, however, were insufficient in the investigation and analysis of the incidence of infection occurrences and reoccurrences.	

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		For example, fungal infections, wounds, and urinary tract infections (with and without catheters) were concerning to the monitoring team. The ICN recently obtained an additional staff (i.e., an Assistant Infection Control Nurse RN) to assist with Infection Control activities. The ICN, who had only been in her role for less than one year, had additional responsibilities, such ass providing new employee orientation and participating in mandatory staffing. The monitoring team was concerned the ICN will now have less opportunity for educational activities for obtaining certification as an Infection Control Preventionist. Other ICN activities were conducting random handwashing checks, real time monitoring of acute infections, and home inspections. The monitoring team noted the facility's action steps for these activities projected as 8/1/13 and "not started." The monitoring team could not discern from the information without availed data, if these activities had begun. Certainly, the delay can be attributed to the infection control workload activities, given the increased number of infections and recent environmental issues with bed bugs. The monitoring team will review the progress at the next monitoring visit. Although the ICN was involved in various important tasks, such as reviewing reported information of newly prescribed antibiotics to treat infections and positive culture reports, performing unit educational activities, tracking infections, and chairing the infection control meeting, the monitoring team found the infection control program itself problematic as far as: • Omission of a standardized definition of infections for surveillance activities. • Omission because infection control polices had not been reviewed or revised against current standards, for example, Reporting Notifiable Conditions Texas State Department of Health, CDC current immunization schedules for including Zoster (Shingle) vaccinations, etc. • Omission of policies and procedures for new admissions regarding established testing and screening for sexually transmitted disease. • Omission of analysis following conducted investigations as to underlying reason for infections and reoccurrence of infection. The Nursing Action Plan indicated policy revisions with a start date of 1/1/13, however, the monitoring team reviewed all infection control polices and did not find evidence of policy revisions. This was confirmed in an interview with the CNE. Reportedly, there were discussions between nursing and medical regarding guidelines for new admission testing and screening for sexually-transmitted diseases. The monitoring team was provided, as part of the documents requested, information on revised or new policies, in which the Infection Control Committee documented a revision date of 11/29/12. The set	

#	Provision	Assessment of Status	Compliance
		of documents, however, did not include the policy. During the monitoring team unit observations on 8/13/13, Individual #23 was diagnosed with shingles. The individual was observed to be seen promptly in sick call, with notification to the Infection Control Nurse by telephone, institution of contact precautions, and reassignment of staff, all related to susceptible individuals' exposure to shingles. The monitoring team requested the record for an offsite review. The record contained physician orders referencing a 8/13/13 diagnosis of shingles and a plan of treatment. The Nursing IPN noted that an Acute Care Plan had been initiated, with education and training completed. Nonetheless, the Acute Care Plan was blank for any signatures. The 8/13/13 IPN nursing notes did not contain an initial nursing assessment, vital signs, or SOAP documentation related to the diagnosed case of shingles. In accordance with facilities Nursing Protocols Minimum Documentation Requirements, the nurse must document a note in the IPN, and all documentation, whether chronic or acute, requires the same essential format elements of subjective data, objective data, assessment, and plan, and must always include instructions for the Direct Support Professional to follow. The Nursing Department should ensure acute care health problems are documented promptly. The facility administration released a memo dated 8/7/13, "Bed bug precautions following off campus overnight stay," in reference to the recent incidence of bed bugs. Of concern to the monitoring team, was that the facility allowed a non-certified/unlicensed employee to order and disperse chemical treatment for the infestation of bed bugs in residential areas. Only at the behest of the monitoring team, did the facility acquire a licensed external company to inspect the facility. Fortunately for the staff and individuals, no other infestations were noted on the date of the inspection. Hiring a licensed exterminator experienced with developing an Integrated Pest Management Plan (IPMP) for bedbugs, which includes non-chemical methods of eliminating infestations, may have eliminated a number of individuals having to be removed from their residence. At the time of the monitoring visit reportedly a number of individuals and one staff were treated for bed bug bites. During the Daily Clinical Meeting, attended by the monitoring team, and to the credit of the Medical Director, after being informed a staff member had been sent home due to bed bug bites, recommended facility to support the staff member in having her home be evaluated and receive exterminator treatment if required. The home inspection occurred and reportedly revealed findings of bed bugs in the staff home. <u>Emergency Response</u> During the monitoring team visit, random various units were inspected for availability and accessibility of emergency equipment in accordance with the facility's emergency response policy and procedures, including reference documents provided for location of emergency bags.	

#	Provision	Assessment of Status	Compliance
		There were new/revised State/Local Policies, Procedures, and Protocols for Emergency Response since the monitoring team's last visit. • Emergency Response, Revised: 11/29/12 • AED-Oxygen ER Equipment Checklist, Revised: 11/29/12 • Emergency Walkthrough Checklist, Revised 11/2/12 • Emergency Response Call List, Revised 11/29/12 • Nursing Crash bag Monthly Checklist, Revised 11/29/13 The monitoring team conducted unannounced inspection of emergency equipment, and reviewed emergency checklist. The monitoring team was accompanied primarily by the CNE. The monitoring team found: • Presence of Direct Support Professional emergency equipment bags, nursing equipment crash bag red lock numbers, oxygen, suction machine and backboards, and Automated External Defibrillator (AED). • Demonstrated operable emergency equipment, including for example, oxygen. • Omission of emergency checklist sheets . • Omissions for month and year recorded on the emergency response checklist. • Omissions of documentation of emergency equipment checks occurring. • Omissions of issues not addressed as resolved in the Emergency Drills Checklist 12/31/12 through 5/31/13. To the credit of the CNE, she quickly addressed the identified problems with omissions associated with the checklist. No information was available to the monitoring team regarding reviews of actual emergencies. In other words, there was no documentation of any debriefing/review after the occurrence of any real emergency. The monitoring team also reviewed and found: • Basic Life Support (BLS) training requirements completion, with the exception of three staff (attributed to mid-month rehire, medical leave, emergency family leave). <u>Quality Enhancement Efforts</u> A number of quality improvement activities occurred to help ensure significant health care changes were promptly addressed, physicians were notified promptly, and appropriate care was delivered. These activities included recently implemented joint nursing and medical meeting to address communication, and to problem solve issues related to care and services; and Clinical Interdisciplinary Team meetings to discuss and solicit input from senior management and clinical staff on individual cases. There was not enough	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>information because (these meetings were newly established) to evaluate the overall progress in keeping with the goals of the meetings. The monitoring team will review at the next meeting.

The Compliance Nurse prepared a detailed monthly summary of the monitoring activities and results from those activities. The summary identified the number of audits conducted for each tool, and findings from the audits and Corrective Action Plans.

The Nursing Department CNE, NOO, Compliance Nurse, and RN Case Management Supervisor instituted quality enhancement activities. Two activities were (a) monitoring timeliness and accuracy of nursing assessments (December 2012), and (b) instituted a peer review process for monitoring IHCP (May 2013). These processes included a detailed analysis of the identified issues, for example, incomplete inaccurate summaries, and were shared with the supervisors, further providing opportunities for mentoring of staff toward performance improvement.

The monitoring team interviewed the QA Nurse who reported that she engaged in the following activities: completing clinical death summaries; tracking death recommendations; attending nursing, RN case management, infection control, Medication Variance Committee meetings; and performing inter-rate reliability. In addition, she produced assigned sections of the Quality Assurance Report, as exampled in the overall monthly average scores for documentation protocol percentages contained in the report. January 2013 through May 2013 information is below.

<table>
<tr><td>Month</td><td>January</td><td>February</td><td>March</td><td>April</td><td>May</td></tr>
<tr><td>Percentage</td><td>36%</td><td>28%</td><td>37%</td><td>38%</td><td>52%</td></tr>
</table>

Nursing Corrective Action Plans included the development of protocol prompts with implementation planned for June 2013. The Nursing Department had not had enough time to evaluate the effectiveness of the protocol prompts. The monitoring team will review at the next visit..

In addition to the above activities and since the last monitoring team visit, Departmental QA Benchmark meetings had been implemented (also see section E). The monitoring team attended the nursing benchmark meeting. In attendance were the CNE, Compliance Nurse, ADOP, QA Director, and SAC. The meeting consisted of reviewing and updating the following items QI Council Action Plans/Referral, Corrective Action Plans (CAPs), and monthly monitoring. The monitoring team reviewed SGSSLC Center Facility Status Report Section M for Nursing June 2013 Report and found most of the discussion to be regarding supervisory/administrative activity, such as using correct font and proofing for spelling.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Examples of QA compliance were reliant on whether credit was given by the QA department for activities engaged in, such as the number of tools to be completed. Nursing Leadership should continue its progress to ensure corrective action plans are directly related to the findings, CAPs contain measurable statements, and CAPs have been validated. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The monitoring team reviewed records for Individual #34, Individual #103 and Individual #400). Records were reviewed for assessments and documentation associated with individuals who had acute changes in health status and found: • Three of three (100%) contained nursing assessment for the acute change in health status. • Three of three (100%) nursing assessments contained full vital signs, with SOAP note for the acute change in health status. • Two of three (66%) nursing assessments contained relevant information about the individuals' acute change in health status. • Two of three (66%) Acute Care Plans contained information to identify the reason for the Acute Care plan. • Two of three (66%) Acute Care Plans contained documentation staff were instructed on the Acute Care Plan. • Two of three (66%) Acute Care Plans were individualized sufficient to meet the individual's care needs. • Two of three (66%) Acute Care Plans addressed the acute illness or injury. • Two of three (66%) Acute Care Plans were for infections. • One of the three (33%) Acute Care Plans were for an acute injury. The monitoring team also reviewed from five individuals' Seizure Records and corresponding Integrated Progress Notes. Individuals rated medium and high risk were selected across the units. Records were reviewed for Individual #85, Individual #164, Individual #153 Individual #145, and Individual #241. The monitoring team reviewed Seizure Records and associated Integrated Progress Notes for a total of 41 seizure episodes for the above individuals. Findings included: • 38 of 41 (93%) seizure episodes had a Seizure Record completed. According to DADS Nursing Seizure Management Guidelines, February 2011, and DADS Nursing Protocol, all seizures were required to be documented on the seizure record and in the IPN. Completed seizure records are used make assessment and treatment decisions, and longitudinally track the individual's seizure activity. • 37 of 41 (90%) had a corresponding Integrated Progress Note, some contained more relevant information than others. • 30 of 41 (73%) Seizure Records were filled out correctly as required.	

#	Provision	Assessment of Status	Compliance
		Nursing had made improvements in documenting acute care changes. These included documenting in SOAP format, documentation that Direct Support Professionals notified nursing at any time on any shift, and nurses responded and documented interventions in the Integrated Progress Note. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. CNE should consider in addition to "on the job training," a more formal orientation for administrative positions and associated chair committee assignments. This applies to training for Infection Control Nurse, RN Case Management Supervisor, and Nursing Operations Officer. 2. CNE should consider a staffing acuity for utilization of nursing resources and a "no float" policy. 3. The facility s should continue to support nursing recruitment and retainment activities to reduce overtime, floating of nurses, and promote a more stable nursing workforce. 4. Consider obtaining the resources of a certified Infection Control Preventionist experienced in long term care settings to support the infection control program for reliability and validity of surveillance data using accepted standardized infection definitions.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The facility section M self-assessment stated they were not in compliance with this provision because assessments continued to be delinquent or not completed in the appropriate time frame. The monitoring team conducted its own review of this provision and found similar results. The monitoring team observed an RN Case Management meeting on 8/14/13 and following the meeting, met with the RN Case Management Supervisor. It was evident that the RN Case Management Supervisor was engaged with the Case Managers, as they reviewed and discussed details pertaining to documentation, completion of MOSES and DISCUS, and responded to their general needs of supervision related to completing daily activities or how to complete an activity. In addition, Case Management Nursing Peers voluntarily responded, assisting the needs of their peers with case management activities. The RN Case Manager, although receiving orientation from the CNE, had quickly taken steps to make improvements within the case management systems. These included: • Schedule regular RN Case Management meetings. • Developed internal tracking reminders for when Annual and Quarterly Nursing Assessments are due and send out a notice to the RN Case Manager.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team also attended an "At risk meeting for section I," the first meeting with the RN Case Manager Supervisor as co-chair. During this meeting the RN Case Manager Supervisor was engaged in this interdisciplinary team approach to identifying and integrating the process of risk identification and management. The RN Case Management Team had 15 RN Case Manager positions, of which at the time of the monitoring visit, two were vacant. Reportedly, the case management caseload varied from 12 to 18 individuals per RN Case Manager. They had not developed acuity standards for assignment and management for caseloads. Case Management activities also include completing Nursing Discharge Summaries of which the monitoring team reviewed five of the most recent along with accompanying Integrated Progress Notes, and Health Care Plans for individuals discharged to the community for the period of 12/1/12 through 5/31/13. These were for Individual #162, Individual #252, Individual #114, Individual #305, and Individual #164). The findings were as follows: • Two of five (40%) Nursing Discharge Summaries were documented on the current Nursing Discharge Form dated 11/7/11. • Five of five (100%) Nursing Discharge Summaries had documented current laboratory studies and their results. Three of the five were in an old format entitled "Community Living Discharge Nursing Planning Summary." There were some positives in this form, such as it captured pertinent health information, notably excluded on the current newer required form. For Individuals #162, Individual #114, and Individual #305 the summary included documentation of current immunization and tuberculosis status and medication history, and provided qualitative information about risks in the community. The information was written in understandable language transferable to the community settings and included, for example, what providers needed to know, and ways to ensure recommendations were oriented toward supports and services needed in the community. All of these aforementioned items are considered important when transitioning individuals to the community in order to ensure a more individualized, continuum of care support plan. The monitoring team did not find written guidelines for discharge planning for the nursing staff. Much work is needed here. Individual #162's record was reviewed. The individual was discharged to the community, but re-admitted due to behavioral/psychiatric problems. Active medical problems were Axis I: bipolar disorder, Axis II: borderline personality, and Axis III: first trimester pregnancy, hypothyroidism, dyslipidemia, dyspepsia, cystitis, microprosopic hematuria and proteinuria, intermittent, season allergies and tobacco abuse (cigarettes). The individual was also diagnosed with a urinary tract infection on admission. The monitoring team conducted an in-depth reviewed of the record and found some positives:	

#	Provision	Assessment of Status	Compliance
		• Comprehensive Nursing Review completed within 30 days of re-admission. • Braden Scale completed within 30 days of admission. • Comprehensive Nursing Admission Assessment contained RN signature and completion dates dated within 30 day of admission. • Presence of an Acute Care Plan for Urinary Tract Infection. • Implementation of Antibiotic Therapy Nursing Protocol associated treatment of Urinary Tract Infection. • Acute Care Plan contained documentation, signatures staff were trained on the Acute Care Plan for Urinary Tract Infection. Some negatives were also found: • Comprehensive Nursing Review were blank Immunization history for Polio, Measles, Mumps/Rubella (MMR), Tetanus/Diphtheria, and did not contain an sufficient analysis of the data or absence for the data . • Comprehensive Nursing Review Summary was insufficient in providing a complete and relevant analysis of the individual's health problems. • Omission of Health Care Plan addressing pregnancy, first trimester. • Omission of NANDA nursing diagnosis for pregnancy. The records submitted by the facility with regard to identifying information were fraught with errors, for example the Quarterly Comprehensive Nursing Assessments dated as completed 3/18/13 provided a date of birth as 6/13/13. The IPN admission note documented a head to toe physical assessment, which included height, weight, and full vital signs. The admission note, however, did not denote if there was any assessment of the fundus, such as measurements. Nursing should ensure nursing assessments represent the individual's health conditions, and that plans of care are implemented to support those identified health conditions, including a record review of the physician's history, physical, and orders, especially given the absence of correlation related to the individual immunization status. The absence of a nursing care plan for first trimester pregnancy nursing care plan might be due, in part, to facility staff not being accustomed to admissions that require the specialty of maternal health nursing. The Nursing Department should promptly seek out resources to support the nurses with maternal health education and obtain specialty equipment to have readily accessible, such as an Emergency Delivery Tray, if one does not exists. The monitoring team will `` on the ISP, IRRF, and IHCP at the next visit. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure the Nursing Services Policy 010.3 is fully operational. 2. Consider the development of discharge planning guidelines.	

#	Provision	Assessment of Status	Compliance
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The facility section M self-assessment stated they were not in compliance with this provision because assessments continued to be delinquent or not completed in the appropriate time frame. The monitoring team conducted its own review of this provision and found similar results through interviews, observations, and record reviews. The RN Case Manager Supervisor, even though new to the position, developed an extensive spreadsheet that contained the individual's name, case number, dates for annual ISP, quarterly and nursing assessments, and dates completed. In addition, there was a tracking log for progress for implementation of Integrated Health Care Plans. The monitoring team selected a sample of records to review, for the last three months and for the current month Admissions, Annual, and Quarterly Comprehensive Assessments and associated Health Management Plans (HMPs) for Individual #58, Individual #218, Individual #3, Individual #370, Individual #275, Individual #244, Individual #117, Individual #337, Individual #34, and Individual #37. The monitoring team noted positive improvements in the last three months. . • Nine of 10 (90%) had individual HMPs for all risk ratings and/or nursing diagnoses requiring nursing interventions. • Ten of 10 (100%) of the HMPs included instructions for the Direct Support Professional, although many were not written in understandable terminology. • Eight of nine (88%) individuals' HMPs contained documentation the HMP information of education/training on the HMP. • 24 of 32 (75%) HMPs contained goals that were observable, measurable, and realistic. • 24 of 32 (75%) HMPs contained evidence of a revised HMP. • For these 10 individuals, there were a total of 14 Annual/quarterly nursing assessments. Of the 14, 10 (71%) were completed timely, in accordance with facility policy. • Two of the 10 (20%) reviewed were new admissions. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. RN Case Manager Supervisor should continue to develop case management structures that support training opportunities. This should include shoulder-to-shoulder supervision for competency based nursing summaries and individualized health care plans, which include preventive health measures to ensure health risks are sufficiently addressed to meet the needs of the individual.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M4</td><td>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.</td><td>The facility section M self-assessment stated that they were in substantial compliance because protocols had been developed to address the health status of individuals and staff had been trained on these protocols. As reported below, the monitoring found that additional work was determined to be necessary.

<u>Policies, Procedures, Protocols and Guidelines</u>
The Nursing Department reported receipt of revised policy/protocol changes from the SSLC state office on the following:
• Nursing Protocol Gastrostomy Tube: Insertion by a nurse: Dated 6/1/13
• Nursing Guides for Reporting Elevated Blood Pressure, Dated: 4/1/13
• Weight Management Protocol

<u>Inservice Education/Training</u>
• Mosby Class
• Medication Administration Class
• Medication Error Class
• RN Physical Assessment Class
• Documentation Class

The facility reported for January 2013 through July 2013 for the following monthly averages scores for documentation by protocol:

<table>
<tr><th>Month 2013</th><th>Constipation</th><th>Head Injury</th><th>Pain</th><th>Respiratory</th><th>Seizure</th><th>UTI</th><th>Vomiting</th><th>Average Totals</th></tr>
<tr><td>Jan.</td><td>29%</td><td>43%</td><td></td><td>47%</td><td>36%</td><td>27%</td><td>29%</td><td>35%</td></tr>
<tr><td>Feb.</td><td>14%</td><td>51%</td><td></td><td>47%</td><td>17%</td><td>13%</td><td></td><td>23%</td></tr>
<tr><td>March</td><td>15%</td><td>50%</td><td></td><td>40%</td><td>38%</td><td>41%</td><td></td><td>37%</td></tr>
<tr><td>April</td><td>32%</td><td>28%</td><td>48%</td><td>43%</td><td>51%</td><td>23%</td><td></td><td>38 %</td></tr>
<tr><td>May</td><td>38%</td><td>49%</td><td>54%</td><td>63%</td><td>62%</td><td>46%</td><td>51%</td><td>56%</td></tr>
<tr><td>June</td><td>21%</td><td>49%</td><td>56%</td><td>63%</td><td>50%</td><td>28%</td><td>39%</td><td>42%</td></tr>
<tr><td>July</td><td>54%</td><td>56%</td><td>56%</td><td>56%</td><td>37%</td><td>27%</td><td>33%</td><td>46%</td></tr>
</table>

The facility reported that the monitoring tools for January 2013 for Enteral Feeding Tolerance, Status Epilepticus, and Hypothermia were not completed. The facility combined the aspiration and respiratory monitoring tool and implemented it in April 2013. The facility had taken steps for each protocol to identify, with specificity, protocol monitoring questions in order to address training needs. For example, question 8 on the Urinary Tract Protocol required assessment for tenderness, guarding, suprapubic distension, rebound pain, and masses. From January 2013 through July 2013 for UTI, documentation was zero percent. The Nursing Department should further investigate the underlying reasons for the lack of the abdominal assessment.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		It was positive to find that the Nurse Educator had developed educational materials and inservices for supporting nursing activities associated with medication administration, such as how to conduct a cart change for medications. Regarding trainings: • 100% of the RN completed documentation class • 98% of LVN completed documentation class • 91% of RN completed RN assessment class • 98% of all nurses completed Medication Administration Class in May 2013. All nursing staff, with the exception of new hires, had completed the training for the 18 protocol cards. Five additional statewide protocol cards were recently released for Hypoglycemia, Pain, Emergency/Hospital Transfers, Fall or Suspected Fall, and Suspected Fractures/Dislocation. Training continued on these protocol cards, but the status of the total number trained was not available. The monitoring team will follow-up at the next monitoring visit to evaluate training status. In addition to the protocol cards, the audit process was revised on 3/28/13. The monitoring team review showed that the 18 protocol cards previously developed had been implemented. Any new inservices or required trainings would not negate any future substantial compliance rating when there is evidence that all nursing staff continued to be trained on any additional required training or facility recommended training, and when there is observable evidence that they were put into clinical practice. • Nurses were observed across various units at various times of the day were carrying their Protocol Cards on their person. • Training records were reviewed for the implementation of policies and procedures and found compliant. • Observation of nursing staff on the units and in meetings, and observation of contact and interaction with the individuals demonstrated the presence of the protocol cards. • Nurses reported that the protocol cards were helpful, however, they also noted that the Vomiting Protocol was often in conflict with the physician standing orders. As a result, during the onsite review, the CNE scheduled meeting to discuss this with the new medical director. The monitoring team reviewed individuals' records for the last three months and current month to review admission, quarterly nursing assessments, observation notes, integrated progress notes, Post Hospital/ER/LTAC Nursing Assessment, and associated health care plans for Individual #400, Individual #96, and Individual #339. • One of three (33%) was a new admission to the facility. • One of three (33%) was an acute illness/injury, secondary to a bug bite and follow-up to sexual allegation.	

#	Provision	Assessment of Status	Compliance
		• One of three (33%) was an acute illness/injury secondary to injuries sustained. • Individual #400's IPN indicated that the individual had eluded his staff by running and climbing up to the roof, where he found a piece of glass and self-inflicted cuts, requiring an emergency room visit for treatment of lacerations with 31 staples. The IPN note contained sufficient information regarding the incident, including notification to the physician, documentation of a nursing assessment post receiving a chemical restraint, and prior to being sent to the emergency room. The assessment contained full vital signs and a sufficient head to toe physical assessment. The record contained a Post Hospital/ER/LTAC Nursing assessment and Acute Care Plan dated 8/14/13. The Post Hospital/ER/LTAC Nursing assessment had an omission of the date/time the assessment was completed, and had omissions for subjective data, a pain assessment, and information /instructions that the RN communicated to other IDT members about the changes in the individual's condition or health care needs. The IPN noted the ACP was started with staff and individual. The IPN had omissions as to which staff were trained, as the ACP was absent signatures. The IPN did not contain information if staff or the individual related an understanding for the instructions contained on the ACP for wounds. The IPN note was problematic for the absent for any documentation evaluating pain, given the severity of the laceration. • Individual #339's IPN contained a note dated 7/30/13 at 7:50 a.m. It documented the following: individual stating "I itch," full vital signs, assessment of rash, and referral to the physician. The individual was diagnosed with a "macular papular rash, acute dermatitis to arms, prickly heat rash to back," and prescribed a Medrol dose pack (oral steroid). The next IPN was a nursing note dated 8/1/13 at 1:50 a.m. It contained documentation of an individual coming to staff with a trash can with "bugs he'd gotten off of himself." The nurse documented "not familiar with bed bug so not ruling those out." The SOAP note documented A (for analysis) infestation. Staff were sent to shower the individual, bag old clothes, redress in clean clothes, and temporarily remove to another room. The note indicated notification to the RN Case Manager. The IPN note of 8/1/13 was absent for a head to toe assessment skin integrity issues related to possible bed bug bites, given the facility had a documented infestation of bed bugs. The next note by any discipline was documented on 8/8/13 as a rehab note followed by an IPN nursing entry for follow-up on a sexual allegation. The monitoring team was concerned for the lack of referral to a physician for examination, given the nature of the allegation. Moreover, the note was problematic in that the RN conducted "sexual allegation visual inspection." These types of assessments are usually reserved for nurses having advanced training and education, such as a board certified family or obstetrical/gynecological nurse practitioner. The Observation Note on 8/2/13 noted "book quarantined 8/2/13 to 8/9/13." The record, however, was absent	

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		for any follow-up or Acute Care Plan related to the 7/31/13 IPN note and absent for any follow-up related to the bug issue. There was no information indicating notification of the Infection Control Nurse or any follow-up by nursing as to status with regard to the bugs. • Individual #96's record contained an admission Comprehensive Nursing Reviewed and Physical Assessment completed within 30 days of admission. The Comprehensive Nursing Assessment was absent for information as to the status of the vaccine or vaccine history other than for Hepatitis A or B, and recorded in the analysis of data "no new vaccines ordered." The Comprehensive Nursing Assessment included a NANDA diagnosis, related to the medical diagnosis of asthma. The Comprehensive Nursing Assessment contained the RN signature. The record did not contain a HCP related to the diagnosis of asthma. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure individuals identified health problems are sufficiently assessed and documented through resolution. 2. Stress the importance of obtaining sufficient information for new admissions with regard to immunization history, or document why reasons for the absence of the history.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The facility section M self-assessment stated that they were not in compliance with this provision because IRRF tracking had not be completed at this time, and that, therefore, the goals for this provision had not met criteria. The monitoring team conducted its own independent review of this provision and found similar results. The facility began implementation of the Integrated Health Care Plan in January 2013. The monitoring sample included 34 records of which nine had current Integrated Health Care Plans (IHCPs) and Integrated Risk Reduction Form (IRRFs): Individual #59, Individual #385, Individual #37, Individual #38, Individual #153, Individual #331, Individual #145, Individual #9, and Individual #132. Over the last five months the facility had made improvements • One of the nine had a change of status and IHCPs and IRRFs relevant to the change of health care status were sufficient. • Nine of nine (100%) had a comprehensive interdisciplinary completed assessment. • Three of nine (33%) included preventive interventions to minimize individuals' risk rating. • Eight of nine (88%) IHCPs and IRRFs identified clinical indicators. • Seven of nine (77%) IRRFs provided baseline data that helped to identify risk	Noncompliance

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		ratings. • Five of nine (55%) contained functional and measurable objectives in the ISP to measure the efficacy of the individual plan. • Eight of nine (88%) IHCPs were clinically sufficient to meet the needs of the individuals' risk; although most were not individualized and contained "canned statements." • Five of nine (55%) IHCPs addressed the inclusion of Direct Support Professional in participating in risk reduction activities, as opposed to task list. • Two of two (100%) IHCPs and IRRFs relevant to a change of health care status was sufficiently updated. • An example: Individual #59: in reviewing the Individual Support Plan (ISP), IRRF, IHCPs, Change of Status IHCPs, the monitoring team found sufficient observations/assessments and from those there appeared to be observations/assessments implemented interventions, as evidenced by the completed Nursing Protocol for Hospital, Transfers, and Discharges, PNMT Post Hospitalization Assessments/Evaluation, for post hospital for "Right frontal bore hole evacuation of subdural hematoma." There was also evidence in the IPN documentation that the Nursing Pain Protocol was followed. The monitoring team also reviewed a sample of five Trigger Data Sheets, Integrated Progress Notes, and Observation notes, for triggers identified for July 2013, on individuals rated at high risk for aspiration: Individual #85, Individual #164, Individual #153 Individual #145, and Individual #241. The results of this review were: • Four of five (80%) had a current Trigger data sheet for July 2013. • Zero of four (0%) had individualized triggers identified. • Two of four (50%) sheets were reviewed and initialized by the RN Case Manager at least weekly, as required. • Zero of four (0%) sheets were reviewed and initialed by the nursing staff daily on the 6-2 shift, as required • Zero of four (0%) sheets were reviewed and initialed by the nursing staff daily on the 2-10 shift, as required • Zero of four (0%) sheets were reviewed and initialed by the nursing staff daily on the 10-6 shift as required • One of four (25%) had triggers marked on the on the 6-2 shift for the month: o Individual #180 had triggers reported on 7/3/13 on the 6-2 shift (which was shortly after hospital admission from which he returned with a PEG tube for eternal feedings) for three episodes of spitting up formula. It was positive that the direct support staff, nursing, medical, PNMT, Registered Dietician had conducted sufficient observations and assessments and from those observations/assessments implemented interventions, as	

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		evidenced by the completed Nursing Protocol for Hospital, Transfers, and Discharges, PNMT Post Hospitalization Assessments/Evaluation, and post hospital for "Incision and Drainage of Right Septic Knee" and Percutaneous Gastrostomy Tube (PEG) placement. There was evidence in the Integrated Progress Notes documentation that the Nursing Vomiting Protocol was followed.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility section M self-assessment stated that they were not in compliance with this provision because nurses were not correctly documenting medication administration on the MAR per facility policy. The monitoring team conducted an independent review that included thorough observations, review of medication record and medication treatment records, conducting inspections of medication rooms, observing shift-to-shift drug counts, conducting interviews, and attending a Medication Variance meeting. <u>Medication Administration</u> The monitoring team conducted unannounced medication pass observations on units 508A, 508B, 509B, 510A, 510B, and 516, and interviewed nine nurses in each of the units at various times of the day and evening. These observations included oral medications, crushed medications, and medications given with different mediums (e.g., pudding, thickened liquids). Observation of medication passes, conducted by the monitoring team, included the presence of the CNE primarily, and on one observation pass the Compliance Nurse, too. From these observations:: Positive Findings • Handwashing or the application of hand sanitizer prior to, after a number contacts, and at completion of a contact. • Appropriate glove exchange between contacts, or soiling of gloves. • Interaction between the individual receiving their medication and the nurse administering. • Preparation of fluids (juice) or mediums (pudding) for individuals' personal preferences. • Reviewing and following the instructions located on the individual's PNMP prior to the administration. • Contaminated medications were discarded. Negative Findings • Identification of the individual prior to administration (508A), 8/14/13. • Pre-pouring, pre-setting of medication prior to administration unit (508A), 8/14/13 • Pre-signing the Medication Administration Record prior to administering (508A,	Noncompliance

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		516 W), 8/14/13 (observed being done by the same nurse during two separate medication passes on two different units). • Failure to read the label three times (observed being done by the same nurse during two separate medication passes on two different units) (508A, 516 W), 8/14/13. • Omission of cart being sanitized prior to, or between, medication passes for individuals on unit (observed the same nurse doing this during two separate medication passes on two different occasions) (508A, 516A), 8/14/13. During the observation of the pre-poured medications, the CNE provided a written physician's order that medications (more than one) could be crushed and added to a medium, such as applesauce, and mixed one hour ahead of administration. The physician order was problematic because general standards of medication administration require that the medication must be identifiable up to the point of administration. In addition to the standard, the physicians' order were in direct conflict with the facility's own Medication Administration Guidelines February 2011 "Safe and Secure Practice," which stated "Read the medication label three (3) times; when reaching for the medication, immediately prior to pouring or opening medication, and when replacing the medication back into the drawer or prior to disposal." The CNE was in agreement; the medication was not identifiable up to the point of administration. She planned to address the concern with the new medical director. The monitoring team, at the next onsite review, will evaluate the status of the continuation of the physician's order. <u>Review of Medication Administration Records for Omissions (Blanks on the MAR)</u> The facility over the last six months made in improvements in the reduction of Omissions (blanks on the MAR). The facility's monthly report of total Omissions (blanks) on the MAR were as follows: • February 2013 -196 • March - 98 • April - 76 • May - 116 • June - 82 • July - 133 The Medication Variance Trend Report did not contain any cumulative trends. • 13 of 16 (81%) of Individuals' records selected for medication pass observation contained no blanks on the MAR. • Based on a review of 34 records of which 31 included the last three months of current MARs, 14 of 31 (66%) contained no blanks on the MAR.	

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		The facility should continue to review MARs for omissions, and reconcile those omissions in collaboration with pharmacy. <u>Storage</u> In the areas where medication observations were conducted, the monitoring team conducted focus reviews of the medication rooms and found: • Medications were properly stored and locked. • Medications with expiration dates. • External and Internal Medications were separated from each other. • Controlled substances were under double lock. • Controlled substances records with evidence of medication counts. • Records for documenting daily refrigerator temps, a number units contained blanks. • Glucometer strips had current expiration dates, with the exception one bottle of strips. o The CNE immediately removed the expired Glucometer strips from the individual's medication box. <u>Oversight and Monitoring</u> The SSLC Policy for Medication Administration stated that all nurses working in State Supported Living Centers who administer medication will be observed during a medication pass at least quarterly, and as appropriate. All Medication Administration Observations are to be completed by a licensed nurse using the Standardized Medication Observation Form. The policy included a procedure for scoring and competency. The Medication Administration Observations document request contained 39 observations conducted during the period of 1/15/13 through 5/31/13. The documents were reviewed by the monitoring team: 17 of 39 (44%) Medication Administration Observation sheets contained a calculated percentage of "Yes and No," used to determine retraining. However, some forms contained numbers at the top of the document, and the monitoring team was unable to discern the determination of the score without the completed tallies of Yes and No scores. The Nursing Department should ensure Medication Observation forms are completed correctly. Five of the Medication Observations forms did not contain the second page and were, therefore, excluded from the review. There were Medication Administration Observation Audits. The reports from the Medication Administration Audits were to occur monthly using a sample size of 10. The audit for December 2012 reported only one was completed, and only eight were conducted for March 2013 and April 2013 due to positions being vacant or the nurse assigned for evaluations leaving employment prior to the observation being completed.	

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		The monitoring team reviewed the summary findings from the audits found the same concerns found by the monitoring team during its own observations, such as failure to identification of the individual prior to administering medication. The summary audit indicated the two most commonly missed essential items were verification of allergies, and identify the individual with two identifiers. For March 2013, April 2013, and May 2013, a total of 26 Medication Observations occurred with an average individual score of 96%. The facility should continue its progress for monitoring and analyzing Medication Observations Passes to ensure individuals receive their medications safely. The SSLC Medication Variance Policy #053, 9/23/11, stated that all medication variances are reviewed, trended, and assessed by the director of the responsible department on a monthly basis. Each department is responsible for investigation variances, analyzing data, and presenting a report of department medication variances monthly to the Medication Variance Committee. Recommendations and findings are reported to the Pharmacy and Therapeutics (P&T Committee). The monitoring team attended the Medication Variance Committee on 8/13/13. The meeting was chaired by newly promoted Nurse Operations Office. The meeting was attended by nursing, medical, dental, and pharmacy. The meeting discussed concerns and issues regarding medication reconciliation and the continuation of those processes. The meeting also identified the need to continue to track omissions (blanks) on the Medication Administration Record. The meeting was unorganized, and there was an absence of data for discussion and review, attributed to the Chair being only recently assigned as the NOO and assuming the Chair for this committee. In addition, this was the pharmacist and medical director's first meeting. The nursing department discussed its concerns regarding medication reconciliation and the directive from central office to continue the process of medication reconciliation. The monitoring team reviewed the medication variance meeting minutes for 2/27/13, 3/11/3, 4/17/13, and 5/8/13. The minutes noted an absence of attendance by the pharmacist and medical. Moreover, the minutes contained no substantive data, and instead were more of a recording of what was discussed. The more recent meeting minutes were changed, a notable improvement over the previous ones. The July 2013 minutes noted missing minutes for the Medication Variance Committee, irregular meeting dates and times, and missing data. A plan of correction and responsible person were noted. During the absence of the facility having a staff pharmacist, dispensing errors were not documented or tracked by the pharmacy (see section N). Of concern to the monitoring team were the number of omissions, and where the lack of any other category of medication variance indicated that the facility may have been under-reporting. The facility should ensure key stakeholders are at the table, as medication administration is	

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		not limited to nursing. The facility plan of correction included a request to the QA department for the QA nurse to conduct an audit of medication records and medication variances. Some of this was in response to the monitoring team's concern at the 8/13/13 Medication Variance Committee related in to the absence of other reportable categories, such as transcription. The CNE should consider chairing or co-chairing this committee until such time when the NOO has been sufficiently trained in how to conduct positive and productive meetings, and has completed training in data collection and analysis, perhaps by the Compliance Officer. The monitoring team will review medication variance reporting, minutes, and data from the QA department related to medication variances at the next monitoring team visit. The monitoring team submitted a request for available data from any Medication Variances Trend Report from December 2012 through May 2013. The trend report contained information by variance type, variance by home, discipline, severity, medication, nodes, time, estimated dosages administered and the estimated variance ratio. A review of the medication variances spreadsheets provided the following: • December 2012 181 variances • January 2013 13 variances • February 2013 202 variances • March 2013 220 variances • April 2013 120 variances • May 2013 120 variances The facility reported that there were no medication variance spreadsheets available for June 2013 or July 2013. The trend report did not contain a summary of the analysis of the data. The monitoring team reviewed a sample of the twenty of the most recent Medication Variance Reports and corrective action plans included in the document request. Findings included: • Two of 20 (10%) were completely filled out. Four of the Medication Variances did not contain any data to identify why the variance occurred. For two, the second page was blank. • Nine of 20 (45%) Medications Variances were discovered and reported within 24 hours. One error, a transcription, however, was not discovered for 21 days. The individual received morphine for pain, but failed to receive an adequate dosage as prescribed. Two other errors were not discovered for nine days, for administration at the wrong dosage. Three others were administered for five days, given at the wrong time. • Nine of 20 (45%) had appropriate corrective action taken by the supervisor.	

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		• Six of 20 (30%) Medication Variances were graded correctly on the severity index. Twelve were not marked as to the severity. Two were noted to be category B, as to the type of variance, but coded as Category A, which was not congruent with Medication Variance Policy #25 guidance. • 15 of 20 (75%) Medication Variances described how the variances occurred. • Medication Variance trends by home were 516 E, six of 20 (33%); and 508 A, four of 20 (20%). CNE and Nursing Leadership should make sure Medication Variances Reports thoroughly address all sections of the Medication Variance Form, as the information is reflected in the data entry systems. <u>Medication Administration Training and Education Activities</u> The monitoring team was impressed of educational activities in addition to the required Medication Administration Training in the promotion of medication safety components and medication accountability as noted below. • Medication Administration Training was completed by nursing staff in May 2013, with a 98% completion. • New hires and nursing staff received inservice on nursing activities for Cart Refill, completion of Overage and Shortage Forms, conducting Shift to Shift Medication Counts, and facility schedule for medication reconciliation Nursing should continue its efforts supporting nurses to have the necessary education and training to support medication safety, which ensure individuals receive their medication safely. <u>Pharmacy and Therapeutics Committee Meetings</u> The monitoring team received the Pharmacy and Therapeutics Committee Agenda and attendee signature sheet for 12/4/12 and 1/23/12. Nursing was documented as being present at both meetings. The agenda contained a listing of agenda items that included Monitoring use of Discus and Moses, Medication Error Report and recommendations, and Infection Control, all of which referred to the summaries that were not included with the agenda items. The 12/4/12 meeting contained the same agenda items, but noted N/A for those items. Refer to N8 for additional information. Although the Nursing Department made progress in tracking mediation variances, much continued work is need in medication safety practices to ensure individuals receive their medication safely.	

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The CNE should develop orientation and training for conducting positive and productive meetings, ensure nursing staff assigned to these tasks have had training and adequate resources to plan, develop, analyze for data trends 2. Ensure there is a standardization of terminology and methodology for documenting, track and trending medication variances 3. Ensure all stakeholders who administer, prescribe, dispense are documenting medication variances actively participate in the Medication Administration Committee 4. Ensure the facility continues to practice medication reconciliation 5. Ensure the facility should support the Medication Variance Committee and its practices to ensure individual receive their medication safely.	

SECTION N: Pharmacy Services and Safe Medication Practices	
	Summary of Monitor's Assessment: Prior to the compliance review, the state informed the monitoring team that due to the complete turnover of staff in the pharmacy department, the facility was not in compliance with any of the provision items for section N and requested that a full monitoring review not be done at SGSSLC. Therefore, the monitoring team did not conduct a compliance review for section N. Throughout the week, the monitoring team met with the pharmacy staff to review each provision item and discuss the current status of the provision and the next steps that were needed to move towards substantial compliance. Two issues surfaced during meetings that the monitoring team deemed worthy of highlighting. First, during several discussions, the pharmacy director presented ideas for systems changes that were needed to correct problems that had been identified. Many of the solutions appeared reasonable. However, it became apparent that the pharmacy director was not aware of many of the regulatory issues related to the provision of pharmacy services in an intermediate care facility. It will be important for the new pharmacy staff to have a clear understanding of the regulatory framework as they work to provide services, develop, and implement systemic changes. The second issue that needs to be emphasized was the breakdown of the medication variance system. Over a period of months, the pharmacy was staffed by several locum tenens pharmacists whose focus appeared to be providing medications to the individuals. It was reported during the medication variance meeting that the pharmacy had many boxes of medications that were not accounted for. This information was presented to the nursing department for the first time during the week of the compliance review. The extent of the problem was not known. The facility should consider reconciliation of medications and correction of identified problems a priority matter in order to ensure that individuals are receiving medications as prescribed.

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 Physical Nutritional Management Policy o Habilitation Therapy Services Policy o PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o PNMT Trigger Log o PNMT Recommendation Log o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o Pneumonia Committee meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months o PNMT meeting review form template o PNM spreadsheets o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Annual Refresher curriculum related to PNM, tests and checklists o List of staff delinquent in PNM/lifting refresher o Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves o List of individuals requiring positioning assistance associated with swallowing activities o List of individuals who have difficulty swallowing o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids

	o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Documentation of choking events submitted o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs submitted o APEN Evaluation for Individual $278 o PNMT Assessments and ISPs submitted for the following: Individual #294, Individual #134, Individual #287, Individual #210, Individual #38, and Individual #145 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o PNMP section in Individual Notebooks for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last

12 months for the following:

- Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251.

Interviews and Meetings Held:

- Dena Johnston, OTR, Habilitation Therapies Director
- Maria Luna, RN (8/1/11)
- Deanna Worden, RD, LD (2/1/13)
- Erin Bristo, MS, CCC/SLP (6/10/11)
- Dena Johnston, OTR (2/8/11)
- Judy Perkins, PT (8/1/11)
- Dr. Jolivet
- Dr. Stanley Cal
- Various supervisors and direct support staff

Observations Conducted:

- Living areas
- Dining rooms
- Day programs
- Work areas
- Bathroom areas
- PNMT meeting
- Pneumonia Committee Meeting
- Skin Integrity Team meeting
- ISP Meeting for Individual #132 and Individual #379

Facility Self-Assessment:

The self-assessment completed by Dena Johnston, OTR, Habilitation Therapies Director, was again improved over previous assessments submitted for this section. There were very clear and relevant activities conducted and were linked well to previous monitoring reports. Findings reported were in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was specific analysis of the data to support the self-rating, as well as statements of actions planned to demonstrate attempts to move toward compliance in the future in the self-assessment document.

Ms. Johnston and her staff continued to be on track to ensure progress would be made for the next review. Though continued work was needed, the monitoring team acknowledges the strides that were made since the last review by the monitoring team. The facility rated itself as not in compliance with 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, and 0.8. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with all of these findings, except 0.1 which was rated in

	substantial compliance. On the other hand, the facility rated itself in substantial compliance with O.7, but the monitoring team did not concur. Effectiveness monitoring was conducted; the system appeared to be a good one and was well documented, however, a number of the individuals were not consistently monitored at least on a quarterly basis. As stated above, the facility should use caution in permitting a therapy assistant to make a clinical judgment as to actual effectiveness of the programs and plans. The facility reported that therapy assistants were allowed only to complete chart review and staff interview for program effectiveness monitoring. It was also a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. Improved compliance with the existing system of effectiveness monitoring system is indicated to achieve this.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O, including substantial compliance in provision O1. The PNMT was fully staffed, and the membership had remained consistent and there had been the addition of a second dietitian which was greatly needed for the facility of this size and permitted a back-up to be designated for position. The active participation of Dr. Jolivet and Dr. Cal was also very positive additions. The monitoring team had the opportunity to attend a PNMT meeting during the week of the onsite visit. The meeting again involved excellent active participation by the IDT members who attended for each of the individuals reviewed, which was routine at each of the meetings held. Discussion and review was comprehensive and documentation was consistent and thorough. The team had identified measurable outcomes and in addition to specific status updates, the PNMT reviewed progress toward these goals and clinical indicators of improved health, individual benchmarks and efficacy of interventions provided, as well as readiness for discharge from the PNMT. Continued strides were noted in the area of mealtimes. Trouble spots noted on previous visits had made clear progress with regard to staff implementation of strategies in the Dining Plans, organization of meal preparation, and service, as well as staff knowledge about why specific strategies and adaptive equipment was necessary for the individual they were assisting. Improvements were still needed related to preparation of meals for serving, as DSPs in some homes had a lot of responsibilities before the meal, such as adjusting textures and consistencies of foods that perhaps could be better adjusted in the main kitchen. This would cut down on wait times for the individuals, ensuring that food items were the proper temperature, and that staff were not as rushed and could take more time with individuals they were assisting. Positioning, particularly in wheelchairs, and repositioning of individuals continued to be a weak area of staff performance. Staff awareness of improper position was not consistent and proper techniques were not always effectively used. The monitoring team observed parts of the annual refresher training offered to staff. The format was

	excellent and ideas for improvement of content and instructional design were discussed for these. Ms. Johnston and her staff will need to further review the training, check-off and monitoring process to identify the possible disconnects for staff reflected in their performance related to positioning. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 15 individuals who were chosen from a list provided by the facility of individuals identified as being at a medium or high risk for or experienced an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of the individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of individuals at SGSSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan	SGSSLC had an established PNM policy (7/18/13) that included the following elements, though some of these were operationalized into the At Risk Policy, the ISP Policy, QA Policy, and the new Habilitation Therapy Policy (5/30/13): • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); • The annual review process of an individual's PNMP as part of the individual's ISP; • The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; • The roles and responsibilities of the PNMT; • The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; • Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); • The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; • Requirements for continuing education for PNMT members;	Substantial Compliance

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	meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• Referral process and entrance criteria for the PNMT; • Discharge criteria from the PNMT; • Assessment process; • Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; • The PNMT consultation process with the IDT; • Method for establishing triggers/thresholds; • Evaluation process for individuals who are enterally fed; • PNMT follow-up; • Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (not stated specifically in the policy, but clearly in practice); • A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. • A system of effectiveness monitoring; and • Description of a sustainable QA system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers meeting, QA/QI meeting):	

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		o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). ; o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. <u>Core PNMT Membership</u>: The PNMT at SGSSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. Team members included the following with start dates: • Maria Luna, RN (8/1/11) • Deanna Worden, RD, LD (2/1/13) • Erin Bristo, MS, CCC/SLP (6/10/11) • Dena Johnston, OTR (2/8/11) • Judy Perkins, PT (8/1/11) This team had no new members since the previous review. Back-ups for each position had been assigned. <u>Consultation with Medical Providers and IDT Members</u> The current medical staff, David Jolivet, MD and Stanley Cal, MD were listed as the physician consultants to the team, and Dr. Jolivet attended the meeting held during the week of this onsite review. Dr. Bessman and Scott Lindsay, FNP, had previously participated in the PNMT process. • For 10 of 10 individuals (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. Initially, there was sporadic evidence of physician and/or FNP participation in the PNMT meetings due to personnel changes. Overall attendance, however, was noted for 29 of 37 meetings (78%) and 82% since 4/24/13, when the new medical personnel began to attend. While attendance at the meeting is an excellent method to gain the input of the medical staff, alternate methods to demonstrate their availability to the PNMT were also noted. A physician signed two of the five PNMT evaluations submitted for review (Individual #294 and Individual #134), and this was now a standard practice. As described below, the RN Case Manager attended each of the PNMT meetings when an individual they served was reviewed. The RNCM also served to communicate with the PCP related to questions that came up during the meetings, when orders were required, or	

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		a need for diagnostic testing came up during the PNMT at which the PCP was not in attendance. There was also consistent participation by one or more PNMT members in meetings of the pneumonia committee and in the daily medical provider meetings. A number of individuals followed by the PNMT were routinely reviewed in the pneumonia committee meetings (e.g., Individual #210, Individual #146, Individual #203, and Individual #38). These meetings addressed both individual-specific issues and systems issues as well. The Skin Integrity meeting was in the development stage and, thus, individual reviews had not yet started. It was noted, however, during the meeting observed by the monitoring team, that an individual was discussed due to a significant wound identified (Individual #379). PNMT members also were present at that meeting. Daily medical provider meetings were held every afternoon and the PNMT RN (SLP was the back-up) was the assigned representative at these meetings. Per the QA Benchmark report submitted, attendance compliance was recorded as follows: October 2012 (55%), November 2012 (53%), December 2012 (76%), January 2013 (86%), February 2013(83%), March 2013 (85%), April 2013 (89%), and May 2013 (90%). <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas, as verified online. 5 of 5 core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The five team members had a collective 80 years of experience in their respective fields and, together, approximately 41.5 years with individuals with intellectual disabilities. <u>Continuing Education</u> 5 of 5 PNMT core team members (100%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and/or transferrable to the population served during the past 12 months. Courses attended by the team members included the following: • Medication Training (6 contact hours), Bristo, DeLuna • Working with Autism (.5 contact hours) Bristo, DeLuna, Perkins • Socialization, Communication and Independence During Mealtime (.5 contact hours) Bristo, Johnston, Perkins • Nutritional Supplementation (.5 contact hours), Bristo, Johnston • Supports vs. restrictions Related to Rehabilitation (.5 contact hours), Bristo,	

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		DeLuna, Johnston, Johnston, Worden • Hospice Services (.5 contact hours), Bristo, DeLuna, Perkins • Sensory Diets (.5 contact hours), Bristo, Perkins • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (12 contact hours) Bristo, DeLuna, Perkins, Worden • Operation of Baclofen Pump (16 hours, Nerren) • Overview of the Nutrition Care Process (1 contact hours), DeLuna, Worden • ACLS Provider Renewal Course (1 contact hours), DeLuna • Gus Eckart Trauma Symposium (contact hours), DeLuna • Medical –Surgical Nursing Certification Review (7 contact hours), DeLuna • Autism, Asberger's, SPD, and ADHD (6 contact hours) Perkins • Recognizing/Defining Adult Malnutrition (1 contact hours) Worden • Maintaining Gut Function and Structure (1 contact hours) Bristo, Worden • Integration of Care with Pharmacy/ ADA Drug Updates (1 contact hours) Worden • Heart Healthy Lifestyle Counseling (1 contact hours) Worden • Enteral Feeding Tubes (1 contact hours) Worden • Making Safe Enteral Tubing Connections (1 contact hours) Worden Additional continuing education was documented for three back-up team members (OTs and SLP). The extent of continuing education obtained by this group of clinicians was commendable and exceeded 12 hours per year for each team member. Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is maintained for all team members, individually and collectively via cross-training. <u>PNMT Meetings</u> The PNMT Meeting Review form had been implemented in 2012. This information was completed by the IDT and PNMT members to ensure that current information was available for discussion and review. • 37 of 37 PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (c) PNMT actions, (d) follow-up, and (e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The meeting minutes were maintained in an action plan format and also included the following elements: • Attendance • Individual reviewed (referrals and active caseload)	

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		• Current weight • Ideal body weight range • Level of PNMT involvement • Reason for referral • PNMT goals • Discussion • Recommendations • Due dates • Date of next review Other issues tracked for review, discussion, and action included: hospitalization, change in health status, and weekly incident reviews (choking, pneumonia, skin breakdown, falls, fractures, weight loss, dysphagiagram, and other). Incident dates, risk levels associated with the incident, level of PNMT involvement needed, recommendations, and due dates were addressed for each individual who experienced an incident in these categories. Other documentation contained in the weekly summary included PNMT oversight tracking, PNMT data analysis, and discussion of training and policy/procedures. Meeting minutes were submitted for 12/5/12 to 8/14/13. There were no signature sheets, but attendance was clearly and consistently tracked in the minutes. Since the last onsite review, the team met 37 of 38 weeks (97%) and met two times in one of those weeks, exceeding the criterion of 90%. Based on review of the minutes, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: • RN: 34/37 (92%) attendance by core member, 3% for back-up, 92% overall. • PT: 31/37 (84%) attendance by core member, 3% for back-up, 86% overall. • OT: 34/37 (92%) attendance by core member, 3% for back-up, 95% overall. • SLP: 35/37 (95%) attendance by core member, 3% for back-up, 97% overall. • RD: 34/37 (92%) attendance by core member, 3% for back-up, 95% overall. Attendance was generally above criterion of 80% for core team and 90% overall, though slightly lower for PT. The core team PT absences had generally occurred prior to the designation of a back-up and, since 6/5/13, she had 100% attendance. • For 10 of 10 individuals in Sample 0.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. A number of IDT members attended 100% of the 37 meetings. This provided significant opportunities for collaboration with assessment, planning, implementation of interventions and actions, follow-up, and monitoring. These team members included, but were not limited, to RN Case	

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		Managers, DSPs, home managers, psychologists, QIDPs, and parents. When the IDT was not able to attend due to conflicts in the schedule, the review was rescheduled so that the team members could attend. IDT members signed each of the five PNMT assessments submitted for review. Further the PNMT attended numerous ISPs and ISPA meetings for the individuals they reviewed or who were referred to the PNMT. • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies in place and evidenced in the monthly QA reports. There was a system of corrective action plans in the case that system issues were identified in the process of individual assessment. The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies in place and evidenced in the monthly QA reports. There was a system of corrective action plans in the case that system issues were identified in the process of individual assessment and review, requiring corrective action. For example, a recent issue was discussed related to lack of consistent and accurate documentation in the trigger data sheets. The PNMT, in corrective action plans, included home manager monitoring that the data forms were completed correctly and the nursing conducted retraining related to the necessary review of these forms. There was a Recommendation Tracking log that included tracking of individual-specific recommendations, as well as follow-up on actions related to corrective plans (e.g., weights and documentation). Section O requires that the PNMP 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. Also, the PNMP is to be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. This aspect of O.1 is reviewed in O.3 below. The monitoring team finds SGSSLC in substantial compliance with the elements of this provision.	
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	<u>Identification of PNM risk</u> All individuals at SGSSLC identified with PNM needs (147 per the list submitted) were provided a PNMP, thereby ensuring that, as per the Settlement Agreement, each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration, collectively, "individuals having physical or nutritional management problems") were reported to be provided a current PNMP. There were 61 individuals identified with no PNM needs.	Noncompliance

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	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.	Based on lists of individuals with identified PNM concerns, there were individuals who required positioning assistance associated with swallowing (34 individuals), were dependent on others to eat (11 individuals), had difficulty swallowing (65 individuals), and/or were considered to be at medium or high risk of choking (approximately 110 individuals) or aspiration (approximately 58 individuals). Of those identified as requiring positioning assistance associated with swallowing, each was listed with a PNMP. Of those identified as not able to eat independently, each was listed with a PNMP. Of those identified with difficulty swallowing, only one was not listed with a PNMP (Individual #314), though he was not included in the census list submitted at the time of this onsite review. • 147 of 147 individuals (100%) who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, and/or who was at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. • There were six incidents of choking documented from 10/1/12 through 5/31/13 for Individual #21, Individual #381, Individual #77, Individual #26, Individual #304, and Individual #31. Four incidents were described as "self-clear choking" with no Heimlich required. The Heimlich was successfully performed for two (Individual #77 and Individual #26). A PNMP was in place for each (except for Individual #304 who had moved to the community by the time of this onsite review, however, a PNMP had been in place at that time). In three cases, the SLP assessed the individual, though the time frame for review varied: Individual #31 and Individual #77 (the following day), Individual #26 (seen two days later with documentation four days later), and Individual #21 (several hours later that same day). It was standard practice to reduce the texture following a choking event as a precaution. Though this was typically an appropriate step, there may be a number of other issues unrelated to diet texture that may have caused the choking. Observation by the SLP prior to the next meal would be indicated. An on-call system for Habilitation Therapy was currently in place that would permit this in cases where an event occurred outside of regular work hours. This number of near-choking and actual choking events during a seven month period (10/1/12 to 5/31/13) was of concern to the monitoring team. Three of these had occurred during the previous review period (June 2012 to early December 2012) and three since that time. Three events occurred in December 2012 and one only since 1/1/13. With the exception of Individual #21, there was evidence that each of the individuals who were reported with a near-choking or actual choking event had been monitored at least quarterly. This was of further concern because Individual #21 had two choking incidents in a one year period (7/20/12 and 10/3/12). He was actively followed by the PNMT per the weekly summary dated 12/13/12. Routine review of plans related	

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		to effectiveness and staff compliance with implementation is critical to ensure that PNMPs/Dining Plans are effective in mitigating identified risks for choking on an individual basis to prevent choking as well as careful and consistent follow-up after such an event to ensure that the plan continued to work as expected. The existing staff compliance system was based on a sample, which is generally an appropriate approach to assessing implementation of plans, however, after a choking or near choking event, greater scrutiny may be required for a period of time to ensure that changes made to the plan were properly implemented and were effective. It was also noted that the on-call system was implemented as of 8/1/13 to ensure that there was immediate notification and timely intervention for any unusual incidents related to PNM, such as choking. The weekly incident reports reviewed by the PMNT identified choking events, near choking events, and cough with struggle. Needs for review and follow-up were discussed at that time. Follow-up actions were to be tracked through to completion (Individual #90 and Individual #31), though follow-up was not always evident (Individual #50 and Individual #26). Improvements were noted in the completion of the risk rating tools, as evidenced by the ISPs attended during this onsite review and based on review of those submitted. Action plans were not provided in the same manner as during the previous review. Rather, the plans to address specific health risk issues were included in the IRRF and IHCP (integrated plans developed collaboratively with IDT members). <u>PNMT Referral Process</u> Criteria for IDT referral were included in the SGSSLC Physical Nutritional Management (effective 7/1/13) as follows: • Any hospitalizations or diagnosis of aspiration pneumonia; • Decubitus: Two or more Stage II in one year, or any Stage III, IV, or any wound with delayed healing; • Weight: Verified significant unplanned weight loss defined as 5% in one month, 3 or more pounds or 7.5% of body weight per month for 3 consecutive months, or 10% in 6 months; • Hospitalizations due to bowel obstruction in the past year; • Any consult that requires additional assistance by PNMT such as abnormal swallow sturdy, upper GI, or EGD or hospitalization for GI bleed; • Fracture of a long bone, spine, hip, or pelvis • Unresolved triggers (as identified by trigger data sheet); • New or proposed gastrostomy tube for enteral nutrition or reversal of G-tube for transition to oral intake; • Any nutritional or physical concerns not successfully resolved by IDT for HIGH	

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		risk respiratory compromise, skin integrity, or seizures; • Unresolved vomiting (3 or more episodes in 30 days, not related to viral infections); • Two episodes choking in one year; and • Unresolved fall episodes greater than 3 per month for 2 consecutive months. The PNMT had a system for IDT referrals outlined in the policy. The IDT completed the referral form (which had recently been simplified) or the physician wrote an order. The PNMT could self-refer based on the post-hospitalization assessment completed by the PNMT RN. The PNMT was to meet within five days of the referral to review and determine their level of involvement required for each case (direct service or consultative service). When services were indicated, a PNMT representative attended the ISPA to discuss recommendations. From June 2012 to June 2013, there were 29 individuals referred to the PNMT with three referred twice during that 12 month period (Individual #17, Individual #112, and Individual #40). Seven of these were listed as self-referrals. Reasons for referrals listed included the following: • Pneumonia • Aspiration pneumonia • Weight loss • Dementia • Falls • Increase in aspiration triggers • Choking incidents • Constipation • Frequent UTI • Decreased mobility • Exacerbation of COPD • Respiratory compromise • Hospitalization for bowel obstruction • New gastrostomy tube • Pressure ulcers Stage II • Cyst in Liver (guardian request) • Left craniotomy due to large subdural hematoma • Chronic subdural hematoma • Bacteremia right knee It was difficult to determine which of these met the guidelines outlined above, though all were referred prior to implementation of these specific guidelines. While these were developed as guidelines for the PNMT, other individuals were followed as deemed necessary by the team based on individual circumstances, as per policy.	

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		Twenty-four referrals were listed as active, while eight others were identified as consults or monitoring. There were 11 individuals on the active caseload for the PNMT at the time of the monitoring team's document request. • 5 of 5 individuals in the sample O.1 (Individual #287, Individual #210, Individual #203, Individual #294 and Individual #134) referred to the PNMT within the last six months were appropriately referred per the facility policy (per criteria and within five days). Most of these were referred at the time of hospital discharge or no more than 48 hours later. Others in the sample were previously referred per criteria and in a timely manner (Individual #7, Individual #77, Individual #104, Individual #251), or were already on the PNMT caseload at the time of the event. In the case that there had been a hospitalization, the PNMT RN completed an assessment, concluded whether a referral was indicated, and met with the IDT to initiate. Some individuals had experienced numerous falls, and although not exactly meeting the criteria, they likely would warrant review (e.g., Individual #52, Individual #46). There were likely others, but the spreadsheet related to falls involving an injury appeared to list one fall with multiple injuries so it was not possible to track how many falls actually occurred. Falls with and without injury must be considered when determining a need for referral to the PNMT. An improved tracking system for falls should be considered. The following metrics did not apply because there were no new tube placements for enteral nutrition during the last year. • __ of __ individuals who received a feeding tube (not on an emergency basis) since the last review (%) had been referred to the PNMT prior to the placement of the tube. • _____of _____individuals who received an emergency feeding tube placement (%) since the last review had been referred to the PNMT after the emergency feeding tube placement. Incidence of conditions in various PNM-related risk areas were tracked by the team based on data derived from a variety of sources and entered into the PNMT meeting minutes. This practice was intended to identify needs for supports and interventions early, rather than waiting for significant health issues to occur before action was taken. Issues tracked included the following: • Weight • Fractures • Falls • Skin Breakdown	

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		• Pneumonia • Choking • Hospitalizations/Change in Health Status • New Enteral Tube Placement • Other A PNMT meeting was observed by the monitoring team. IDT members and Dr. Jolivet were present. The PNMT continued to improve its process for review. A computer and a projector were available for use. The discussion was thorough and the team members appeared to be very familiar with the status of the individuals discussed. The IDTs were not merely guests or observers, but were active participants. This was reflected in multiple IDT members in attendance at all meetings for which minutes were submitted. <u>PNMT Assessment and Review</u> The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status, with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Based on review of the assessments in the last two months (Individual #134, Individual #145, Individual #294, Individual #287, and Individual #210), the comprehensiveness of the PNMT assessment components was as follows: • 5 of 5 PNMT assessments submitted (100%) were initiated at a minimum within five working days of the referral; • 3 of 5 PNMT assessments (60%) were completed in 30 days or less of the date of referral. Assessments for Individual #287 and Individual #145 were completed in 35 days and approximately six weeks respectively; ; • 5 of 5 (100%) contained date of referral by the IDT (or self-referral); • 5 of 5 (100%) contained date assessment was initiated; • 5 of 5 (100%) contained evidence of review and analysis of the individual's medical history; • 4 of 5 (80%) identified the individual's current risk rating(s), including the current rationale. The identification of risk levels was incomplete for Individual #287. • 4 of 5 (80%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data; • 3 of 5 (60%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; • 5 of 5 (100%) contained assessment of current physical status. The assessment reported relevant findings from previous assessments as well as identified	

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		current assessment needs with a rationale in most cases. The purpose of the PNMT is not merely to review the supports provided by the IDT, but also to present a new perspective on the individual's status, history, issues and supports and this was consistently noted in the PNMT assessments reviewed; • 2 of 5 (40%) contained assessment of musculoskeletal status. This was incomplete, though likely appropriate for Individual #145 at the time of the PNMT assessment due to non-weight bearing status secondary to hip fracture; • 2 of 5 (40%) contained evaluation of motor skills; • 3 of 5 (60%) contained evaluation of skin integrity; • 4 of 5 (80%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning. There was no evidence that the PNMT addressed positioning that may impact PNM status including during bathing and oral hygiene; • 0 of 5 (0%) contained evaluation of current adaptive equipment; • 3 of 5 (60%) contained nutritional assessment, including, but not limited to, history of weight and height; intake, nutritional needs, and mealtime/feeding schedule; • 4 of 5 (80%) contained a list of medications with potential side effects listed. None reflected potential or actual drug/drug and drug nutrient interactions. Few addressed actual or suspected side effects, or ruled this out if it was not an issue; • 0 of 0 (NA) identified residual thresholds, if enterally nourished. No one received enteral nutrition per the evaluations submitted. • 2 of 5 (40%) contained a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation; • 5 of 5 (100%) contained information about the individual's current respiratory status based on a physical assessment that included, but not limited to, respiratory rate, heart rate, lung sounds, breathing patters, or oxygen saturation levels. • 1 of 5 (20%) contained evidence of review/analysis of lab work, though how this was done was inconsistent; • 5 of 5 (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. Changes in medications and/or doses were not reported consistently, nor was the start date for current medications prescribed; • 4 of 5 (80%) contained discussion as to whether existing supports were effective or appropriate; • 5 of 5 (100%) contained oral hygiene status. None documented observation of oral hygiene/toothbrushing by the team. Not only is oral hygiene status an important element to consider, position and other techniques related to	

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		toothbrushing should also be investigated to rule out any concerns that potentially increased the individual's risk of aspiration. • 5 of 5 (100%) contained evidence of observation of the individual's supports at their home and/or day/work programs; • 5 of 5 (100%) contained evidence that the PNMT conducted hands-on assessment; • 5 of 5 (100%) identified the potential causes of the individual's physical and nutritional management problems; • 3 of 5 (60%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; • 1 of 5 (20%) contained recommendations for measurable skill acquisition programs, as appropriate; • 5 of 5 (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; • 3 of 5 (60%) contained measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but there were no specific indicators for when nursing staff should contact the PNMT; • 4 of 5 (80%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); • 4 of 5 (80%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 1 of 5 (20%) contained signatures of all core team members (or alternate), but dates by the PT were omitted in most of the assessments reviewed. Compliance with each of the 33 elements outlined above was 100% for 36% of the elements. Seven others were rated at 80% with all others at 60% or below. In some cases, it appeared to be difficult to get a clear idea of the individual's mobility status. For example: • Individual #287 was reported to have returned to baseline status with ambulation without use of adaptive equipment. There was no description of a previous loss of independence. The assessment stated that he had returned to his baseline functional status, but this was not described. • Individual #294 was reported to have a change in his functional status following a left subdural hematoma with uncal herniation with craniotomy (3/3/13) and frontal left subdural hematoma. It was reported that the existing wheelchair was not appropriate for him and that a wheelchair assessment was needed. It was not clear why this was not completed. Further it was reported that OT and PT were	

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		to evaluate for strengthening and ROM to prevent contractures. It was not clear why this was not completed by the PNMT at the time of their assessment. • The PNMT nurse provided the most information about the mobility status for Individual #134. There was no evidence of his motor abilities identified through assessment by OT or PT. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. These should be integrated into the individuals' IHCPs. The IHCPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the IHCP interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, staff were adequately trained, etc. If the team determined interventions were not effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern was critical, when a change was indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were at least 12 individuals who had been referred to the PNMT who were included in Sample O.1. Documentation available for review was as follows: • PNMT Assessment (within last 12 months): Individual #134, Individual #145, Individual #287, Individual #210, Individual #294, Individual #38, Individual #150, and Individual #251 • Current ISP: Individual #203, Individual #344, Individual #7, Individual #38, Individual #251, Individual #287, Individual #294, Individual #77, and Individual #134, Individual #203, and Individual #77. • Current IRRF: Individual #287, Individual #134, Individual #38, Individual #7, Individual #150, Individual #210, Individual #344, Individual #251, Individual #294, and Individual #145 • Current IHCP: Individual #344, Individual #38, Individual #287, and Individual #145. • Current PNMP: Individual #203, Individual #344, Individual #7, Individual #38, Individual #251, Individual #287, Individual #294, Individual #77, and Individual #134, Individual #203, Individual #77, Individual #210, Individual #150, and Individual #145. Comments on the plans resulting from PNMT recommendations are below: • Plans did not consistently address the individual's identified PNM needs as	

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		presented in the PNMT assessment. Specific recommendations could not be clearly tracked across most plans for implementation. • There was no evidence that an ISPA was held to review the PNMT assessment findings and to document integration into the ISP, IRRF, and IHCP. In some cases there was evidence that, at some time, the IRRF was revised to reflect recommendations by the PNMT and the PNMP was typically updated to reflect recommended changes. An IHCP was not submitted for many of the individuals. • Specific clinical indicators identified by the PNMT were not consistently reflected in the plans. • Triggers identified were not consistently included in the various plans. • The recommended frequency of monitoring for various aspects of the plans was not clearly outlined. • For 4 of the 5 individuals (80%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into the PNMPs. It was not possible to track this in each of the plans. • In 12 of the 12 assessments reviewed (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plans. These did not consistently translate to the various plans, however. • Timeframes were clearly established in the PNMT meeting minutes, but these did not consistently translate to the plans reviewed. The PNMT also consistently documented in the IPNs to update the status of the individual and actions required, but the integration into the individual plans was not routinely evident. <u>PNMT Follow-up and Problem Resolution</u> • For 2 of 9 individuals, the actions outlined in the PNMT meeting minutes were clearly addressed within the time frames established. Up to three actions were randomly identified and tracked through to documented completion to assess this element. In a number of cases this was documented in IPNs, but was not captured in the minutes. Each of the recommendations identified in the PNMT assessment was not clearly and consistently tracked through to completion for each individual reviewed. A number of actions were discussed with a due date, but was not clearly addressed at that time. This was easier to see in the PNMT Recommendation Log. This log confirmed that many were not completed as per the due dates. It did not appear to track the recommendations that were included in the original assessment, but most were those identified as interventions and supports required as a function of ongoing review. Intervals of PNMT review were typically noted as monthly or quarterly. A system that addresses implementation of recommendations and other actions should permit the PNMT (meeting minutes) and	

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		others to readily review this information (IPNs). The IPNs were consistently utilized by the PNMT, but did not accurately reflect actions taken, with outcomes and dates of completion. There was often no explanation for delays in completing the action steps outlined. Guidelines for these were in development. <u>Individuals Discharged from the PNMT</u> Per the list submitted, there were 17 individuals discharged from the PNMT from 1/1/13 through 8/14/13. Of these, two had been discharged to hospice and three had expired. Three of these 17 were included in the sample O.1 selected by the monitoring team. For individuals discharged by the PNMT: • 0 of 3 individuals (0%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. • 2 of 3 individuals' discharge summary/action plan (67%) provided objective clinical data to justify the discharge. • 0 of 3 individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. • 0 of 3 individuals' ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or IPN by the PNMT. All outstanding recommendations should be integrated into the IHCP with specific criteria established for referral back to the PNMT. An ISPA should be held to discuss the terms of discharge. Meeting minutes should reflect status updates and actions taken by the team for each individual they review. This should provide them with an easy method to review their work and individual status without having to sort through IPNs. As stated in previous reports, an effective PNM program requires that the referral to the PNMT must occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner. At this time, the SGSSLC PNMT appeared to understand this responsibility and referrals and assessments were completed in a timely manner. The team is commended for its hard work, expertise, and follow-up. The monitoring team concurred with SGSSLC that they were not in substantial compliance with this provision of Section O at this time. To move in the direction of substantial	

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		compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Assessments should be initiated within five days of referral and completed within 30 days. 2. PNMT recommendations should be addressed by the IDT and documented via the ISP process, generally with an ISPA to integrate all findings (though this may be via the IHCP, PNMP and IRRF). While all recommendations may not be implemented by the IDT/PNMT, each should be discussed with rationale documented to accept these or not. 3. Documentation should clearly identify the completion of all recommendations and subsequent actions required and specify outcomes as indicated. 4. Address toothbrushing and bathing position via actual observations in the PNMT evaluations and OT/PT evaluations.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>Identification of Individuals Requiring a PNMP</u> In section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. Attendance by key IDT members for review and approval of the PNMP included the following for current ISPs with signature sheets (12/15): • Medical: 8% (1/12) • Psychiatry: 18% (0/12) • Nursing: 100% (12/12) • RD: 25% (3/12) • Physical Therapy: 42% (5/12) • Communication: 75% (9/12) • Occupational Therapy: 42% (5/12) • Psychology: 100% (12/12) • DSP: 75% (9/12) • Dental: 25% (3/12) • Pharmacy: 0% (0/12) 12 of 13 PNMPs (92%) were reviewed by the individual's IDT in the annual ISP meeting (ISP current within the last 12 months). This included evidence of review, update/revision, effectiveness, and specified changes required with rationale.	Noncompliance

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		It is not 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 cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the key team members is present to participate in that process. The new pre-ISP process will identify which team members are required to attend the ISP meeting and the needs for review of the PNMP should be considered when making this determination. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 15 of 15 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 15 of 15 individuals (100%) included a list of PNM risk levels. This was consistent with the previous review. • In 1 of 15 PNMPs (7%), there were large and clear photographs with instructions. Only one plan had photographs for staff reference. This was an improvement from 0%. • 15 of 15 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified. • In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was an improvement from 95%. • In 15 of 15 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was an improvement from 95%. • In 15 of 15 PNMPs (100%), bathing instructions were provided. This was an improvement from 95%. • In 14 of 15 (93%) PNMPs, toileting-related instructions were provided, including check and change. Not addressed for Individual #210. This was an improvement from 0%. • In 0 of 15 (0%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. This was a decrease from 29%. • In 15 of 15 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 15 of 15 individuals' (100%) Dining Plans were current within the last 12 months.	

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		• 2 of 15 individuals had feeding tubes with no oral intake. 0 of 0 PNMPs/dining plans (0%) specifically stated that the individual was to receive nothing by mouth. This was consistent with the previous reviews. • In 15 of 15 dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was consistent with the previous review. • In 13 of 13 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 13 of 13 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was an improvement from 89%. • In 13 of the 13 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular dining utensils. This was an improvement from 89%. • In 15 of 15 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was consistent with the previous review. • In 15 of 15 PNMPs (100%), oral hygiene instructions were included. Positioning was most often omitted. This was an improvement from 95%. • 6 of 15 PNMPs (40%) included information related to communication (how individual communicated and how staff should communicate with individual). While this was consistent with the previous review, again most did not offer strategies for staff use as a communication partner. Some merely referred staff to the communication dictionary, but offered no guidelines for how staff should communicate with the individual. The PNMPs reviewed were generally excellent, with comprehensive content in most areas. The plans typically used a person-first approach ("I need a gait belt and staff assistance when walking long distances"). PNMP audits were conducted by committee (eight per month) for PNMPs for individuals who just had an ISP and some others that were drafts prior to the ISP as a sample. Instructional guidelines were developed to ensure consistency and attention to the areas described above will ensure greater consistency and improved content. Additional findings included the following: • 75% of the essential elements were noted in 100% of the plans. • 80% of the essential elements were noted in 93% or more of the plans. • 40% of the elements were maintained at 100% since the last review. • 45% of the elements reflected improvements since the last review. • 5% (one element) reflected a decrease since the last review.	

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		There were a limited number of IDT members present at the IDT meetings in which PNM risk was established and the elements of the PNMP should be reviewed, though a greater number of ISPs documented actual review of these plans. The PNMPs continued to improve and move toward the criterion of 100% of the elements in 90% of the sample plans. The monitoring team concurred with the facility that they were not in compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. IDTs need to consider review of the PNMP when determining who is required to attend the ISPs. 2. Address the areas of the plans that were deficient above (photographs, communication, designation of NPO, movement and handling precautions).	
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>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were readily available in the dining areas and PNMPs were typically in the individual notebook. General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists and PNMPCs. Based on observations conducted by the monitoring team, it was noted that: • 22 of 36+ individuals' (61%) dining plans were implemented as written. • 31 of 43+ individuals' (72%) PNMPs related to positioning and mobility were implemented as written or alignment and support were consistent with generally accepted standards. Based on additional observations: • 1 of 2 (50%) individual's oral hygiene plans were implemented appropriately or consistent with generally accepted standards. • 1 of 9 (11%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. • 0 of 1 (0%) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. Some additional comments: • The findings highlighted above related to implementation and staff compliance were not consistent with the findings reported in the self-assessment. • TED hose for Individual #203 were not tight. Staff stated they were only used to protect her skin with AFOs. • The bathing transfer for Individual #203 was of significant concern. The gait belt was positioned across her g-tube and handling techniques were unsafe as staff	Noncompliance

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		did not lower the Arjo to allow her feet to be in contact with the floor and before they stood her up. They used her underarm area to lift her to standing. • Individual #38 had just finished his morning routine, yet was in very poor alignment in his wheelchair. He was leaning to the left, his hips were not back in the wheelchair, the seatbelt was very loose, and his feet were not supported. Individual #38 was identified at very high risk of aspiration and had a significant history of aspiration pneumonia. • Staff tilted Individual #145 back for repositioning without telling him first. • DSPs and home manager in 516W did not appear to recognize improper positioning and did not appropriately reposition individuals when prompted. • Individuals in home 510A, were seated at the dining tables for more than 20 minutes without food being served. The majority of staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan, most with minimal prompts. Staff should not routinely need to refer to the plans to answer these types of questions. Review of the plans and risks should be done when the staff are initially assigned for the day, and reviewed prior to implementation. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • The staff were assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. • Staff should review plans just prior to implementation of strategies, particularly at mealtime. The monitoring team concurred with the facility that they were in noncompliance with this provision. While improvements were noted, the rate of errors observed continued to be too high, though the facility's self-monitoring for staff compliance was not consistent with the monitoring team's observation. The monitoring system was revised as a result. This system is established per policy and QA elements for tracking were developed. A number of other initiatives were reported to address concerns with staff compliance. Mealtime Coordinator training was developed initiated in April 2013 and completed in June 2013. At this time, it was reported that there were insufficient staff assigned for implementation. Once implemented, the Mealtime Coordinators will be monitored for their role performance by the home managers. The annual refresher training was revised	

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		to improve the content. As more staff attended this training improved compliance was anticipated. Special weekly training topics were also initiated for staff in their assigned homes. Staff will be competency checked across the day with informal training occurring to reinforce learning. Tool rings that served as staff references had been revised as well.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills, taught by PNMPCs. Class time was included at least two days (and an additional four hours when necessary) to address the PNMP, lifting and transfers, and dining plans and eating skills. Content included risk guidelines, aspiration pneumonia, philosophy of PNM and policy and procedures, lifting and transfers, positioning, mealtime, equipment, communication, and monitoring. The content, based on review of the curriculum materials, was very comprehensive. The curriculum for communication was addressed in section R of this report. There was a presentation of foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies. Shadowing was then conducted prior to new employees being permitted to work independently on their assigned homes. At that time staff were trained for each PNMP and Dining Plan on the assigned home as well as, individual specific (non-foundational skills) competencies. All home-based check-offs were completed 30 days after the NEO classroom training. Staff were coached and retrained until competency was established. In the case that staff did not pass NEO, they were rescheduled for classes. There were no clearly established criteria in the policy related to actions required for staff who were persistently not able to pass the core competencies. There were a number of core competencies including: • PNMP/Dining Plan review • Safe mealtime management • Positioning in wheelchair • Positioning in bed • Positioning during activities • Communication • Assisted mobility and transfers • Lifting • Stair chair • Mechanical lifts/Sara lifts There was a system to establish and maintain competency for staff who provided the	Noncompliance

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		training, conducted by the Director and PNMPC Supervisor on annual basis. The PNM-related core competencies (i.e., foundational skills), included in the NEO training appeared to be comprehensive. There were a number of associated knowledge and skills-based competency check-offs for most of this content. It was reported that 100% of staff were identified as competent in PNM skills taught in NEO. Failed skill drills and staff who failed more than one skill drill were tracked for each area. <u>PNM Core Competencies for Current Staff</u> Refresher courses for all existing staff were required annually for lifting and transfers and eating skills. Skills-based competencies were also required. Consideration for an additional refresher course related to communication had been added. Staff were coached and retrained until competency was established. In the case that staff did not pass refresher training, they were rescheduled for class. There were no clearly established criteria in the policy related to actions required for staff who were persistently not able to pass the core competencies. There were 22 staff who were delinquent in completion of the lifting refresher course as of 8/15/13. <u>Individualized Non-Foundational Training</u> The facility was in the process of implementing a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. At this time, there were only a few individuals that would require this for implementation of their PNMPs. The monitoring team looks forward to review of this during the next onsite visit. <u>Other Training</u> When changes were made to existing plans, staff were re-trained on the plans. Samples of training records for dining plans were submitted for four individuals in Sample O.1 (Individual #251, Individual #134, Individual #38, and Individual #287). In each case, the training was conducted by a licensed clinician and staff trained included the PNMPC supervisor, the home manager, nursing and one or both PNMPC(s), as well as, the DSPs. Compliance monitoring was completed subsequent to the training. Training was provided as follows: • PNMPC Supervisor (4 of 10, 40%) • Home Manager (4 of 10, 40%) • Nursing (6 of 10, 60%) • PNMPC (6 of 10, 60%) • Both PNMPCs (1 of 10, 10%) • DSPs (10 of 10, 100%) There was no system to ensure that pulled staff were trained to competency to implement	

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		plans. While progress was made in this area, the facility self-rated noncompliance with this provision and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Carefully audit the level of coaching provided for check-offs. Observations by the monitoring team indicated that the PNMPCs were likely providing significant coaching in order to pass staff, rather than permitting them to fail and providing retraining at another time. Otherwise, they are essentially "teaching to the test" rather than establishing actual competent skill performance. 2. Develop system to address training for pulled staff. 3. Address the selection of the sample used for compliance monitoring and ensure that all staff are routinely re-checked for competency in the implementation of plans.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> SGSSLC had discontinued use of the Universal Compliance Monitoring Form developed by the state. The elements of the form were very general and it made it difficult to identify more discrete issues for tracking and analysis. New monitoring forms that included more discrete measures were developed, so that specific issues could be more readily identified for individual and/or systemic change. These areas included safe mealtime, communication, assisted mobility and transfers, PNMP/dining plan review, lifting, positioning-bed, positioning-wheelchair, and positioning during activities. There was no clearly established frequency to conduct staff compliance monitoring, though 16 tools were completed per area across each of the three shifts. If the staff did not pass an element of the initial compliance check, additional training was provided at that time. If compliance was below 80%, retraining was conducted and the staff was rechecked for compliance. This process was repeated if the staff failed the second competency check, though an alternate PNMPC conducted the third check-off. In the case, the staff failed a third time, the employee's supervisor was notified with a recommendation to attend the next scheduled annual refresher. While the department had the ability to track staff names, these were not used to ensure that all staff were routinely monitored. It was likely that some staff were not monitored routinely for continued compliance with plans for which they were deemed to be competent. Inter-rater reliability were completed within three months of new hire and repeated annually. The monitoring team requested compliance monitoring forms that were completed in the last month by OT and PT, and monitoring forms completed for individuals included in	Noncompliance

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		Sample O.1 for the last three months. There were 103 Compliance Skill Drill Forms completed by the PNMPCs during May 2013. Forms were submitted for different areas: • PNMP Review (11) • Safe Mealtime (13) • Communication (12) • Transfers and Mobility (21) • Positioning in Bed (15) • Wheelchair Positioning (19) • Positioning During Activities (12) Monitoring was completed across all shifts for each area. Completion was as follows: • 46 forms (45%) were marked on the 6-2 shift. • 57 forms (54%) were completed on the 2-10 shift. Compliance scores were calculated for 100% of the forms submitted. Scores ranged from as follows: • 100%: 32 • 95%: 1 • 90%: 19 • 80%: 19 • 60%: 1 • Compliance score calculated improperly: 23 • Multiple trials required: 8 The calculations of compliance scores were not accurate in the cases where elements were "NA." For example, a transfers and mobility monitoring was conducted on 5/6/13. There were two items scored "N," six scored "Y," and two "NA." Rather than 10 items, there were only eight applicable, so the actual score was 75% rather than 80%. In that case the staff would not be in compliance. In other cases, the score remained the same, as with scores of 100%, but others would skew the averages calculated for analysis. Further, in the case that staff failed the compliance drill, they were immediately retrained and a re-drill was conducted by the PNMPC assigned to that caseload. In each of these cases, the staff achieved 100% the second time. If this was recorded for analysis, it would appear that this would skew the results. Another concern was noted that staff could miss some very key elements and still be considered to be in compliance. For example, on 5/6/13, one staff was monitored for wheelchair positioning. He did not check the hips or the feet and legs, yet scored an 80% (i.e., in compliance). These issues related to the current system may be skewing the findings enough that the compliance scores do not accurately reflect staff performance.	

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		That said, competency and compliance results for staff observed in homes 516 East and West by the monitoring team. Staff that were interviewed that demonstrated knowledge and compliance with mealtime plans had recently participated and passed the revised annual refresher training. In addition, compliance checks that were conducted demonstrated results that correlated with what was observed during the mealtime interview. The staff observed had recently failed compliance drills in other areas. There were no drills noted for mealtime. This is a key issue for the facility to examine. As stated above a failed drill, repeated immediately after retraining would likely not reflect actual competency at the level scored the second time (in most cases 100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Identify and correct scoring issues related to the monitoring forms.	
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>Effectiveness Monitoring</u> There was also a system established for routine evidence of effectiveness monitoring by the therapists. There were 35 PNMP monitoring forms for 34 individuals submitted for May 2013 by OT or PT. Two plans were missing pages and could not be reviewed. These were focused on compliance for implementation as well as a review of plans and equipment to determine if they were effective to address the identified needs. Per the local PNM policy, individuals with PNM needs were to be monitored at least quarterly for effectiveness, or more often based on level of risk and the intensity of supports and services required. Of the monitoring sheets submitted, approximately 63% were completed at least quarterly, while three were first time monitoring for new programs or new admissions (Individual #248, Individual #243, and Individual #398). The others reflected effectiveness monitoring anywhere from four to 10 month intervals. Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring was requested for 12 months. Based on the submission quarterly effectiveness monitoring was documented at least quarterly for 6 of 15 individuals in the sample (40%). It was noted in some cases that the monitoring was conducted by a therapy assistant. While the monitoring was appropriately done, the facility should use caution in permitting the assistant to make a clinical judgment as to actual effectiveness of the programs and plans. The facility reported that therapy assistants were allowed only to complete chart review and staff interview for program effectiveness monitoring. Therapy assistant were not allowed to document program effective analysis in the active record. Therapists were to be the ones to complete analysis and to document program effectiveness analysis in the active record.	Noncompliance

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		There was a form serving as a worksheet for review and used for data entry. In each case, there was an IPN that stated effectiveness monitoring was completed, though findings were inconsistently documented there. The policy outlined the required content of these notes, though very few actually met those requirements. A number of these were completed prior to the establishment of this policy. In the current manner, effectiveness of the strategy as implemented was addressed as well as the effectiveness related to health and/or safety concerns. Review of specific health concerns for which the specific strategy was intended to address were also reviewed. Effectiveness monitoring should include programs across all environments and not only in the home. Spreadsheets maintained by the Habilitation Therapy department included supports and services provided, PNMT Trigger Log and summary, and findings from effectiveness monitoring. The effectiveness monitoring spreadsheet should track the timeliness of the monitoring in addition to the findings. There were approximately 35 individuals seated in wheelchairs as their primary means of mobility, and approximately 14 who required wheelchairs for distance and transport. It could not be determined from the maintenance log whether monthly maintenance checks were conducted for wheelchairs or other assistive equipment, though individuals appeared to be seen routinely. All were listed as requests, though general maintenance was routinely listed as completed. Most appeared to be completed on the same day, or within 24 to 48 hours. A very few required up to a week. More extensive work related to a new system or modification occasionally required several months. It was a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Audit IPN documentation to ensure staff were following the established guidelines. 2. Address effectiveness monitoring across all aspects of the plans or other indirect supports and services. These should occur across all environments and not only in the home. 3. Ensure the tracking system tracks timeliness of effectiveness monitoring as recommended, in addition to the findings.	

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O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Individuals Who Received Enteral Nutrition</u> There was a list of individuals who received non-oral intake that identified approximately 8 individuals (and one other, now deceased) who received enteral nutrition (4% of the current census). None were listed as having received new tube placements since the previous review, though Individual #210 had received a gastrostomy tube and was not included on this list. All were NPO, or nothing by mouth at this time. Two individuals were listed with poor oral hygiene, increasing their risk for aspiration pneumonia (Individual #66 and Individual #217). Four individuals were noted with at least one incidence of pneumonia in the last six months (Individual #217, Individual #203, Individual #90, and Individual #210). Individual #38 and Individual #78 had multiple incidents of pneumonia (Individual #78, three, and Individual #38, two), though neither were categorized as aspiration pneumonia. Four were listed with aspiration pneumonia (Individual #210, Individual #203, Individual #18 and Individual #134), while six others were listed as bacterial pneumonia, and four were not categorized. <u>Evaluation of Individuals who Received Enteral Nutrition</u> Ten APENs were requested and only one was submitted as completed since the previous review. It was not clear why none of the other individuals were assessed in the eight months since the previous review. • 1 of 13 individuals (8%) who received enteral nutrition and or had aspiration pneumonia in the sample were evaluated at a minimum annually. • 1 of 11 individuals (9%) with enteral nutrition had an assessment to determine the medical necessity of the tube. Assessment of oral motor status by the SLP and/or OT did not provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate for any assessment based on the APEN submitted. No one admitted to SGSSLC since the previous review received non-oral intake, so the following metric did not apply: • ___ of the ___ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • 1 of 11 individuals who received enteral nutrition had been evaluated by the IDT to determine if a plan to return to oral intake was appropriate, though this was incomplete. It did not clearly reflect assessment by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual was a	Noncompliance

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		candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake, but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. • 0 of 1 APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the least restrictive or there were potential modifications needed in preparation of transition to oral intake. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Proceed with plans to establish protocol related to the completion of assessments on an annual basis to determine the medical necessity of all individuals with enteral nutrition.	

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 Staff list and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o OT/PT Tracking o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Documentation of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months

	o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Tracking Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to SGSSLC: **Alma Flores, .** o OT/PT Assessments and ISPs for the following individuals: • Individual #288, Individual #349, Individual #45, Individual #144, Individual #200, Individual #34, Individual #381, Individual #398, Individual #165, Individual #216, Individual #365, Individual #186, Individual #291, Individual #59, Individual #112, Individual #126, Individual #331, Individual #277, Individual #314, and Individual #361. o OT/PT Assessments, ISPs, ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #271, Individual #85, Enrique Garcia, Individual #145, Individual #243, Individual #202, and Individual #26. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o PNMP section in Individual Notebooks for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251.

	Interviews and Meetings Held: o Dena Johnston, OTR, Director of Habilitation Therapies o Judy Perkins, PT o Brandon Fox, COTA o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #132 and Individual #379 o Treatment session for Individual #273
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, OTR, Habilitation Therapies Director, was again improved over previous assessments submitted for this section. There were very clear and relevant activities conducted and were linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was specific analysis of the data to support the self-rating, as well as, statements of actions planned to demonstrate attempts to move toward compliance in the future in the self-assessment document. Ms. Johnston and her staff continued to be on track to ensure progress would be made for the next review. Though continued work was needed, the monitoring team acknowledges the strides that were made since the last review by the monitoring team. The facility rated itself in noncompliance with P.2 and P.3. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings. The facility rated itself in substantial compliance with P.1 and P.4. The monitoring team concurred with continued compliance with P.1, but did not substantiate compliance with P.4. Improved compliance with the existing system of effectiveness monitoring system is indicated to achieve this.

	Summary of Monitor's Assessment: There was continued progress towards substantial compliance in several aspects of provision P. Consistent with the previous two reviews, there was substantial compliance for P.1 with 19/21 (90%) of the elements listed found in 90% or more of the assessments reviewed. Further, there had been a continued significant effort to ensure that assessments were completed, and done so 10 days prior to the ISP. For example, for ISPs scheduled for June, July, and August 2013 there were 44 assessments due. Approximately 86% were completed at least 10 days prior to the ISP and 98% were completed by the ISP meeting. While the assessments were excellent, they continued to focus primarily on the clinical aspects of health and safety, with rather limited focus on skill acquisition and/or motor skill improvements. There were some notable exceptions, with an increase noted in OT and PT services and direct therapy overall. It is critical, however, that these interventions be based on sound rationale, with measurable and functional objectives with clearly stated performance criteria. Documentation showed that services were consistently reviewed regarding the individual's status related to the objectives. Documentation of the interventions selected for review met generally accepted standards. The monitoring team observed an individual treatment session for Individual #273. She had made significant progress related to standing and mobility. She was a great example of how important it is for the therapists to look beyond the PNMP and to carefully consider opportunities for individuals to expand existing skills or to identify their potential to learn new ones. This is the reason that it is important to promote an improved quality of life that allows individuals to more fully participate in life skills and activities that interest and motivate them. To that point, during the ISP meeting for Individual #379, the therapist reported that everything was in place to address his falls. The IDT essentially left it at that because he had not had any injuries, but had had 14 falls in the last year. When prompted by the monitoring team, the IDT began to consider other possible key issues that might be impacting his falls, such as cataracts and dementia. The clinicians should challenge themselves to always ask the question, "What more could be done or explored?" Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs. Guidelines for use during the ISP meetings (with prompts) were in place for use by the clinicians in attendance to assist the QIDPs. There was an established system of staff compliance monitoring (reviewed in section O) and effectiveness monitoring for the PNMPs. • Sample P.1 = 15/15 individuals for whom an individual record was submitted and the most current assessments completed by each OT and PT clinician (19). Actual comprehensive assessments reviewed are identified in P.1 below. • Sample P.2 = 5/5 individuals newly admitted to SGSSLC in the last six months for whom a current assessment was submitted. • P.3 = 8/16 individuals who were provided direct OT and/or PT services per the list submitted.

#	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.	<u>Assessments</u> Assessments submitted as contained in the individual records included the following: OT/PT Comprehensive Assessment • Individual #38 (8/3/12) • Individual #294(9/5/12) • Individual #251 (8/5/11) • Individual #130 (8/13/12) • Individual #7 (1/26/12) • Individual #379 (7/7/11) • Individual #189 (9/26/12) • Individual #344 (7/31/12) • Individual #210 (11/7/11) • Individual #203 (9/18/12) Occupational Therapy/Physical Therapy Assessment of Current Status • Individual #38 (4/16/13) • Individual #294(5/7/13) • Individual #134 (3/27/13) • Individual #251 (7/31/13) • Individual #130 (7/30/13) • Individual #7 (12/21/12) • Individual #379 (7/30/12) • Individual #151 (1/16/13) • Individual #77 (5/21/13) • Individual #344 (5/28/13) • Individual #203 (7/16/13) Rehabilitation Therapy Assessment • Individual #134 (4/7/11) • Individual #77 (7/13/11) • Individual #287 (4/24/11) Evaluation Update • Individual #134 (4/19/12) • Individual #151 (5/14/12) • Individual #287 (4/24/12) Rehab Assessment • Individual #251 (8/28/12) • Individual #210 (8/10/12) • Individual #379 (8/6/12) • Individual #77 (7/28/12) Occupational/Physical Therapy Evaluation	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Individual #150 (4/13/13) Rehabilitation Therapy Assessment Update • Individual #151 (2/9/11) Rehabilitation Therapy Evaluation • Individual #151 (2/24/09) Rehabilitation Therapy Annual Review • Individual #151 (3/19/10) The most current assessments for some individuals included in this sample were identified as (a) updates or assessments of current status or (b) were not current within the last 12 months. These were not included in the review of comprehensive assessments below. Assessments submitted as the most current for each OT and PT clinician included the following: Occupational Therapy/Physical Therapy Assessment • Individual #381 (2/7/13) • Individual #398 (1/22/13) • Individual #349 (4/2/13) • Individual #314 (2/25/13) • Individual #277 (3/25/13) • Individual #331 (2/5/13) • Individual #126 (1/23/13) • Individual #112 (5/21/13) • Individual #59 (1/25/13) • Individual #291 (2/8/13) • Individual #186 (6/11/13) • Individual #365 (3/22/13) • Individual #216 (6/10/13) • Individual #150 (4/13/13) • Individual #165 (5/23/13) Occupational/Physical Therapy Evaluation • Individual #45 (2/15/13) • Individual #144 (2/25/13) • Individual #200 (4/4/13) • Individual #34 (3/15/13) Occupational Therapy/Physical Therapy Assessment of Current Status • Individual #288 (4/22/13)	

#	Provision	Assessment of Status	Compliance
		Though the names varied slightly, the evaluations and assessments appeared to be intended as comprehensive and, as such, were included for review below. Only the Assessment of Current Status for Individual #288 was omitted. <u>Screenings</u> Eleven individuals were admitted to SGSSLC since December 2012. Comprehensive Evaluations were submitted for five of these (Individual #246, Individual #20, Individual #47, Individual #30, Individual #63). The facility may want to consider developing a strong, but brief, screening to rule out a need for assessment for individuals newly admitted rather than this lengthier document to determine if a comprehensive assessment was needed. • 5 of 5 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessments. The following metric was not applied because SGSSLC did not use an OT/PT screening at the time of this review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. <u>OT/PT Assessment</u> Only current and complete assessments included in Sample P.1 (19) were included in the following analysis: • 2 of 19 individuals (11%) had comprehensive assessments that contained each of the 21 elements listed below. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. Based on review of Sample P.1, the analysis for comprehensiveness of the OT/PT assessments was as follows: • 14 of 19 OT/PT current assessments (74%) for individuals in Sample P.1 were dated (dates of signatures) as completed at least 10 working days prior to the annual ISP. This was an improvement from 42% in the previous review. • 19 of 19 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. This was an improvement from 79% in the previous review. • 19 of 19 assessments (100%) included diagnoses and relevance to functional status. This was consistent with the previous review. • 19 of 19 assessments (100%) included previous medical history and relevance to	

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		functional status. This was an improvement from 84% in the previous review. • 17 of 19 assessments (89%) addressed health status over the last year. An improvement from 53% in the previous review. • 19 of 19 assessments (100%) listed medications and potential side effects relevant to functional status. This was an improvement from 95% in the previous review. This should be limited to those side effects that may impact functional motor skill performance and should address whether the individual has experienced any of the potential side effects. • 19 of 19 individuals' OT/PT assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 19 of 19 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was an improvement from 84% in the previous review. • 19 of 19 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This was consistent with the previous review. • 2 of 2 assessments provided a description of the current seating system for those requiring a wheelchair (100%). This was consistent with the previous review. • 16 of 19 assessments (84%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. This was a decrease from 95% in the previous review. • 16 of 19 assessments (84%) included discussion of the expansion of the individual's current abilities. This was a slight decrease from 88% in the previous review. Usually, it was a general statement related to overall learning rather than specifically related to new motor or self-help skills. • 16 of 19 assessments (84%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 57% in the previous review. Usually, it was a general statement related to overall potential for learning rather than specifically related to new motor or self-help skills. • 19 of 19 assessments (100%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous assessments. This was consistent with the previous review. • 19 of 19 assessments (100%) included documentation of the relationship between the individual's risk levels and their performance of functional skills. This was an improvement from 95% in the previous review. • 19 of 19 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs. This was consistent with the previous review. Many of the individuals in this sample happened to have limited OT/PT-related needs. • 18 of 19 assessments (95%) included a monitoring schedule. This was an	

#	Provision	Assessment of Status	Compliance
		improvement from 47% in the previous review. • 19 of 19 assessments (100%) included a re-assessment schedule. This was consistent with the previous review. • 19 of 19 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 7 of 19 assessments (37%) provided a statement detailing the supports and services needed for successful community living. This was a decrease from 100% in the previous review. The supports and services may be inferred from what was in the assessment, but very few made specific recommendations about what would be necessary for successful community living. Even if the clinician did not believe the individual was ready at that time, recommendations as to what would be necessary for readiness, as related to PNM and OT/PT, should be outlined. These needs should become a focus of OT/PT direct and indirect interventions to ensure that the individual was working toward successful community placement. Other recommendations should pertain to the need for OT or PT follow-up related to aspects of the PNMP and dining plans, adaptive equipment (wheelchair, AFOs, for example) and the need for a specialist, such as a podiatrist or orthotist. • 19 of 19 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review, though was limited predominately to the PNMP. Further findings revealed continued improvements related to OT/PT assessments as follows: • There were improvements in 43% of the elements. • There was regression in 14% or 3 of the elements, though only two of these were below 80%. • Nine others were consistent with the previous review, each at 100%. • The average for all 19 assessments was approximately 92%. • 16 of 19 assessments (84%) contained more than 90% of the 22 elements listed above. • 19 of 19 assessments contained 84% or more of the elements listed above. • 0 of 19 assessments contained less than 83% of the elements listed above. • 14 of 21 (67%) of the elements listed above were noted for 100% of the assessments reviewed. • 19 of 21 (90%) of the elements listed above were noted for 90% or more of the assessments reviewed. • Improvements from the previous review were noted in 46% of the 21 elements. Nine others maintained at 100%, consistent with the previous review. Minor	

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		decreases were noted for two elements (only one of those was below 90%: assessments completed 10 working days prior to the ISP). Assessments for individuals newly admitted (5/5) were completed within 30 days of admission. There was continued progress related to the adequacy of the OT/PT assessments and these were determined to be in substantial compliance with the majority of the identified essential elements. Approximately 74% of assessments for individuals in Sample P.1 were dated (dates of signatures) as completed at least 10 working days prior to the annual ISP. The self-assessment reported compliance with this to have improved from 31% in December 2012 to 92% in May 2013. There was a noted improvement in the availability of the comprehensive assessment for an associated Assessment of Current Status. Fifteen of 15 individuals in the sample selected by the monitoring team for review of individual records had OT/PT assessments and 67% had an appropriate Assessment of Current Status for a comprehensive assessment as required. Two others had comprehensive assessments current within the last 12 months so an Assessment of Current Status was not indicated (Individual #150 and Individual #189). There was no comprehensive assessment submitted for the Assessment of Current Status for Individual #151 (1/16/13) and no Assessments of Current Status within the last 12 months for Individual #210 and Individual #287. SGSSLC maintained substantial compliance with provision P.1 based on the improved compliance with the quality of OT/PT assessments, as well as the continued improvement in their timely completion. This was a considerable accomplishment given that the caseload levels continued to be high. Improvement in these ratios would likely permit clinicians to ensure that quality assessments are completed on time, as well as provide more opportunities for direct and indirect services, staff training, and monitoring.	
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	<u>Direct OT/PT Interventions:</u> There were 16 individuals listed as participating in direct PT and 14 individuals participating in direct OT. There were six individuals listed as receiving both OT and PT. There was evidence that Individual #77 participated in direct PT though she was not included on the list submitted. The records of individuals in Sample P.3 were reviewed with the following findings: • 7 of 8 individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or	Noncompliance

#	Provision	Assessment of Status	Compliance
	plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	safety. Though listed as participating in direct therapy, there was no evidence of this based on the documentation submitted for Individual #145. • For 7 of 7 interventions for individuals (100%), the current OT/PT assessment or consult identified the need for OT/PT intervention with rationale. • For 0 of 7 individuals' records (0%), there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Each intervention had clearly established measurable goals, but none were integrated into the ISP via an ISPA. • For 6 of 7 individual's record (86%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. There was no discharge documentation for Individual #77 from 7/29/13 through the time of this onsite review. The last progress note indicated that discharge was intended, but the notes merely stopped without a summary clarifying the rationale and plan. The system for documentation was consistent for each of the individuals reviewed. There was an assessment or consult to identify the need for OT or PT intervention, but the rationale and plan with measurable and functional objectives was noted in all cases. There was no associated SAP associated with these services. Data sheets were used inconsistently, but a standardized form was used to document intervention sessions. In the case that the COTA or PTA provided the intervention, there was evidence of review or monthly progress notes completed by the OT or PT with a plan outlined in the case that the service was not continued. • 7 of 8 individuals receiving direct OT/PT Services (88%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: o Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. o Termination of the intervention was well justified and clearly documented in a timely manner.	

#	Provision	Assessment of Status	Compliance
		The only concern was that the majority of the documentation was contained on a form that was filed in the Habilitation Therapy tab rather than the IPNs. It appeared that in most cases, the monthly summary was included in the IPNs, but this was not always consistent (Individual #77 and Individual #202). These two were filed in the Habilitation Therapy tab and, as such, were not readily available to other team members. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP. Implementation of PNMPs is addressed in section O.5. PNMPs were monitored for effectiveness. • For 9 of 15 individuals reviewed in the sample for whom individual records were selected by the monitoring team, the PNMP was updated within 30 days of the ISP. Even in the case that no changes were indicated, there should be an update of the PNMP within 30 days of the annual ISP to reflect that it had been reviewed at that time. There were no SAPs implemented for the sample reviewed so the following metric did not apply: • For 0 of 0 individuals who received indirect OT and/or PT programs (e.g., SAPs), monthly documentation from the OT and PT and/or QDDP was present for ___ (%), including the following: o Information regarding whether the individual showed progress with the stated goal(s), including a summary of clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. <u>Integration of OT/PT Supports and Services in the ISP</u> Attendance by either OT or PT or both disciplines was noted for approximately 69% of the ISPs included in Sample P.1. Review of the ISPs submitted was as follows: • 87% (13 of 15) of the ISPs submitted were current within the last 12 months. Those for Individual #150 (6/14/12) and Individual #210 (6/21/12) were not considered current. • 92% (12 of 13) of the current ISPs had attached signature sheets. • 15% (2 of 13) of the current ISPs with signature pages submitted were attended by both the OT and PT.	

#	Provision	Assessment of Status	Compliance
		• 30% (4 of 13) were attended by PT only. • 23% (3 of 13) was attended by OT only. • 23% (3 of 13) of the current ISPs had no representation by an OT or PT. This was noted for Individual #251, Individual #130, and Individual #287, each of whom had identified OT/PT needs. The self-assessment, which was based on the total number of ISPs requiring attendance by Habilitation Therapy reported that attendance ranged from 56% in December 2012 to 92% in May 2013. By discipline, OT attendance was 89% in April 2013 and 100% in May 2013. PT attendance was 100% in April 2013 and 91% in May 2013. The new system of pre-ISPs will clearly designate which disciplines will be required to attend the ISP. For 6 of 12 individuals for whom a current ISP and OT/PT assessments were submitted with the individual records (50%), OT and/or PT supports and services (0%) were reviewed by the individual's IDT in the annual ISP meeting or ISPA. This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale for therapist attendance in the pre-ISP process needs to be sound and clearly supported**.** 2. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
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 were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment. See section O.5 above for recommendations related to staff training.	Noncompliance

#	Provision	Assessment of Status	Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Monitoring There was a comprehensive Habilitation Therapy policy that included the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identification of monitors and their roles and responsibilities; • Definition of a formal schedule for monitoring to occur; • Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identification of the frequency of assessments; • Definition of how individuals' OT/PT needs will be identified and reviewed; and • Requirements for documentation for individuals receiving direct services. The facility implemented a system for the adequate monitoring of PNMPs. Staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment was implemented at SGSSLC. This was addressed in section O.6 and O.7 above. There was also a system established for routine evidence of effectiveness monitoring by the therapists. There were 35 PNMP monitoring forms for 34 individuals for May 2013 done by OT or PT. These were focused on compliance for implementation as well as a review of plans and equipment to determine if they were effective. Per the local PNM policy, individuals with PNM needs were to be monitored at least quarterly for effectiveness. Of the monitoring sheets submitted, approximately 63% were completed at least quarterly, while three were first time monitoring for new programs or new admissions (Individual #248, Individual #243, and Individual #398). The others reflected effectiveness monitoring anywhere from four to 10 month intervals. Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring was requested for 12 months. Based on the submission, quarterly effectiveness monitoring was documented at least quarterly for 6 of 15 individuals in the sample (40%).	Noncompliance

#	Provision	Assessment of Status	Compliance
		In some cases, the monitoring was conducted by a therapy assistant. While the monitoring was appropriately done, the facility should use caution in permitting the assistant to make a clinical judgment as to actual effectiveness of the programs and plans. The facility reported that therapy assistants were allowed only to complete chart review and staff interview for program effectiveness monitoring. Therapy assistant were not allowed to document program effective analysis in the active record. Therapists were to be the ones to complete analysis and to document program effectiveness analysis in the active record. There was a form serving as a worksheet for review and used for data entry. In each case, there was an IPN that stated effectiveness monitoring was completed, though findings were inconsistently documented there. The policy outlined the required content of these notes, though very few actually met those requirements. A number of these were completed prior to the establishment of this policy. There were approximately 35 individuals seated in wheelchairs as their primary means of mobility and approximately 14 who required wheelchairs for distance and transport. It could not be determined from the maintenance log that monthly maintenance checks were conducted for wheelchairs or other assistive equipment to ensure that these were in proper working condition, though individuals appeared to be seen routinely. All were listed as requests, though general maintenance was routinely listed as completed. Most appeared to be completed on the same day, or within 24 to 48 hours. A very few required up to a week, with most requiring less than a month. More extensive work related to a new system or modification occasionally required several months. This element was self-rated to be in substantial compliance. There was a comprehensive policy that outlined essential elements related to monitoring and OT/PT supports and services. There was a system of staff compliance monitoring, though compliance with this was reviewed in section 0.5 and 0.6 above. While there was an established system of effectiveness monitoring, compliance with this at least quarterly was not substantially in compliance with the monitoring team's expectations and the established facility policy. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Adjust tracking of maintenance activity to reflect routine maintenance checks as well as problem-oriented work orders with dates received and dates completed in order to effectively track the timeliness of completion. 2. Establish benchmarks and a tracking system and schedule for quarterly effectiveness monitoring by OTs and PTs. 3. Conduct audits and staff training as to the process expected for effectiveness monitoring.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15.1: Dental Services, dated 8/15/13 o SGSSLC Policy: Dental Services, 9/15/11 o SGSSLC Comprehensive Provision of Dental Services Policy and Procedure, 12/3/12 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 – Suction Toothbrush, 5/1/12 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 Policy and Procedure Pretreatment Sedation Notification and Referral for Assessment Process, 7/26/12 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 Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Behavioral Rehearsal Programs for the following individuals: • Individual #385, Individual #39, Individual #144, Individual #185, Individual #222, Individual #201, Individual #134, Individual #386, Individual #389 o Comprehensive/Annual Dental Assessments for the following individuals: • Individual #298, Individual #251, Individual #235 Individual #383 Individual #100, Individual #277, Individual #265, Individual #250, Individual #132 o Comprehensive Dental Records for the following individuals: • Individual #280, Individual #196, Individual #186 Individual #37, Individual #112 Interviews and Meetings Held: o William Todd Walker, DDS, Dental Director o Ken Rees, DMD, Contract Dentist o Belinda Lendermon, RDH

	o Lisa Willingam, RDH o Andre Golden, Dental Assistant o Lisa Owens, RN, Quality Enhancement Nurse o David Ann Knight, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Dental Department o Administrative IDT Meeting o Daily Medical Provider Meetings o Observation of treatment in clinic
	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 each provision item, a numbered list of activities engaged in to conduct the self-assessment was provided. The results of each activity were listed. Based on the results, a self-rating was determined. Dental clinics statewide utilized a template for completion of the self-assessment. The self-assessment utilized was based on a template issued by state office. The assessment was expanded to cover additional areas for review. The self-assessment was primarily a review of data that were collected by the facility. The assessment covered many of the areas assessed by the monitoring team. To take this process forward, the monitoring team recommends that the center lead continue this type of self-assessment adding additional items if necessary. The facility found itself in noncompliance with both provision items. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The facility made significant progress in the provision of dental services. There were no staffing changes since the last compliance review. The dental director was involved in all aspects of the clinic's operation. He provided direct patient care, participated in Settlement Agreement activities, and participated in many facility meetings and committees. Oral hygiene ratings showed improvement. Individuals with poor ratings were enrolled in the clinic's toothbrushing program. Suction toothbrushing was provided to more individuals and documentation indicated that the treatments were being completed. Individuals with modified diet consistencies were receiving additional supports as well. The practitioners provided very good documentation of treatment. IPN entries were concise, but included

	adequate information for the IDTs. Compliance with completion of annual exams also improved compared to the previous compliance review. The clinic failure rate increased. The majority of failed appointments were due to missed appointments of undetermined etiology. Refusals continued to occur and were addressed by psychology staff. In recent months, reassessments were conducted by psychology. This resulted in discontinuation of desensitization plans and the development of other types of strategies and interventions. It appeared that this had some positive impact, but the outcomes of many strategies and interventions were not known.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff, medical director, medical staff, the medical compliance nurse, and the QA nurses. <u>Staffing</u> The dental clinic staff was comprised of a full time dental director, full time hygienist, and full time dental assistant. The part time dentist and part time hygienist both worked two days a week. The full time hygienist did not routinely provide any direct clinical care. She was responsible for programmatic issues and served as the center's lead for provision Q. <u>Provision of Services</u> The clinic had two fully equipped and functional operatories and provided basic dental services including prophylactic treatments, restorative procedures, such as resins and amalgams, extractions of non-restorable teeth, and x-rays. The total number of clinic visits and key category visits are summarized below.	Noncompliance

Dental Clinic Appointments 2012

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
OH Instructions	20	30	39	39	26	32	36	10
Preventive	20	14	37	37	47	32	36	10
Emergency	0	0	0	0	0	0	0	0
Extractions	0	1	2	4	0	2	3	3
Restorative	20	8	19	19	20	16	18	13
Total	168	165	130	144	145	169	202	111

Most individuals were seen every three to six months for prophylactic treatment. The overall number of extractions was low. However, discrepancies were noted among documents. The listing of clinic appointments indicated that the extraction data in the record was the number of clinic appointments. Other documents referred to the number

#	Provision	Assessment of Status	Compliance
		of teeth. Data provided during the Administrative IDT indicated that as of December 2012, the data for restorations was being reported as the actual number of restorations and not the number of clinic appointments. The facility utilized the services of a dental anesthesiologist for three days in January 2013. It was reported that discussions with another provider were ongoing, however, no dates for service had been finalized. Following the onsite review, the facility reported that a contract was in place for service to begin in October 2013. <u>Oral Surgery</u> The facility referred two individuals to a local oral surgeon. Individual #85 was evaluated for an asymptomatic remote condyle fracture. Individual #394 was evaluated for a cyst associated with an impacted molar. Neither individual required additional treatment. <u>Emergency Care</u> Emergency care was available at SGSSLC during normal business hours. In May 2013, the contract dentist began providing on call coverage. The dental director was on call when the contract dentist was not available. Individuals were referred to the emergency department at Shannon Medical Center if necessary. It was also reported that the emergency dental treatment policy was updated to reflect this change. The facility reported no emergency visits. <u>Radiographs</u> Individuals received bitewing radiographs at least annually. Panoramic radiographs were recommended every five years. The overall compliance for the reporting period was 41%. This compliance was increasing and greater than 50% for the last two months of the reporting period. The monitoring team found in the various record reviews that compliance with x-ray requirements was increasing. For the 10 comprehensive assessment reviewed, only one individual did not have documented x-rays. The most recent assessments also documented the completion of dental panoramic radiographs. <u>Oral Hygiene</u> The dentist and hygienist used the plaque index score as a more objective process for determining oral hygiene ratings. Oral hygiene ratings were documented during annual exams. The table below summarizes the ratings.	

#	Provision	Assessment of Status	Compliance

Oral Hygiene Ratings (%)				
	Good	Fair	Poor	No Rating on File
Oct - Dec	56	36	3	NA
Jan	64	28	8	NA
Feb	71	23	6	NA
Mar	22	9	3	63
Apr	24	5	4	66
May	13	2	3	80

There were 12 individuals with poor oral hygiene at the time of the compliance review. All of these individuals participated in the dental clinic's toothbrushing program. This program required weekly evaluation and toothbrushing in the dental clinic. An SAP related to toothbrushing and oral care was also required. When the individual had three consecutive good hygiene ratings, the individual no longer participated in the toothbrushing program. This was somewhat concerning because many dental notes indicated that the individuals were present in clinic for toothbrushing due to poor care in the homes. Systemic changes related to home care would appear warranted. The dental monthly report indicated that the dental department's comprehensive policy was revised to reflect this change, but the monitoring team was not provided the revised policy.

Suction Toothbrushing

The habilitation department identified individuals who were at high risk for aspiration and would benefit from suction toothbrushing. Thirty-one individuals received this treatment, which were provided by direct support professionals who underwent competency-based training. Individuals received treatment two times a day. The dental hygienist conducted quarterly audits of the required documentation to ensure that treatments occurred as ordered. Documents provided to the monitoring team indicated that compliance was noted for all individuals. The RDH cited the need for better documentation for most individuals.

Modified Consistency Fluoride Program

Individuals who received a modified diet and required thickened liquids were prescribed PreviDent, a neutral pH sodium fluoride. The program was relatively new to the facility, so outcomes had not been assessed.

Staff Training

All new staff received competency-based training during new employee orientation. The contract dentist continued as the instructor. An annual oral hygiene refresher was available online through iLearn. Data provided by the facility indicated compliance with the requirements for training.

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director should continue to pursue a contract with the dental anesthesiologist or ensure that adequate supports in the community are available for those individuals who will require sedation for treatment. Following the onsite review, the facility reported that a contract was in place for service to begin in October 2013. 2. The clinic should continue to move towards meeting compliance with the requirements for radiographs. 3. The provision of oral care in the homes should be further examined given the documentation in clinic notes related to poor home care. Appropriate corrective actions should be implemented as deemed necessary. 4. The facility should clearly identify what data are reported (e.g., actual procedures versus clinic appointments).	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating	Policies and Procedures The Comprehensive Provision of Dental Services Policy was revised on 12/3/12. The revision captured changes including the suction toothbrushing program and the use of the plaque index scores. Although it was documented that several policies were updated, those policies were not included in the document request. Dental Records Dental records consisted of an IPN entry, dentist progress record, Dental Exam Summary (initial/annual/placement), and the Dental Record Initial Exam Report. Plaque index score charts were also included in the records. The Dental Progress Record was a duplication of the IPN entry. Both were typed, done in SOAP format and contained detailed information regarding the assessment and treatment provided. Annual/Comprehensive Assessments In order to determine compliance with this requirement, a list of all annual/comprehensive assessments completed during the past six months, along with the date of previous annual assessment, was requested. Assessments completed within 365 days of the prior assessment were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	medications and dental restraints.		

Annual Assessment Compliance						
	Dec	Jan	Feb	Mar	Apr	May
Number of Exams Due	30	35	26	36	4	16
Exams Completed	23	23	22	29	4	15
% Compliance	77	66	85	81	100	94

The overall compliance score was 84%. This was an improvement from the 80% compliance noted during the previous review. The comprehensive/annual dental exams for 10 individuals were reviewed. Copies of the IPN, DPN, Dental Exam Summary, and Dental Record Initial Exam Report were submitted for each of the 10 individuals. The following is a summary of information found in the assessments:

- 10 of 10 (100%) assessments included an entry in both the IPN and DPN
- 10 of 10 (100%) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use
- 10 of 10 (100%) assessments had entries for oral hygiene, teeth and restorations, and periodontal conditions
- 10 of 10 (100%) assessments included documentation of oral cancer screenings
- 10 of 10 (100%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff
- 10 of 10 (100%) assessments documented the risk rating
- 10 of 10 (100%) assessments documented x-rays or the need for x-rays.

The IPN and DPN entries were dated, timed, and signed. All of the notes reviewed were completed in SOAP format. Each assessment summarized the services provided, the exam findings, types of x-rays completed, and any abnormal x-ray results. For the one individual who did not complete x-rays, the reason was documented. The plan of care was clearly outlined along with the rationale when appropriate. There was an entry made in the Dental Record Initial exam Report regarding any further treatment that was necessary. Overall, the documentation for the assessments was very good and provided good information for the IDTs.

Initial Exams

The facility submitted data for 12 individuals admitted since the last onsite review. Ten of 12 (83%) individuals completed initial dental evaluations within 30 days.

Failed Appointments

The facility reported data on refusals, no shows, and rescheduled/cancelled appointments. The numbers as identified and reported by SGSSLC in the document request are summarized in the table below:

#	Provision	Assessment of Status	Compliance

Failed Appointments								
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
No Show (Missed)	29	35	21	21	27	11	29	20
Refused	7	9	12	8	8	5	10	6
Rescheduled/cancelled	18	10	10	1	9	3	23	8
Total Missed (Failed)	54	54	43	30	44	19	62	34
% Failed	32	33	33	21	30	11	28	31
Total Appointments	168	165	130	144	145	169	202	111

The dental hygienist explained that a no show appointment was the equivalent of a missed appointment. The guidelines issued by state office required reporting of missed appointments and refusals. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals.

The self-assessment noted that no shows and refusals continued to be problems. Data submitted for failed appointments provided no explanations for the no show/missed, cancelled and rescheduled appointments. The monitoring team specifically requested reasons for missed appointments. One document for March 2013 through May 2013 listed some explanations for a small number of the missed appointments. Explanations included behavior, staffing, and dental clinic. Presumably, the reasons for the other failed appointments were not known.

The monitoring team reviewed a series of email notifications sent from the dental clinic to the IDTs regarding the missed appointments. The monitoring team learned, through attendance at the Administrative IDT meeting, that no shows occurred with other facility programs. It was reported that a committee was formed to address no shows and missed appointments for the entire facility, but was later dissolved because each department addressed the problem.

The facility will need to have a better idea of the reasons for the failed appointments because the overall failure rate for the six month reporting period was 31%. The vast majority of the failures were due no shows/missed appointments. The monitoring team did notice through the review of the monthly dental reports that the calculation of the failure rates changed after March 2013. Prior to that time, the failure rate did not include cancelled/rescheduled clinics and was, therefore, lower.

<u>Dental Restraints</u>
The dental clinic did not utilize TIVA on a regular basis. The reported data for the use of TIVA and anxiolysis is summarized in the table below.

#	Provision	Assessment of Status	Compliance

General Anesthesia/Minimal Sedation						
	Dec	Jan	Feb	Mar	Apr	May
TIVA	0	9	0	0	0	0
Oral Sedation	0	0	2	1	0	1

Strategies to Overcome Barriers to Dental Treatment

The facility's average refusal rate for the reporting period was 5.6%. Refusals, on average, accounted for 22% of failed appointments. At the time of the December 2013 compliance review, the IDT was no longer required to create strategies for a single missed or refused appointment because the team met monthly and addressed every failed appointment. The IDT would submit strategies to the dental clinic only if there were three failed appointments. This approach changed. The dental clinic sent notification to the psychologist for every refusal beginning in January 2013. It was reported that psychology usually responded promptly. Clinic staff reported that some walked individuals over to the clinic and the appointments were successfully completed. The IDT was notified if an individual missed three appointments in a month.

Discussions with various staff indicated that dental desensitization at SGSSLC was challenging. This was confirmed in the Administrative IDT minutes. The minutes documented problems with the desensitization PIT, ineffective dental desensitization plans, plans implemented without training, and unknown status for desensitization plans. Psychology began re-assessing many individuals. Over a period of months, the number of required desensitization plans decreased from five to zero.

The monitoring team reviewed the dental clinic's referral spreadsheet, the psychology assessment tracking spreadsheet and numerous emails related to failed appointments. The dental clinic referral list included request for assessments for 22 individuals due to refused appointments. The spreadsheet listed the date of referral, date of assessment, and the outcome of the assessment. For most of the individuals, the assessments were completed in a timely manner. Six individuals did not have assessments completed. Those names were also not listed on the psychology spreadsheet. The outcomes included various strategies and interventions, such as providing reinforcers, and development of behavioral rehearsal programs. For some individuals, it was documented that the strategies were successful and the individual completed an appointment. Other individuals did not have successful appointments. The status was unknown for several individuals.

Discrepancies were noted in the psychology and dental spreadsheets. The psychology spreadsheet also listed desensitization plans for some individuals. The monitoring team was informed that there were no desensitization plans. Nine behavioral rehearsal programs were submitted to the monitoring team. They were written by the SAP

#	Provision	Assessment of Status	Compliance
		writers. It appeared that there was some success with this approach. Overall, the number of refusals was low, but several individuals had outstanding needs. The monitoring team was informed by clinic staff that the consent process at SGSSLC was resulting in delays in treatment and impacting clinical care and outcomes. The facility had relatively little use of pretreatment sedation. However, the monitoring team did find in the dental documentation of the record sample and in the review of comprehensive records some examples in which sedation was requested or treatment needs remained outstanding: • Individual #179 was seen in clinic on 9/5/12 for an annual assessment that could not be completed. Visual exam and toothbrushing were attempted, but unsuccessful on 10/9/12. On 11/12/12, the individual was unsuccessfully seen again. The dentist recommended that sedation be used to complete prophylactic treatment. On 12/17/12, another attempt was made to examine the individual and provide toothbrushing. The individual expired in January 2013. • Individual #38 had tardive dyskinesia and missed several appointments. Psychology assessed the individual on 3/20/13 and documented that "no program will treat the problem. Missed appointments are not due to fear." This individual's last clinic appointment was in July 2012 and the last annual assessment was done in October 2011. • Individual #188 had an annual exam completed on 8/2/12 in which a lost filling and two additional teeth were identified for restoration. On 11/20/12, the lost filling was replaced. Treatment was attempted again on 2/11/13. On 5/8/13, the individual refused treatment. The dentist recommended sedation for completion of restorations. The individual expired in June 2013. • Individual #37 had a history of refusals. The psychology log indicated that an assessment was done on 2/22/13. Incentives were implemented because the individual did not think that going to the dentist was important. The individual completed an annual assessment on 3/28/13 and several teeth were identified that required restoration. The individual missed one appointment then returned to the clinic for prophylactic treatment in June 2013. Subsequent appointments were listed as no shows. • Individual #112 had an annual assessment completed on 7/15/13. Multiple dental caries were identified. The dentist recommended that the individual return to clinic when sedation could be arranged. A review of the active records did not show any acknowledgment of this by the PCP. The status could not be determined through record review.	

#	Provision	Assessment of Status	Compliance
		Generally, most individuals whose treatment was not complicated by issues related to sedation and refusals received prompt care. For example, Individual #186 completed an annual assessment on 2/25/13. The need for dental restoration was identified. The individual returned to clinic on 4/26/13 and the restoration was completed. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Policies and procedures should be updated, if not already done, to reflect current practices. 2. The clinic should continue to work at meeting compliance with the requirements for annual assessments. 3. The facility must address failed clinic appointments. The reasons for the missed appointments should be determined and appropriate corrective actions implemented. 4. The current management of refusals should be addressed. The dental clinic should have better and more current information on the status of the strategies and interventions implemented by psychology. 5. The facility should review the current process of obtaining consent for pretreatment sedation to ensure that it is efficient and does not delay proper treatment.	

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 Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs, license numbers, caseloads o Continuing education and training completed by the SLPs since the last review o Facility list of new admissions since the last review o Master Plan o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o Speech Language Pathology Screening template o List of individuals with behavioral issues and coexisting severe language deficits o List of individuals with PBSPs and replacement behaviors related to communication o PBSP minutes and attendance rosters for the past six months o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Communication Assessment for individuals recently admitted to SGSSLC: Individual #246, Individual #30 Individual #63, Individual #96 o Communication Assessments and ISPs for the following individuals: • Individual #188, Individual #68, Individual #582, Individual #535, Individual #471, Individual #519, Individual #34, and Individual #258. o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #273, Individual #78, Individual #220, Individual #173, Individual #201, Individual #40, Individual #217, Individual #389, and Individual #211. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210,

	Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o PNMP section in Individual Notebooks for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #344, Individual #130, Individual #151, Individual #287, Individual #210, Individual #134, Individual #203, Individual #77, Individual #38, Individual #294, Individual #7, Individual #379, Individual #150, Individual #189, and Individual #251. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Director of Habilitation Therapies o Brittenee Valade, MS, CCC-SLP o Erin Bristo, MS, CCC-SLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISP Meeting for Individual #132 and Individual #379 o Treatment session for Individual #78
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, Habilitation Therapies Director, continued to improve over previous assessments submitted for this section. There continued to be very clear and relevant activities conducted and these linked well to previous reports by the monitoring team. Findings reported were in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. Ms. Johnston and Ms. Bristo and the other communication services staff were on track to ensure that progress is made for the next review. While there were overall improvements, on-time assessments, completion of assessments, and integration into the ISP and PBSP continued to be problematic. Benchmarks were established in measurable terms and were used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the strides that Ms.

	Johnston and her staff have made during the last eight months. The facility rated itself in noncompliance with R.1, R.3 and R.4. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings. The facility rated itself in substantial compliance with R.2, but due to the inconsistency with timely completion of assessments and inconsistencies with integration of communication supports in the ISPs and PBSPs, the monitoring team did not agree.
	Summary of Monitor's Assessment: There was continued progress toward substantial compliance in all aspects of provision R. The SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC. The addition of another full time clinician helped with this, but it continued to be a very big job for two therapists (as of the end of August 2013). The loss of the SLPA was unfortunate and the department would benefit from the reinstatement of that position. Erin Bristo continued to necessarily focus on the dysphagia side of things and was a member of the PNMT, while each of the clinicians also had responsibilities related to mealtime in addition to communication. Careful examination of the identified needs of individuals must occur to ensure that sufficient resources are available for effective implementation of the necessary supports. The therapists appeared to be applying a creative approach to the selection of AAC. These devices appeared to be functional and meaningful to the individual. For example, Individual #78 was asked for input on the pictures to be included with his voice output device during a treatment session with his SLP that was observed by the monitoring team. He continued to initiate with the monitoring team to add more throughout the rest of the week. Refresher training related to communication was observed and the trainers did an excellent job with instruction of the content material. One of the great initiatives by the facility was the new Life Skills Center program designed and developed primarily for the individuals in home 510B. The concept was excellent, and the potential huge. The addition of the special education teacher to assist with curriculum design and staff training will be of great benefit. Participation by therapy clinicians is an excellent model for how to integrate therapeutic supports and strategies into real life environments in order to make a big impact upon individuals and their participation. Quick completion of the available kitchen is encouraged to further expand the opportunities for individuals who participate in this program. Further, problem solving will be necessary to ensure continuity of SLP support in this program with the conclusion of Susan Holler's contract this month. Many assessments remained outstanding and contributed to the unknown needs. Many assessments continued to be completed after the established deadlines. This clearly created a void in the development of ISPs in an integrated team manner. Significant information related to communication was based either on very old assessments or none at all. The content aspect of assessments reflected progress in that 80% of the assessments reviewed contained more than 90% of the 24 essential elements and, moreover, 100% of the assessments contained 83% or more of the required elements. Improvements from the previous review were noted in 46% of the 24

	elements. Nine others were maintained at 100%, consistent with the previous review. Minor decreases were noted for two elements and it was noted that approximately 70% of the assessments were completed prior to the ISP. It is critical that clinicians use what they learn from observing individuals in home, work, day program and in direct therapy into the documentation needed for completion of the assessments. The therapists are commended for the impressive quantity of direct services they provided each week. Integration of communication into the ISP and real time coaching and modeling for staff are also keys to effective functional implementation. Maintaining equipment already provided to individuals was reported as an ongoing and costly problem. Clear expectations from administration and supervisory staff regarding the care of these is essential in order that they are always available to the individuals who need them. Further, there was a need to expand the time available for staff training related to communication to further emphasize its importance throughout the day for every individual who lives at SGSSLC. <u>The following samples were used by the monitoring team:</u> • Sample R.1: Individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals with assessments submitted by LSSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals receiving direct speech services

#	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.	<u>Staffing</u> There were two full-time SLPs with responsibilities primarily related to communication: Brittenee Valade, MS, CCC-SLP, and Melissa McDonough, MA, CCC/SLP. Erin Bristo, MS, CCC-SLP, was a PNMT member, dysphagia therapist, coordinator of SLP task assignments, assisted with section R provisions and action plans, mealtime monitoring, direct therapy as indicated, and served as a member of the PBSP Committee. One other full time clinician working at the time of the previous review was no longer employed with the department and a part-time clinician, Susan Holler, MS, CCC-SLP was to complete her contract at the end of August 2013. The single SLP Assistant position was no longer available. A recruitment log was maintained by the Director, Dena Johnston, OTR, who continued to actively seek the identification of qualified candidates for state and contract positions. There were three positions budgeted per the document submitted, and two were listed as filled as of 7/12/12. Per Ms. Johnston, however, only one of these positions (Ms. Bristo) was filled by a SLP at the time of this onsite review, supplemented by two full-time and one part-time contract positions. The other state position was filled by the audiologist, who did not provide communication assessments and services as described in this provision. While Ms. McDonough was not actively	Noncompliance

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		working during the week of this review, as she had taken a month off at the end of her contract term, she was scheduled to return at the end of the month. Per the self-assessment, the established measure of success was to maintain three FTEs or equivalent for SLPs. The Director identified two budgeted SLP positions with a varying number of FTEs from December 2012 through May 2013. Contract staff hours ranged from 333 (May 2013) to a high of 428 (February 2013). There was no evidence of the method used to identify the need for this level of staffing. Responsibilities of the communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication and dysphagia. Recruitment efforts continued and were well documented in the recruitment log maintained by the Director. There had been no responses to fliers, phone calls and college postings for budgeted positions. The only success was through the use of contract clinicians at this time. The census was 214 individuals. The SLPs were assigned caseloads as follows (totals based on individual list by home, adjusted for deaths and discharges and based on census of 214 per documentation submitted): • Brittenee Valade: 502, 504A and B, 508A and B, 509A and B, and 516E (99 individuals, approximately 17% with severe language deficits and 16% with mild to moderate deficits). These numbers indicated that she served approximately 33 individuals with identified communication needs with others requiring at least an assessment or screening every five years. • Melissa McDonough: 505A and B, 510A, 511A and B, 512A and B, and 516W (97 individuals, 24% with severe language deficits, 13% with mild to moderate deficits, and another 6% with identified needs based on the Master Plan). These numbers indicated that she served approximately 35 individuals with identified communication needs with others requiring at least an assessment or screening every five years. • Susan Holler: 510B, PBSP Committee, Life Skills Center Training and Therapy (16 individuals, 88% with severe language deficits and 6% with mild to moderate deficits). These numbers indicated that she served approximately 15 individuals with identified communication needs with others requiring at least an assessment or screening every five years. There were a number of individuals included in the plan with no priority level assigned, though most of those had been provided a screening. There were only a few of those provided a comprehensive assessment, or who had failed the screening and required	

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		further assessment. It was not known how Ms. Holler's caseload would be distributed at the end of the month. SGSSLC appeared to provide an adequate number of SLPs to provide communication supports and services. These caseload assignments were reasonable based on need, but the number of screenings and comprehensive re-assessments required was significant and may impact the ability of the speech clinicians to appropriately provide adequate supports and services as noted below. The addition of SLPAs would sufficiently help them to attain a better on-time record for completion of assessments, stay current with re-assessments, and most importantly, maintain and expand the supports and services needed for individuals with high communication needs. <u>Qualifications:</u> • 4 of 4 SLPs (100%) were licensed to practice in Texas as verified online. • 0 of 0 SLPAs (n/a) were licensed to practice in Texas as verified online. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 5 of 5 current SLP staff (100%) had completed continuing education related to communication relevant to the population served in the last six months. The SLP assistant had attended two courses, but was not employed with SGSSLC at the time of this review. Continuing education attended by the clinicians for which contact hours or CEUs were provided that appeared to be relevant to communication included: • Mental Illness in Children, 6 CEU hours (Holler) • The Way I See It, 4 CEU hours (Holler) • Utilizing Social skills to Address Challenging Behaviors, 6 CEU hours (SLPA) • Video Modeling for Special Populations, 6 CEU hours (SLPA) Only "The Way I See It" attended by Ms. Holler was identified as AAC-specific. A number of others listed included SASSLC inservice training relevant to communication with no contact hours listed. It was not clear if the clinicians attended or presented the training, though this appeared to be inservice training conducted during the weekly Rehabilitation Therapy Clinical Supports meetings. This included the following: • Working with Autism (Bristo, Holler, McDonnough, and Valade) • Socialization, Communication and Independence During the Mealtime (Bristo and McDonough) • Supports vs. Restrictions Related to Rehab (Bristo and McDonnough) • Hospice Services (Bristo and McDonnough)	

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		• Sensory Diets (Bristo, Holler, McDonnough, and Valade) The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to seek continuing education courses beyond in-house training to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at SGSSLC, per the self-assessment. That said, the clinicians generally appeared to recognize the role of relevance, alternate access sites, environmental context, and meaningful contextual training opportunities as effective methods in the development of AAC for this population. They also appeared to understand the important role of the DSPs as communication partners. <u>Facility Policy:</u> There was a local policy related to communication dated 5/30/13. The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an Assessment of Current Status versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • 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. Each of these was sufficiently addressed in the policy submitted. There appeared to be a sufficient allocation of SLP resources, based on identified need. These resources were routinely challenged, however, with changes in contract staff,	

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		identified needs relative to mealtimes and dysphagia, new admissions, and the fact that assessments were not consistently completed 10 working days prior to the ISP. The facility concluded that they were not in compliance with this provision and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Re-establishment a position for at least one SLPA position. This would go a long way to ensure that existing supports and services could be maintained. 2. Consider an additional SLP position. It would ensure the timely completion of high quality communication assessments and the design of appropriate and effective communication programs and interventions.	
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> A Master Plan was submitted dated 7/1/13 and included 211 individuals who were prioritized for communication needs. This plan indicated that 32 individuals were identified as Priority 1 (11%), 22 individuals were identified as Priority 2 (6%), 29 individuals were identified as Priority 3 (5%), 53 individuals were identified as Priority 4 (32%), and 17 individuals were identified as Priority 5 (11%). Approximately 89 (38%) of these had been provided a comprehensive communication assessment, since October 2011. Another 57 (27%) had been provided a recent screening. Others (35%) did not have an assessment, or had assessments that were completed prior to the establishment of the current assessments guidelines and standards for assessments that were comprehensive and met the intent of the Settlement Agreement (as per SGSSLC prior to October 2011). Completion of assessments was generally based on the ISP schedule, with less of a focus on the priorities established in this plan. Frequency and timeliness were clearly outlined in the policy dated 5/30/13. Types of assessments, due dates, and timeliness of completion were tracked in the tracking log. Fifty-six individuals were provided with screenings to determine their needs for further assessment in the area of communication. These were provided to individuals newly admitted to SGSSLC. Approximately 78 individuals not provided a comprehensive assessment since October 2011 were scheduled for one during 2013, with approximately 35 of these past due as of 7/1/13. Ten of these, however, were listed as provided an annual assessment, rather than a comprehensive assessment in 2012 or 2013. It was not known if these were updates to the previous comprehensive, intended to bring it in line with the current standards, or were merely updates related to supports and services provided in the last year. Six of these had proposed dates for a comprehensive assessment or screening to date in 2013, yet these were not completed as of 7/1/13. Seven others had proposed dates from July 2013 through the end of 2013 and the others were projected into 2016 (Individual #53, Individual #173, and Individual #318).	Noncompliance

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		At any rate, there were nearly 70 individuals who had not received an appropriate communication assessment or screening of any type since prior to October 2011. Approximately 20 of these were identified as Priority 1 (11), 2 (1), or 3 (8) needs. Approximately 50 were either Priority 4 or 5, and another three were not prioritized per the Master Plan submitted. The policy indicated that individuals who received direct or indirect communication supports and services would be provided an Assessment of Current Status (ACS) annually, with a repeat Comprehensive Assessment every five years. The projected dates of future comprehensive assessments/screenings varied from individual to individual, however, per the plan submitted and this plan did not identify those individuals who required an annual ACS. The self-assessment/monthly QA report identified the total number of assessments that were required to be completed (per the Master Plan) from December 2012 (223) through June 2013 (215). There had been a steady increase in the percentage of assessments completed as required each month from 39% to 57%, as evidence of progress with the Master Plan across that seven month period. The plan had been revised and entries were made daily to accurately reflect completion of assessments. It was reported that all required assessments for June 2013 were completed, with 87% completed on time. This data did not accurately reflect the number of individuals without appropriate communication assessments per the Master Plan and there were also a number of assessments listed as to be completed early in 2013 that had not been completed. It did not appear that these had been included as "required". The tracking log of assessments completed from 10/1/12 through 6/24/13 identified that 37 individuals were provided a Comprehensive Assessment. Of those, 16 (43%) were completed on or before the due date listed. Another 11 were completed prior to the ISP. There were 23 individuals who were provided an Assessment of Current Status, with 12 (52%) of these completed on or before the due date listed. Another seven were completed prior to the ISP. There were 62 individuals who were provided a communication screening. Of those, 49 (79%) were listed as on time, with another 11 completed prior to the ISP. Overall, approximately 63% of the assessments/screenings were completed 10 working days prior to the ISP, with 87% completed prior to the ISP. There was a facility-wide system to track assessments and to notify Directors of assessments incomplete as of the due date. This system should assist in the management of, and improvement in, the timely completion of assessments for all disciplines. Per the self-assessment, a steady increase was noted from 20% compliance in December 2012 to 87% compliance in June 2013. It was noted that of 116 assessments due for completion during that time period, only 52% were reported as completed on time, though 91% were reported as complete overall. The on-time compliance continued to	

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		improve and as of June 2013; assessments were scheduled 45 days in advance of the ISP date to better ensure timeliness. The data reported related to delinquent assessments in the Communication Services Monthly Review for June 2013 was not consistent with the data reported as to the total number of assessments completed. For example, the data for May 2013 indicated that 15 assessments were due and that 13 were completed on time, but that all 15 were complete. The tracking of delinquent assessments data indicated that neither of the two delinquent assessments had been completed for May 2013. Clarification of these was indicated. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following: • Sample R.1: 15/15 individuals. Assessments were submitted as follows (per date on signature page when available): • Speech-Language Evaluation 1. Individual #210 (8/27/10) 2. Individual #150 (11/8/11)* 3. Individual #287 (12/2/10)* 4. Individual #7 (4/4/12) 5. Individual #203 (10/1/10)* • Comprehensive Communication Assessment 6. Individual #151 (1/28/13)* • Speech-Language Comprehensive Assessment 7. Individual #344 (6/10/13)* 8. Individual #251 (9/4/12)* 9. Individual #189 (1/30/12)* 10. Individual #379 (8/15/12)* 11. Individual #294 (7/15/13)* 12. Individual #130 (8/7/13)* 13. Individual #134 (6/29/12)* 14. Individual #38 (6/29/12)* • Evaluation Update 15. Individual #7 (5/8/12) 16. Individual #150 (11/2/12)* • Assessment of Current Status 17. Individual #379 (7/29/13)* • Speech Language Pathology Screen 18. Individual #77 (6/19/13)* 19. Individual #151 (2/4/13)* Assessments for eight individuals were current within the last 12 months. Six of the	

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		comprehensive assessments were current within the last 12 months and, as such, were included in the analysis of comprehensive assessments below.
		
		• Sample R.2: There were 17 individual assessments completed by four clinicians submitted. One assessment was duplicated in Sample R.1 (for Individual #344). All were considered to be current as follows:
		  • Speech-Language Comprehensive Assessment
		  1. Individual #150 (5/6/13)*
		  2. Individual #253 (3/28/13)*
		  3. Individual #323 (5/3/13)*
		  4. Individual #27 (5/29/13)*
		  5. Individual #154 (5/15/13)*
		  6. Individual #344 (6/10/13)*
		  7. Individual #128 (2/15/13)*
		  8. Individual #180 (4/22/13)
		  9. Individual #25 (5/2/13)
		  10. Individual #18 (6/17/13)*
		  11. Individual #38 (5/29/13)*
		  • Assessment of Current Status
		  12. Individual #21 (4/24/13)*
		  13. Individual #188 (5/6/13)
		  14. Individual #144 (2/28/13)*
		  15. Individual #40 (5/27/13)*
		  16. Individual #98 (4/29/13)
		  17. Individual #338 (6/3/13)*
		
		Thus, 16 of 30 individuals in Samples R.1 and R.2 were provided a current comprehensive communication assessment for analysis below.
		
		There were 11 individuals admitted to SGSSLC since December 2012, per the list submitted. Sample screenings were submitted and included in Sample R.3 (Individual #246, Individual #30, Individual #63, and Individual #96).
		• 9 of 11 individuals admitted since the last review (82%) received a communication screening/assessment within 30 days of admission, based on the tracking log and screenings submitted. A comprehensive assessment was submitted for Individual #374 (2/18/13) with the request for new admission assessments. She was not listed as a new admission on that list, as such, was not included in this metric.
		
		There was a system in place to require that these be completed at least five days prior to	

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		the Admission ISP and all had been completed as required since December 2012 with 70% completed on time. It was further noted, per the Master Plan, that there were 56 individuals listed who were provided a screening since January 2012 across Priority Levels 3, 4, and 5, and for those with no level listed. It was not clear, based on the Master Plan, whether each of these was newly admitted to SGSSLC or that screening was selected (rather than assessment) for any other reason. At any rate, 95% were listed as passing the screen and, thus, did not require further assessment. Individual #71 (6/21/13), Individual #186 (5/14/13), Individual #369 (1/30/12), and Individual #374 (no date identified) were listed as not passing the screening, though only Individual #374 was listed with a current comprehensive assessment. Individual #186 was listed with an annual assessment only and it was not clear if that met the comprehensive standard . There was no evidence that the other two had received a comprehensive assessment as of 7/1/13. • 1 of 1 individuals identified with therapy needs through a screening (100%) received a comprehensive communication assessment within 30 days of identification (Individual #151). A screening had been completed for Individual #132 on 7/26/13 prior to his ISP on 8/12/13 (and attended by the monitoring team during the week of this review). While the screening indicated that further assessment was indicated, this was not completed prior to the ISP. The clinician was still within the 30-day window described in this metric, but further planning related to communication supports could not be addressed during the ISP and a follow-up ISPA would be required. This was both ineffective and inefficient. • 5 of 5 individuals (100%) in the sample of individuals who were provided direct communication supports and services (Sample R.4) were provided an assessment current within the last 12 months. <u>Communication Assessment:</u> Based on review of the sample of assessments submitted and included in Samples R.1 and R.2, there were 16 individuals with comprehensive assessments current within the last 12 months. ISPs current within the last 12 months were submitted for only 10 of those, and only those were reviewed below. Two of the comprehensive assessments contained <u>all</u> of the 24 elements outlined below (20%). These are the minimum basic elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. For the other assessments, some of these elements were missing or they were inadequately addressed. The current state and local SGSSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows:	

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		• 10 of 10 individuals' communication assessments (100%) were signed and dated by the clinician upon completion of the written report. • 4 of 10 individuals' communication assessments (40%) were dated as completed at least 10 working days prior to the annual ISP. This was a slight decrease from 47%. It was noted that 70% of the assessments were completed prior to the ISP (five to 10 working days before the ISP). One of these was completed nine working days before, yet all of the assessment information was addressed in the ISP (Individual #379) and the SLP attended the meeting. The assessment for Individual #253 was completed five working days prior to the ISP, yet again all of the assessment information was addressed in the ISP and the SLP was present for the meeting. One of the three assessments dated after the ISP was for Individual #294 for whom a 30-day change-in-status ISP was held on 5/22/13. The SLP attended and assessment information was included in the ISP document submitted. • 10 of 10 individuals' communication assessments (100%) included diagnoses and relevance of impact on communication. This was improved from 94%. • 10 of 10 individuals' communication assessments (100%) included individual preferences and strengths. This was consistent with the previous review. Though these were listed in most assessments, they were not consistently used to guide the development of communication strategies or AAC systems. • 10 of 10 individuals' communication assessments (100%) included medical history and relevance to communication. This was an improvement from 88%. • 10 of 10 individuals' communication assessments (100%) listed medications and discussed side effects relevant to communication. This was consistent with the previous review. • 10 of 10 individuals' communication assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was consistent with the previous review. • 10 of 10 individuals' communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was consistent with the previous review. • 10 of 10 individuals' communication assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 59%. • 6 of 8 individuals' communication assessments (75%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required. The communication dictionary was discussed and updates to the dictionary were recommended, but two assessments did not specify exactly	

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		what changes were needed. This was an improvement from 55%. • 10 of 10 individuals' communication assessments (100%) included discussion of the expansion of the individuals' current abilities. This was consistent with the previous review. • 10 of 10 individuals' communication assessments (100%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 93%. • 6 of 9 individuals' communication assessments (67%) included the effectiveness of current supports, including monitoring findings. This was an improvement from 14%. Each thoroughly discussed the effectiveness of existing supports, but a few stopped short of referencing the actual monitoring findings obtained. • 10 of the 10 individuals' communication assessments (100%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. This was consistent with the previous review. • 9 of 10 individuals' communication assessments (90%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 80%. • 8 of 10 individuals' communication assessments (80%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 53%. Communication function was thoroughly described and findings from previous assessments were presented, but the clinicians did not always specifically compare the two. • 10 of 10 individuals' communication assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was consistent with the previous review. • 4 of 10 individuals' communication assessment (40%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This is a newly established metric. • 10 of 10 individuals' communication assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 10 of the 10 individuals' communication assessments (100%) supplied a monitoring schedule. This was an improvement from 94%. • 9 of 10 individuals' communication assessments (90%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an improvement from 76%. • 9 of 10 individuals' communication assessments (90%) made a recommendation about community referral and transition. This was a decrease from 100%. One assessment omitted the state-required statement regarding potential for community living, though the recommendations identified suggested that the	

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		clinician believed that the individual could effectively be supported in the community. • 10 of 10 individuals' communication assessments (100%) included specific recommendations for services and supports in the community. This was an improvement from 12%. • 10 of the 10 individuals' communication assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. Additional findings related to the communication assessments were as follows: • 8 of 10 assessments contained more than 90% of the 24 elements listed above. • 10 of 10 assessments contained 83% or more of the elements listed above. • 0 of 10 assessments contained less than 83% of the elements listed above. • 16 of 24 (67%) of the elements listed above were noted for 100% of the assessments reviewed. • 19/24 (79%) of the elements listed above were noted for 90% or more of the assessments reviewed. • 20/24 (83%) of the elements listed above were noted for 80% or more of the assessments reviewed. • Improvements from the previous review were noted in 46% of the 24 elements. Nine others were maintained at 100%, consistent with the previous review. Minor decreases were noted for two elements and only one of those was below 90% compliance (assessments completed 10 working days prior to the ISP). As described above, 70% of the assessments were completed prior to the ISP. There were specific content guidelines used by the clinicians to ensure that the required content was addressed in each assessment and should be considered. A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was well established and clearly effective. Findings based on this audit system identified an improvement from 79% compliance in December 2012 to 93% in May 2013 and 91% in June 2013. These findings were consistent with that of the monitoring team (an average of 94%). The current audit system included review by the lead SLP/Director until competency was established. The clinicians then audited their own assessments against the audit form. One of these self-audited assessments was re-audited by the lead clinician/Director for inter-rater reliability and to ensure continued competency.	

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		SLP and Psychology Collaboration: The facility reported improved integration of speech and psychology services as this had been a focus for treatment of individuals with severe communication deficits. There was an attempt to better reflect communication strategies and AAC devices into the PBSPs. In addition there were efforts reported to improve collaboration between the IDT and SAP writers to ensure that learning styles, communication and processing information was incorporated into these plans. The impact of these additions was not yet evident as described below. There were 27 individuals identified with behavioral issues and co-existing severe language deficits. Each was listed as Priority 1 for a communication assessment. There were 18 of these who had been provided a comprehensive assessment or update since October 2011. Individual #7 had an assessment update on 5/8/12 that referenced a comprehensive assessment on 10/7/10. There was no evidence of a more current update, though she was provided indirect supports. Individual #134 was provided a comprehensive assessment on 6/29/12, though a more current update was not noted which would be expected because he received indirect communication supports. The Master Plan documented that an update was also provided to Individual #288 rather than a comprehensive assessment on 10/23/12. Another nine individuals had not been provided an appropriate and current comprehensive assessment at the time of this review. There were approximately 191 individuals listed with PBSPs and 22 of these were included in the Samples R.1 and R.2 identified above. PBSPs were included in the individual records as submitted for eight individuals in Sample R.1 though three were expired at the time of the onsite review (Individual #134, Individual #210, Individual #150, and Individual #287). Of those that were current, current PBSPs were submitted for only Individual #251, Individual #294, Individual #379 and Individual #344 as present in their individual records. • 10 of 10 communication assessments reviewed for individuals in Samples R.1 and R.2 (100%) addressed some aspect of the individual's behavior in the Behavioral Considerations section. Nine of these individuals were identified as provided a PBSP. This section generally reported behaviors observed by the SLP during the assessment, communicative behaviors noted and also described the target and replacement behaviors per the PBSP. Discussion of the communicative intent of these behaviors was also noted in most cases, though some were more complete than others. • For 0 of 4 individuals (0%) reviewed in Sample R.1 with PBSPs, communication strategies identified in the assessment were at least partially included in their behavior plans. o The PBSP (2/20/13) for Individual #294 included a SAP for him to	

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		shake his head "no," to say "no," or sign "no" or "finished." Per the communication assessment dated 7/15/13, this was discussed by the IDT at his 30 day ISP and ruled out as an appropriate strategy because he no longer used words, had difficulty moving his arms, and was experiencing worsening vision. There was no evidence of a more updated plan in the individual record to reflect these changes. Further, the status of this was not evident in his ISP dated 5/22/13. o In the case of Individual #379, his PBSP (3/6/13) identified a number of verbal strategies for use to address his problem behavior of physical aggression. Per the communication assessment dated 8/15/12, it was reported that he used words to communicate only occasionally and randomly and often without purpose. The PBSP indicated that he should be expected to say or sign "yes" when he wanted to talk or participate, yet it was reported that his yes/no responses were inconsistent with his meaning. The communication assessment (6/10/13) discussed a need for hand-over-hand instruction and fewer verbal cues to prompt him. This was not reflected in his PBSP of 8/1/3. o A communication strip and booklet were provided to Individual #251 per his communication assessment dated 9/4/12, yet these were not referenced in his PBSP dated 10/5/12. Communication strategies identified in the communication assessments and the PBSPs were not adequately integrated or consistent. There were 23 meetings held to review PBSPs from 12/12/12 through 5/29/13 and a SLP attended 14 (61%) of the meetings held. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the SLPs. This should continue with an effort to improve frequency of attendance. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. While significant improvements were noted with the inclusion of the essential elements in the completed communication assessments, this element was not yet in compliance as evidenced by assessments not completed 10 working days prior to the ISP, and limited progress with the completion of communication assessments, and the absence of recommended communication strategies in the PBSPs and the ISPs. The facility concluded that they were in compliance with this element of section R, but the monitoring team did not concur based on the findings reported above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months:	

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		1. Develop a plan, to include benchmarks to address the completion of communication assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Initiate further collaboration with psychology to identify strategies to ensure integration of communication strategies in the PBSPs. 3. Initiate further collaboration with the QDDPs and ISP Facilitators to ensure that essential elements related to communication and communication supports and services are reflected in the ISPs. 4. Identify very specific and clearly stated communication strategies for staff use to be outlined in the assessments so these may be readily referenced by IDT members for application and implementation. Contact with other SSLCs may provide some ideas for this.	
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> An Essential Elements Checklist was developed to guide the therapists in their meeting participation to ensure that all key elements were addressed during the pre-ISP and ISP meetings. • For those individuals included in Sample R.1, current ISPs were submitted for 13 of 15. • For those individuals included in Sample R.2, current ISPs were submitted for two additional individuals, not included in Sample R.1 (Individual #188 and Individual #144). Current assessments were submitted for only nine of those with ISPs in Sample R.1., while each of the assessments for individuals in R.2 was considered current. As such, there were 13 individuals with both current communication assessments and current ISPs submitted for review (Individual #77, Individual #253, Individual #188, Individual #144, Individual #323, Individual #38, Individual #151, Individual #180, Individual #379, Individual #294, Individual #251, Individual #344, and Individual #130). • For 9 of 13 individuals (69%), a SLP was in attendance at the ISP. The pre-ISP process should clarify in which cases a SLP is required to attend the meeting and, if not, provide sufficient rationale for that not being necessary. In cases where there were no supports and services provided, it would not likely be needed unless a new need was identified at the pre-ISP. In that case, a request for assessment by the SLP should be made and attendance to discuss the findings would be indicated. • For 5 of 13 individuals (38%), communication strategies identified in the assessment were included in the ISP. The strategies in the communication assessments for staff use were not generally easily identified, so likely did not also translate to the ISP document for further reference. Other issues were	Noncompliance

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		noted as follows: o The ISP for Individual #77 merely stated that the IDT had reviewed how she communicated during the introductions, but this was not documented in the ISP itself. o The ISP for Individual #188 referenced a previous assessment dated 11/19/12, rather than the most current one dated 5/6/13. But, the newer strategies recommended in the current one were included. o Assessments for Individual #38, Individual #294, and Individual #323 were completed after the ISP. o The SLP had recommended a picture schedule for Individual #151. This was not addressed in the ISP, but rather there was mentioning of him stuttering, though this was not referenced by the SLP. o The ISP for Individual #180 referenced a speech screening, yet he had been provided a comprehensive assessment completed on 4/22/13. There were no references to an Augmentative Communication Interpretation Book or direct therapy recommended. An action indicated that he would be referred to speech related to picture sequencing. A SLP was in attendance at this meeting and the assessment was completed more than 10 working days before the meeting. o The ISP for Individual #379 on 8/28/12 referenced the current comprehensive assessment dated 8/15/12 and addressed the recommendations at that time. There was no more current ISP, though an Assessment of Current Status had been completed on 7/29/13. o It did not appear that the ISP for Individual #344, dated 7/11/13, integrated the most current communication assessment dated 6/10/13. o The ISP for Individual #130 referenced a communication assessment dated 9/22/10 and stated that a more current assessment was not available at that time. A comprehensive assessment had been completed for Individual #130 on 8/7/13 for her upcoming ISP scheduled for 8/22/13. • In 9 of 12 ISPs for individuals with communication supports (75%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, strategies for staff use) were identified, though most of these were limited to the Communication Dictionary only. One individual had been screened with no identified needs (Individual #77). • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 5 of 9 (56%), as evidenced in the ISP. Two of these only documented IDT approval of continued use and stated that they were reviewed and updated, but did not address the accuracy of the content or identify any necessary changes (Individual #130 and Individual #210). The ISP stated that	

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		the dictionary for Individual #38 had been reviewed four months earlier, but did not indicate that this was done at the time of his ISP in May 2013. • 7 of 13 ISPs (55%) included a description of how the individual communicated, though one description was from a previous assessment rather than the most current one and one was stated using professional jargon only. Others were very limited or non-existent. • 1 of 12 ISPs (8%) contained skill acquisition programs to promote communication. One individual had been screened with no identified needs (Individual #77). • In 1 of 12 ISPs (8%), information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP were included. This was non-specific, however (Individual #144). One individual had been screened with no identified needs (Individual #77). <u>Individual-Specific AAC Systems:</u> Approximately 71 individuals were listed with some type of communication system, though 20 of these were provided a communication dictionary only (41 others in combination with one or more AAC systems). The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This enhances staff understanding of the individual and promotes consistent responses, but does not specifically enhance or improve the individual's expressive or receptive communication skills. Instructional guidelines had been developed to improve the interview process for the development of the communication dictionary. Per the Individuals with AAC Devices spreadsheet, dated 6/26/13, the variety of AAC was as follows: • Community systems (5), Go Talk 20 (1), picture schedules (8), communication pictures (2), picture boards/chart (3), display boards (2), picture books (3), object boards (1), activity vest/chewy tubes (1), Put 'Em Arounds (7), schedule ring (1), Time Timer (2), picture timer/schedule book (1), pain scale (1), shower cue card (1), communication pictures/cards (4), sign cards (2), visual reminders (1), scripts (1), social story books (4), choice boards/box (6), picture sequencer (3), visual sequencer (1), communication books (2), calendar (1), visual cueing cards (1), communication interpretation book (1), voice output devices (3), recordable button (1), augmentative display system (2), and 4 space Go Talk (1). These systems were generally portable, very functional and individualized, and there were typically staff instructions available and these plans were clear and informative. Based on this list, all 54 individuals identified at Priority 1 or 2 had been provided some type of communication supports, as well as, 12 individuals listed at Priority 3, one at	

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		Priority 4 and one at Priority 5, with three others not prioritized per the Master Plan. As stated above, there were 20 who had a communication dictionary only. This was not unreasonable to expect in some cases, and each had been provided an assessment since October 2011. While not all individuals would necessarily benefit from AAC or other communication supports and services, an assessment to rule this out was indicated and at least 76 individuals who had not received a screening, comprehensive assessment or update since October 2011. The majority of the assessments for the individuals in Sample R.1 and R.2 provided an adequate assessment of the individual's potential for AAC use. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage. <u>General Use AAC Devices:</u> Though general use devices were noted in some areas, these were not quantified. The meaningfulness and function of the other devices appeared to be very appropriate and many were noted to be in use and/or specific training was occurring to promote their use. The clinicians appeared to understand the application and integration of AAC as there were very excellent supports in place. <u>Direct Communication Interventions:</u> There were 10 individuals listed as participating in direct communication-related interventions provided by the SLP. This was a decrease from 15 individuals as reported in the previous review. Susan Holler, routinely provided group, but individualized training, intervention, and other supports in the Life Skills Center were not included on the list submitted. Some of these individuals had been previously participating in direct communication therapy on an individual basis as this program was just recently developed primarily for individuals living in 510B. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to a comparative analysis of the individual's progress or lack	

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		of progress. Records related to the provision of direct intervention plans for five individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Individual #273 was omitted from this review as the treatment provided did not pertain to communication. • 0 of 4 (0%) individuals received direct therapy documented per generally accepted practice standards related to communication interventions. Some findings were as follows: o Individual #201: The Assessment of Current Status (3/6/13) identified that consultative treatment sessions were initiated on 9/4/12. There was a SAP, and measurable objectives were included in the ISP dated 3/20/13. The purpose of intervention was not clear in the IPNs. There was no additional clarification in the assessment. There was no clear documentation of initiation or termination of intervention by the SLP and the notes did not consistently document the supports provided. The documentation did not meet basic generally accepted standards for communication intervention and was not consistent with the established policy. o Individual #173: He was listed as participating in direct communication therapy and this was recommended in his Assessment of Current Status dated 3/21/3, but there was no evidence that this was implemented. A SAP related to the use of basic signs to communicate with staff was submitted. There was no evidence that this had been developed by the SLP and there was no evidence of staff training or review by the SLP since implementation on 6/2/13, though this had been integrated in the ISP dated 4/4/13. The documentation did not meet basic generally accepted standards for communication intervention and was not consistent with the established policy. o Individual #78: There was one treatment note dated 4/3/12 indicating that he participated in direct therapy for diaphragmatic breathing and this was to continue. There was no documentation of subsequent interventions or termination. His Assessment of Current Status (4/22/13) indicated this need with recommendations for direct therapy three times weekly. This was not included in his ISP dated 5/6/13. The monitoring team observed an excellent intervention with Individual #78 during the onsite review in which the speech clinician worked with him to identify specific icons he preferred to be included on a voice-output device. It appeared that the other intervention had been discontinued, but there was no rationale for termination or this change in direction for intervention and supports. The documentation did not	

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		meet basic generally accepted standards for communication intervention and was not consistent with the established policy. o Individual #220: An IPN on 10/2/12 indicated that direct language therapy was initiated on that date, though this had been recommended in the comprehensive assessment completed on 7/30/12 (two months earlier). The recommendations were not integrated into the ISP dated 8/15/12 and there was no SLP present at the meeting. There was no treatment plan or SAP outlined and no measurable goals were identified. Documentation of three subsequent treatment sessions was submitted through 12/4/12 only. At that time, goals were stated for a SAP and staff training was to be provided upon IDT approval. There was no evidence of further documentation or action related to this intervention noted. The documentation did not meet basic generally accepted standards for communication intervention and was not consistent with the established policy. There were significant inconsistencies and gaps in the documentation and provision of direct intervention and other supports related to communication. Guidelines were needed with routine review and audits of these were indicated. <u>Indirect Communication Supports:</u> Indirect communication supports for individuals included the communication dictionaries, SAPs, and AAC systems. The dictionaries were mentioned in some of the ISPs (but not described) and there was little evidence of annual IDT review. As described above documentation of the supports provided was sparse and incomplete. There was no evidence of documentation for the individuals related to the benefit and effectiveness of the supports, consistency of implementation, or recommendations related to necessary changes (Individual #40, Individual #389, Individual #211, Individual #201, Individual #220, Individual #173), though staff instructions related to SAPs and AAC systems were well done. <u>Competency-Based Training and Performance Check-offs:</u> New employees participated in NEO classroom training and completed competency check-offs for foundational skills related to communication. Per the schedule, there was a four hour block related to AAC to permit an opportunity for new employees to explore the systems, and to present guidelines for use, as well strategies for use as an effective communication partner. This included: • Methods to enhance communication • Implementation of programs • Benefits and use of AAC	

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		• Identification of non-verbal means of communication. A competency check-off form was used to establish participants' abilities to communicate effectively, identify non-verbal communication, use basic low-tech AAC devices, use prompts and cues, offer opportunities for choice-making, and to read the PNMP with respect to the individual's communication skills and how staff should communicate. Instructions on the form indicated that the trainer identified whether the new employee met the criteria for competence in each element of the form. If the employee was not successful, the reason was to be documented by the trainer. Additional training was provided, then the staff was to be rechecked. If the new employee failed a second time, again this was documented and the staff was retrained. The supervisor was also notified. If the new employee failed a third time, the NEO training was to be repeated the following month. All new employees were required to pass all essential elements of the communication portion of the training to be established as competent. NEO shadowing was conducted before the new employee was permitted to work independently on their assigned home. This training included training on each of the PNMPs and communication plans on the assigned home with skill check-offs. These were to be completed within 30 days following completion of the NEO classroom training. There was another hour and a half designated for deaf awareness content. As there were limited individuals for whom this information was relevant, using some of this time for further communication-related content should be considered. Hearing aid use could become a individual-specific training and tips for communicating with individuals who have hearing loss could be incorporated into the general communication partner strategies. Refresher training had been developed in the area of communication and implemented in February 2013. Core competencies included: • Effective communication • Nonverbal communication • AAC • Types of cues • Choice making opportunities • Communication on the PNMP Return demonstration was required and was expected to positively impact program effectiveness. A portion of this was observed by the monitoring team. The refresher training also included the competency check-off used in the NEO training described above. The same system for failed check-offs was in place with a recommendation to repeat the NEO training and notification of the employee's supervisor. The training	

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		contained very good content, including the elements described above and the instruction was excellent. The facility is commended on its efforts with this because it is an area that impacts all individuals at SGSSLC and staff effectiveness is dependent upon successful communication with individuals as well as upon their accurately interpreting and responding to individual efforts to communicate with staff and others. More time to address this critical area is needed for NEO, and communication should continue to be addressed with annual refresher training. Effective staff training and administrative support will be key to ensuring that staff understand the importance of communication and AAC systems to the individuals and their quality of life. Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. Pulled staff were required to review all elements of the PNMP and other plans. They were expected to obtain additional training from their supervisor or therapy staff as needed, but no routine training was available to them. There was insufficient integration of communication supports and services into the ISP. In the ISPs submitted for review, there was a lack of focus on communication as evidenced by the limited descriptions of how the individual communicated and strategies for staff use to be effective communication partners. There were limited meaningful SAPs included in the ISPs though there was no evidence that the SLPs collaborated in the development of measurable objectives and effective strategies for implementation. The provision of direct communication therapy was a notable strength, though improvements were needed in the documentation of these interventions. The facility concluded that they were not in compliance with this provision of section R and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a system to track SLP attendance as described by the pre-ISPs. Guidelines for IDTs should be provided to assist them in making the determination as to whether an SLP was needed at the meeting and how to address the identified needs for assessment. 2. Establish guidelines for the inclusion of communication supports in the ISPs to ensure that there is a clear description of how the individual communicates that includes AAC system where applicable and that there are specific strategies for staff to use as effective communication partners . 3. Establish guidelines for documentation of direct speech therapy.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Monitoring System: A system of monitoring was previously established at SGSSLC using a universal monitoring form rather than one specifically related to communication. As such, it was not possible to discern discrete measures, such as the following: • Type of equipment or support monitored • Communication equipment was present • Equipment was found in the correct location • Equipment was in working condition • Staff response to use of the device • Staff were able to describe the purpose of the device. • Tracking of the effectiveness monitoring of AAC systems that was conducted by the speech therapists or the IDT with documentation in the IPN or ISP. By report, there was a plan in place to return to a communication specific monitoring tool for competency and compliance to address the issues listed above. Based on the monitoring tools submitted, it appeared that this was implemented as of May 2013. The current policy outlined that all elements of the PNMP, including the communication plans were monitored by the PNMP Compliance Coordinator, rather than the PNMP Coordinators, as during the previous review. This process was limited to a fewer number of staff in an effort to improve the accuracy of the monitoring process. The other PNMPCs were responsible for staff training and check-offs. Per the self-assessment, the check-off and monitoring process was revised because early data reflected 100% compliance with implementation. Based on informal observation, this was determined to be inaccurate, resulting in the revision of these systems in February 2013. The new system required that if staff failed more than one skill drill (less than 80% compliance), staff were to attend refresher training again with additional supervision required. It was noted that 78% of staff failed these drills in March 2013 and 47% failed in April 2013. This was reduced to 25% in May 2013. The monitoring team looks forward to further review of the effectiveness of these changes. The habilitation therapy services policy clearly addressed the process for compliance and effectiveness monitoring. The frequency of compliance monitoring was not addressed in the policy, however, the Director reported that 16 tools per essential area were completed across all three shifts. This process was initiated for some areas in March 2013 and for all areas as of April 2013. The selection of the sample was left to the PNMP Compliance Coordinators and there did not appear to be a method to ensure that the sample was randomly selected. Effectiveness monitoring was based on individual risk and the intensity of supports provided, but conducted no less than quarterly, per the policy. A work sheet was used to complete the effectiveness monitoring that also	Noncompliance

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		addressed staff compliance and was submitted to the Habilitation Therapy Coordinator for data entry, with follow-up through to resolution if issues were identified. Frequency of effectiveness monitoring was identified in the communication assessment and was to be included in the ISP with documentation in the IPN. These notes were required to include the following: • Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring • Any documented PNM triggers documented on trigger data sheets • Presence and condition of equipment • Staff knowledge and compliance • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations including the person responsible and timelines for completion The self-assessment reported that 65 effectiveness monitorings were scheduled from December 2012 through June 2013 and that 100% of these were completed. Of these 29% were identified as not effective. Identified issues requiring follow-up included: • Equipment was not available • Staff not compliant with implementation • Documentation was not accurate • Lack of staff knowledge • System issues The primary concerns impacting effectiveness of communication programs were related to missing equipment. Resolution of identified concerns within 30 days averaged 83%, with only 67% in April 2013 and 44% in May 2013. It was not known whether all issues identified were not resolved or just not within the 30 day time period. Completed forms for communication-related compliance monitoring conducted in April 2013 and May 2013 (24) were submitted for review. These were completed by the PNMPCs. The forms completed in April 2013 were using the Universal PNMP monitoring tool, while most of those completed in May 2013 were using a communication-specific tool. Compliance was scored as follows • 100%: 7 individual monitorings • 90%: 6 individual monitorings • 80%: 6 individual monitorings • 70%: 1 individual monitoring • 60%: 1 individual monitoring • 50%: 1 individual monitoring	

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		• 40%: 1 individual monitoring When staff were scored at less than 80% compliance, there was evidence of re-training and rechecking the failed skills. This generally appeared at the time of the initial monitoring, however, and actual competence was questionable. The facility concluded that they were not in compliance with this provision of section R and the monitoring team concurred as the current system was very new and time was needed to determine if it was effective. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a system to ensure a more random sample was selected for monitoring by the PNMP Compliance Coordinators. 2. Continue to track findings of both effectiveness and compliance monitoring. Ensure that these are included in annual communication assessments for individuals.	

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 #189, Individual #148, Individual #318, Individual #97, Individual #48, Individual #52, Individual #73, Individual #388, Individual #273, Individual #375, Individual #34, Individual #367, Individual #349, Individual #314, Individual #175, Individual #99, Individual #35 o Skill Acquisition Plans (SAPs) for: • Individual #189, Individual #148, Individual #318, Individual #97, Individual #48, Individual #145, Individual #78, Individual #273, Individual #196 o Monthly review of SAP progress for: • Individual #189, Individual #148, Individual #318, Individual #97, Individual #48 o Functional Skills Assessment (FSA) for: • Individual #189, Individual #148, Individual #318, Individual #97, Individual #48 o Personal Focus Assessment (PFA) for: • Individual #189, Individual #148, Individual #318, Individual #97, Individual #48 o Vocational assessments for: • Individual #189, Individual #148, Individual #318, Individual #97, Individual #48 o Skill Acquisition and Maintenance plans policy and procedure, 3/21/13 o Skill Acquisition Program Master List, undated o Section S presentation book, undated o Section S action Plans, 7/8/13 o Section S self-assessment, dated 7/8/13 o Skill Acquisition and maintenance plans policy and procedure, dated 3/21/13 o Section S Benchmark meeting analysis, 1/13, 2/13, 3/13, 5/13, 6/13, 7/13 o List of community trips by home, 12/12-5-13 o List of individuals employed on- and off-campus, undated o Description of on-campus and off-campus work programs, undated o List of skill training provided in the community, 12/12-5/13 o List of individuals under age 22 and public school status/placement o ISPs, ARD/IEPs (none), and progress notes for • Individual #99, Individual #35, Individual #175 o Summary of WVISD related activities, Michael Davila, QIDP Coordinator, 9/6/13 o Sign in sheets for training on special education laws, 8 QIDPs, 8/7/13 o Blank WVISD classroom observation tool o Meeting minutes, WVISD and SGSSLC, 3, November 2012 to September 2013

	Interviews and Meetings Held: o Michael Davila, QIDP Coordinator; Tammy Ponce, Program Developer Supervisor o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors o Chris Sandoval, Program Trainer o Vicky Hinojos, Director of Residential Services, regarding public school programming Observations Conducted: o ISPA meeting • Individual reviewed: Individual #395 o Observation of implementation of a skill acquisition plan (SAPs) for: • Individual #273 o SAP Committee meeting 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's self-assessment included many relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report, and represented an overall improvement over the self-assessment submitted in the last review. The monitoring team believes, however, that some items in the self-assessment could better reflect the activities that the monitoring team assesses as indicated in this report. For example, S2 of the self-assessment focused on ensuring that functional skills assessments, vocational assessments, and preference and strengths inventories were completed for each individual. These are important topics, however, S2 in the monitoring team's report also assesses if documentation exists that assessments were used to select individual skill acquisition plans. The monitoring team suggests 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 SGSSLC 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, and the monitoring teams report. 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 facility's 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 suggests that the facility establish, and focus its 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 no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were improvements since the last review. These included: • Establishment of a SAP review committee (S1) • Improvements in the quality of SAPs reviewed (S1) • Improvements in individual engagement (S1) • Improvements in the support of individuals who received public school education (S1) • Improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Improvements in the documentation of data based action concerning the continuation, discontinuation, or revision of SAPs (S3a) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1). • Ensure that each SAP has a plan for generalization that is consistent with the definitions below (S1) • Establish acceptable levels of engagement in each treatment area, and ensure that those levels are achieved (S1) • Consistently document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are consistently based on outcome data (S3) • Track SAP integrity measures, establish minimal acceptable treatment integrity levels, and demonstrate that those levels are achieved (S3) • Ensure that measures of skill training in the community are accurate, 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 by seven program developers, and were implemented by direct support professionals (DSPs). Two SAP trainers trained DSPs in the implementation of SAPs, and monitored SAP progress. Since the last review, SGSSLC established the SAP review committee. This was an interdisciplinary group that met weekly to review SAPs and ensure that they contained all the necessary components of an effective plan discussed below. As discussed in the previous reports, 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. Twenty SAPs across nine individuals were reviewed to determine if they were functional and practical. In 16 of the 20 SAPs reviewed (80%), the rationale appeared to be based on a clear need and/or preference. This represented continued improvement in the percentage of SAPs judged to be practical and functional from the last three reports (16%, 39%, and 62%). 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 #48's SAP for selecting healthy snacks was that she was overweight which placed her at risk, and encouraging healthy eating is important for weight loss Some of the rationales, however, continued to appear generic simply 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	Noncompliance

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		functional for the individual. For example: • The rationale for Individual #318's SAPs of combing his hair and shaving, said he wanted to learn these skills, but there was nothing in his ISP, functional skills assessment (FSA), or preference and strengths inventories (PSIs) to indicate that acquiring these skills was a preference for Individual #318 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 All of SAPs reviewed contained all of the above components. Additionally, the monitoring team noted improvements in the maintenance and generalization plans. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Seventeen of the 20 SAPs reviewed (85%) included a plan for generalization that was consistent with the above definition. This represented a slight improvement from the last review when 82% of the generalization plans were judged to be consistent with the above definition. Additionally, all 20 of the SAPs reviewed (100%) included a plan for maintenance that was consistent with the above definition. This represented a dramatic improvement from the last review when none (0%) of the maintenance plans reviewed were judged to be consistent with the above plan.	

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		An example of a complete generalization plan was: • The plan for generalization in Individual #97's SAP of making phone calls stated that he will be encouraged to use his telephone dialing skills when in the community, and on outings where he has the opportunity to use a phone. An example of an unacceptable plan for generalization was: • The plan for generalization for Individual #318's SAP of eating safely which stated the he will display safe eating without prompts. Finally, one of the 20 SAPs reviewed (5%) had an inconsistent operational definition of the target behavior and unclear staff instructions. Individual #318's safe eating SAP defined the target behavior as eating safely without prompts. The general instructions, however, stated that Individual #318 should have prompt scores for five consecutive meals before moving to the next objective. 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 of these SAPs indicated that much more training and monitoring of SAPs at SGSSLC was necessary (see S3). Overall 14 of the 20 SAPs reviewed (70%) contained acceptable examples of the components necessary for effective SAPs listed above. The monitoring team is encouraged by these continued improvements in the overall quality of SAPs. It is recommended that SGSSLC ensure that each SAP contains an individualized rationale for selection that is specific enough for the reader to understand that the SAP was practical and functional for that individual. Additionally, it is recommended that all SAPs contain generalization plans that are individualized and are consistent with the above definitions. Finally, it is recommended that the staff instructions are clear and consistent with the operational definition of the target behavior. <u>Desensitization skill acquisition</u> As discussed in the last report, the psychology department had 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. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be	

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		reviewed in more detail in future site visits. Replacement/Alternative behaviors from PBSPs as skill acquisition SGSSLC continued to include replacement/alternative behaviors in each PBSP. Several of the PBSPs reviewed 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. Communication and language skill acquisition 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). Service objective programming 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). Engagement in Activities 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. In the residential settings the monitoring team consistently observed staff attempting to engage individuals in active treatment. As found in past reviews, however, the ability to maintain individuals' attention and participation in the activities varied widely across homes. For example, in Homes 510B and 512B, the staff were doing an excellent job of	

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		engaging individuals in meaningful mealtime-related activities. In other homes observed by the monitoring team, organized activities were not apparent, and the individuals appeared to be aimlessly roaming about the homes, or lying in bed. The monitoring team also observed engagement in day programs. The new Life Skills Center represented a good example of meaningful individual engagement, and active participation of staff from various departments (e.g., speech pathologists, psychologists). As noted in the last review, engagement in the other day programs was generally good, however, it only represented a small number of the individuals at the facility. The majority of individuals at SGSSLC appeared to be on campus or in their homes during the day. For example, individuals attended scheduled Building Imaginations programs only 38% of the time during June 2013. 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 64%, an improvement over that observed during the last review (49%), but still not as high the two previous reviews (i.e., 72% and 71%). Engagement data were collected by the facility and shared with managers responsible for improving engagement. June 2013's facility-collected engagement averaged 81%. One potential reason for the variation between the facility's and monitoring team's engagement scores were differences in how engagement data were collected. As described above, the monitoring team used a momentary time sample. That is, engagement data were recorded based on what was seen at that moment of observation. On the other hand, the facility did a three-minute time sample. That is, the facility's observers watched a particular individual for three minutes and recorded engagement if that individual was engaged at <u>any time</u> during the 3-minute observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. Although it is unlikely that both methods would yield the same percentages of engagement, they should both reflect changes in engagement across the facility. The monitoring team is encouraged by the improvements in individual engagement since the last review. It is now recommended that engagement targets for each home and day program site be established, and that the facility ensure that those levels of individual engagement are achieved.	

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Engagement Observations:

Location	Engaged	Staff-to-individual ratio
508 A	4/6	3:6
509 B	0/2	1:2
510 A	0/3	1:3
510 A	0/5	0:5
510 B	8/8	3:8
504 A	2/4	2:4
504 B	2/4	1:4
512 A	2/5	2:5
512 B	6/6	3:6
509 B	2/5	2:5
509 B	1/1	1:1
Life Skills Program	2/2	2:2
Life Skills Program	3/4	2:4
Life Skills Program	3/4	4:4
Vocational Building	8 /8	2:8
Vocational Building	10/13	3:13
Suzy Crawford Center	3/6	3:6
Building Imaginations	2/2	4:2
Building Imaginations	3/3	1:3

Educational Services

SGSSLC continued to maintain an excellent working relationship with the Water Valley Independent School District. Michael Davila remained the facility's primary liaison with the public school. Vicky Hinojos, Director of Residential Services, also provided support when/if necessary. The facility held periodic meetings with the public school's administration. Sometimes additional SGSSLC staff attended, such as a QIDP or a unit director.

Four students attended public school. All of the students now attended on the WISD campus, that is, there was no longer a classroom at SGSSLC. This was great to see and demonstrated the collaborative work between SGSSLC and WISD. Increased opportunities for inclusion and integration were being provided to the students.

The ISPs of three students were reviewed and all indicated that the individuals attended public school. There was indication regarding how the ARD/IEP was integrated into the ISP or into the individual's supports and services for 1 of the 3 students. This was the most recent ISP indicating that it was likely, with the new ISP format, this would now occur for all students.

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		ARD/IEPs were not submitted for the three individuals, so the monitoring team could not determine if there was participation and presence from SGSSLC staff. Ms. Hinojos, however, reported that QIDPs went to all WISD meetings, and that often the home managers, psychologists, etc. also attended, especially annual ARD/IEP meetings. SGSSLC QIDPs were now reviewing WISD progress reports and report cards as part of their monthly reviews. The monitoring team reviewed the QIDP's review for one of the students. Mr. Davila recently worked with the recordkeeping staff to create a process for the filing of these reports into the active record. The facility obtained training on special education laws for the QIDPs. Content also included ways to incorporate the ARD/IEP into the ISP. The classroom observation tool was implemented and was reported to be well received by the WISD administration. SGSSLC was fully responsive to comments, suggestions, and recommendations made in previous monitoring reports. The monitoring team has no further recommendations.	
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. Although improving, only 38% of SAPs reviewed were clearly based on assessments. Therefore this item was rated to be in noncompliance. At the time of the onsite review, all individuals at SGSSLC had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). As discussed in the last review, the FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable	Noncompliance

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		data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. To assess compliance with this item, the monitoring team requested ISPs, FSAs, preference and strengths inventories (PSIs), and vocational assessments for five individuals. In order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. SGSSLC assessment tracking data indicated that 73% of FSAs, 80%of PSIs, and 100% of vocational assessments were completed on time (10 days prior to ISP). All assessments should be completed 10 days prior to the ISP date. Overall, these five individuals had a total of 16 SAPs, and 6 of those (38%) had documentation that assessments (including assessments of preference) were used to develop them. This represented an improvement over the last review when none of the ISPs or assessments reviewed documented how assessments impacted the development of individual SAPs. Examples of assessments that were used to develop SAPs include: • Individual #48's ISP documented that her healthy eating SAP was based on PT recommendations. • Individual #148's ISP documented that her SAP to maintain her dental prosthetics was based on her desire to have a dental prosthetic, and the fact that she had lost them several times in the past. Examples of SAPs where it was not clear how assessments impacted their development include: • Individual #148 had a SAP to increase her social skills, but neither her ISP nor her FSA indicated a need for improved social skills. • Individual #189 had a SAP to manage his money, but no mention in his ISP of any assessment results (e.g., FSA or PSI) that suggested that this was a practical and functional SAP for him. • Individual #97's ISP indicated he could use an electric shaver independently. Nevertheless, he had a SAP to learn how to use an electric shaver • Individual #318's SAPs for shaving and combing his hair indicated that he wanted to learn these skills. There was nothing, however, in his PSI or ISP that documented that he wanted to learn these skills. Additionally, his ISP said these SAPs were chosen because they increased his independence, but his FSA did not document that he had a need in these areas.	

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		• Individual #148 had a reading SAP, however her FSA indicated she was independent in reading. This discrepancy was not addressed in her ISP. In order to achieve substantial compliance for this provision item, SGSSLC needs to ensure that all individuals have assessments of individuals' preferences, strengths, skills, needs that are completed prior to the ISP. Additionally, there needs to be documentation of how assessments were used to select the individual skill acquisition plans.	
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 needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity, before this item is rated to be in substantial compliance. The program developers at SGSSLC summarized SAP data monthly. Monthly SAP outcome data were not graphed. The program developers simply noted if there was progress, or not, in each month. It is recommended that a measure of progress (e.g., the level of prompting necessary, or number of steps in the task analysis completed) be graphed monthly for each SAP to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. An area of improvement was the documentation that some decisions concerning the continuation, discontinuation, or modification of SAPs were based on outcome data. For example: • The monthly summary for Individual #48's SAP of eating healthy foods and walking outdoors, indicated that staff would be retrained due to recording errors. • The monthly summary for Individual #97's shaving SAP indicated that there would be a referral to the IDT due to lack of progress. • The monthly summary for Individual #97's baking SAP indicated that the SAP	Noncompliance

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		would be revised due to lack of progress. There were, however, many examples of the absence of data based decisions concerning the continuation, discontinuation, or modification of SAPs. For example: • The data sheets for Individual #318 SAPs of eat safely and combing his hair, and Individual #189's SAP of safe eating, contained many examples of incorrect recording, but no action documented. • There was no evidence of progress for Individual #148's reading SAP, but no action documented. The monitoring team's visual inspection of monthly SAP data revealed that skill acquisition plans were producing behavior change for four of 14 SAPs (six SAPs did not contain a sufficient amount of data to determine progress) reviewed (29%). This was the same percentage of SAPs judged to be producing a positive behavior change reported in the last review. The implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. The monitoring team and one of the program trainers observed the implementation of Individual #273's SAP of using the easy-stand device. The SAP appeared to be implemented as written, however, the DSP recorded the session as a verbal prompt when the monitoring team and the program trainer thought it should have been recorded as completed independently. In general, DSPs appeared to continue to struggle with the recording of data. Six of the 15 SAPs reviewed, that included completed data sheets, did not appear to be correctly recorded (40%). This compares with the last review when 45% of the data sheets appeared to be incorrectly completed. The only way to ensure that SAPs are implemented and documented as written 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. Over the next six months, it is recommended that SGSSLC begin to graph SAP monthly data, and ensure that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs. Additionally, SAP integrity goals should be established, and SAP integrity measures should be collected across all treatment sites that conduct SAPs.	

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	(b) Include to the degree practicable training opportunities in community settings.	The majority of individuals at SGSSLC participated in various recreational activities in the community, and some 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. As discussed in the last review, the facility began a new tracking of leisure activities and training of SAP objectives in community activities. This documentation revealed that the majority of individual's at SGSSLC participated in community recreational activities each month. Additionally, the self-assessment indicated that, over the last six months, 4% of community trips included SAPs. The QDIP Coordinator indicated that the facility was developing a plan to increase those percentages of community trips that include SAP training. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved. At the time of the onsite review, two individuals at SGSSLC had supported employment in the community. This is the same number of individuals in supported employment in the community reported in the last review.	Noncompliance

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 and again August 2013 o SGSSLC facility-specific policies regarding most integrated setting practices • Continuity of Services, 2.1.01, updated 4/19/12 • Most Integrated Services, 2.1.31, 4/29/11 o SGSSLC organizational chart, undated, probably July 2013 o SGSSLC policy lists, 6/25/13 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 7/8/13 o SGSSLC Action Plans, 7/8/13 o SGSSLC Provision Action Information, 7/22/13 o SGSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/12/13 o Community Placement Report, last six+ months, 12/1/12 through 8/31/13 o List of individuals who were placed since last onsite review (19 individuals over 9 months) o List of individuals who were referred for placement since the last review (28 individuals over 9 months) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (19 individuals), as of 8/31/13 The below 7 open bullets are data through 5/31/13 o List of individuals who requested placement, but weren't referred (14 individuals) • Documentation of activities taken for those who did not have an LAR (7) • Those who requested placement, but not referred due to LAR preference (6) o List of individuals who were not referred solely due to LAR preference (6) o List of rescinded referrals (9 individuals) • ISPA notes regarding each rescinding (9 of the 9) • Special Review ISPA Team minutes for each rescinding (0 of the 9) o List of individuals returned to facility after community placement (2) • Related ISPA documentation (none) • Root cause analysis (2) 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 of 29 individuals who moved since 8/1/12, i.e., 1 year since placement, and for whom SGSSLC had information). Of these 6, 3 were resolved successfully. o List of individuals who died after moving from the facility to the community since placements of 7/1/09 (3, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (2 individuals) o Graphs of some of the above data o APC weekly reports • Detailed referral and placement report for senior management (none) • Statewide one page weekly enrollment report (4) o Timelines for handling referrals, June 2013 o APC Department meeting minutes, 12/10/12 to 6/3/13 (18 meetings) o Transition committee meeting minutes, weekly meeting, minutes submitted from the once per month when they reviewed 90 day status of referrals, December 2012 to June 2013 (7 meetings) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, meeting notes and data • Community tours ▪ Descriptions of tours, 12/1/12 to 5/31/12, 13 tours, 62 individuals ▪ Summary data regarding tours (various databases) • Other activities for individuals ▪ SGSSLC campus coffee houses, 12/14/12 to 6/7/13 (6) ▪ Topics at monthly self-advocacy meetings • Work with local LA ▪ Quarterly meeting minutes, February 2013 and June 2013 (2) ▪ Trainings (none) • Facility-wide staff trainings/activities ▪ New employee orientation (5) ▪ QDDP training 1/23/13, 2/13/13 (2) ▪ Monthly presentations/training at Administrative IDT • Family association meetings (none) • Brochure and facility newsletter (none) • CLOIP and PP tracking tools 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 New blank CLDP format shell o New blank CLDP pre- and post-move support template of pre-determined supports o List of individuals who had a CLDP completed since last review o Blank checklist used by APC regarding submission of assessments for CLDP, completed checklists in the CLDPs reviewed (none)

	o Example of coordinating transition with provider, 7/1/3 o DADS central office written feedback on CLDPs (7) o QA related activities • Monthly QAQI monitoring, December 2012 to May 2013 • Monthly QAD-SAC meeting summary and data supplement, May 2013 and Jun 2013 • Section T QA report, February 2013, May 2013, June 2013 (3) • Completed self-monitoring tools and summary data/graphs for living options, CLDPs, and post move monitoring o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility obstacles data spreadsheets (2), undated, but probably June 2013 o PMM tracking sheet, 12/1/12 to 5/31/13, updated 9/5/13 o Post move monitoring helpful hints, May 2013 o Blank new post move monitoring form o Two examples of documentation of day of move items, 7/18/13 and 8/23/13 o Transition T4 materials for: • Individual #30, Individual #220 o ISPs for: • Individual #345, Individual #388, Individual #53, Individual #151, Individual #52, Individual #362, Individual #375, Individual #277 o Pre-ISP draft used during the pre-ISP meeting: • Individual #208 o Draft ISP used during the ISP meeting: • Individual #265 o CLDPs for: • New format: Individual #60, Individual #304, Individual #80, Individual #305, Individual #45 • Old format: Individual #396, Individual #61, Individual #193, Individual #1, Individual #162, Individual #252, Individual #114, Individual #229, Individual #137 o Draft CLDP for: • (none) o In-process CLDPs for: • Individual #112, Individual #254, Individual #166 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #206: P, 7, 45, 90 • Individual #396: P, 7, 45, 90 • Individual #193: P, 7, 45, 90 • Individual #231: P, 7, 45, 90 • Individual #62: P, 7, 45, 90 • Individual #12: 7, 45, 90

	• Individual #1: P, 7, 45 • Individual #162: P, 7, 45 • Individual #252: P, 7, 45 • Individual #305: P, 7 (new) • Individual #164: P, 7 (new) • Individual #114: P, 7 (new) o 12 ISPA notes for 8 other individuals; the combination of these and the above list accounted for 100% of the post move monitoring required and conducted. <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor; James Reid, Janet Jordan, Facility Transition Specialists; Donnie Varela, Transition Specialist o Roy Smith, Human Rights Officer, Zula White, Human Rights Assistant, and Melissa Deere, Assistant Independent Ombudsman o Community provider agency: Angel Community Services, program director Dante, house manager Eulisha <u>Observations Conducted</u>: o CLDP meeting for: • Individual #166, via audio recording o ISP and pre-ISP meetings for: • Individual #132, Individual #379 Individual #265, Individual #76 o Community group home visit for post move monitoring for: • Individual #123 o Transition Committee (none) o Lack of Consensus meeting (none) o Admissions placement department staff meeting (none)
	Facility Self-Assessment The APC's self-assessment was almost identical to the self-assessment presented during the last onsite review. Therefore, the monitoring team refers the APC back to the previous report where detailed commentary and suggestions were made. For this review, the APC self-rated substantial compliance for eight provisions (T1c1, T1c2, T1c3, T1d, T1e, T1h, T2a, and T4). The monitoring team was in agreement with six of these (T1c2, T1c3, T1d, T1h, T2a, and T4) and also found the facility in substantial compliance with T1c and T2b. The monitoring team did not agree with the facility's self-ratings of T1c1 and T1e. For most of the provisions, even when there was agreement, the APC was not self-assessing the same

	content as was being assessed by the monitoring team. This was most evident in T1e where the APC's self-rating assessed the presence of pre- and post-move supports, but did not self-assess the quality and comprehensiveness of these lists of supports. Further, in T1d, the APC assessed the presence and timeliness of the discharge assessments, but not the quality. The APC's self-assessment needs improvement if it was to be useful to him and his department. The two primary problems were an (a) an over reliance on the statewide monitoring tools and (b) a failure to include in the self-assessment all of the aspects of section T that the monitoring team looks at and includes in this report. This has been a consistent statement from the monitoring team for many years now.
	Summary of Monitor's Assessment SGSSLC continued to make progress across much of section T, including the addition of some new processes and the collection of additional data. The number of individuals placed was at an annual rate of about 12%. Approximately 9% of the individuals at the facility were on the active referral list. 19 individuals had been placed and 28 individuals had been referred for placement since the last onsite review (12/1/12 through 8/31). 18 individuals were on the active referral list as of 8/31/13. Three individuals returned to the facility after community placement (2 in December 2012 and 1 in August 2013). Although some individuals continued to have difficulty following community placement, a higher percentage of individuals were doing better than during the time of the previous onsite review. This was likely due to more thoughtful choices of providers, better preparation of providers, and more careful transitions. Root cause analysis type reviews were being conducted for the individuals who returned to the facility. Transitions were occurring at a reasonable pace. There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 6 of the 8 (75 %) individuals whose CLDPs were reviewed in detail. Professionals' determinations regarding most integrated settings were included in only some of the annual ISP assessments, though there was commentary about the IDTs' determination (as a whole) in almost all of the written ISPs. An adequate living options discussion, however, was only evident in about half of the written and observed ISPs. ISPs identified obstacles to referral, however, most did not do so adequately or thoroughly. Similarly, plans to address obstacles, when identified, were not usually individualized or designed to address the obstacle identified in the ISP. The APC was collecting some data on this, however, the criterion used to assess the presence and quality of obstacles and action plans was not clear to the monitoring team. There were some new activities related to educating individuals, LARs, and facility staff and management about community living. Most important will be for the IDT to develop an individualized plan as part of the ISP. Some components of this already existed.

	CLDPs were initiated and worked on throughout each individual's transition. The transition specialists were more involved with IDTs, provider selections, and moving referrals along than ever before. There were very good improvements in the development of lists of pre- and post-move supports. Discharge assessments were prepared and included good information about the individual, but they were not developed with the individual's new home, day, and employment environments in mind. This needs to be improved (T1d). A quality assurance program did not exist, however, the APC had made good improvements in creating a set of relevant graphs. These were contained in his QA-related documents (QAD-SAC meeting, QA reports, QI Council presentations). Moreover, he created some graphs to monitor length of time to placement because this had been an ongoing problem for the facility.. The annual obstacles report and community placement reports were submitted. Post move monitoring was occurring as required. It was done thoroughly and as required. The PMM ensured that follow-up occurred by involving the transition specialists and IDT as needed. Substantial compliance was maintained for both provisions of T2.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State,	SGSSLC continued to make progress across much of section T, including the addition of some new processes and the collection of additional data. The admissions and placement staff remained the same (one post move monitor and three transition specialists) and continued to operate under the leadership of Tim Welch, the admission and placement coordinator (APC). The number of individuals placed was at an annual rate of about 12%. Approximately 9% 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. • 19 individuals (12/1/12 through 8/31, i.e., 9 months) had been placed in the community since the last onsite review. This compared with 18, 12, 13, 10, 10, and 17 individuals who had been placed at the time of the previous monitoring reviews. o The number was lower than during the previous period (when adjusted for comparable six month periods), but typical when looking across the past few years. • 28 individuals were referred for placement since the last onsite review (12/1/12 through 8/31, i.e., 9 months). o This compared with 18, 12, and 23 individuals who were newly referred	Noncompliance

	the resources available to the State, and the needs of others with developmental disabilities.	at the time of the previous reviews. o 0 of these 20 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals, at an annualized rate of 17% of the census. • 19 individuals were on the active referral list as of 5/31/13 (18 as of 8/31/13). This compared with 23, 27, 33, 27, 21, and 19 individuals at the time of the previous reviews. o As of 5/31/13, 7 of the 19 individuals were referred for more than 180 days. This compared to 6 at the time of the previous review (2 of the 7 were just two weeks past 180 days). ▪ As of 8/31/13, the number had been reduced to 4. o As of 5/31/13, 2 of the 7 individuals were referred for more than one year. This compared to 1 at the time of the previous review. ▪ As of 8/31/13, this was reduced to 1. This was Individual #229. It seemed his placement was held up due to a question about his eligibility. Months had passed with no resolution. After speaking with the monitoring team, the facility director became involved and, hopefully, this can be resolved soon. o The APC created a bar graph that showed the number days since each individual was referred. This was an excellent way to present and monitor referral times. Moreover, the APC began presenting this information to senior management in March 2013. • 14 individuals were described as having requested placement, but were not referred (as of 5/31/13). This compared with 17, 13, 27, 21, 44, and 80 individuals at the time of the previous reviews. o Of the 14 individuals who requested placement, but were not referred, 6 individuals had an LAR who made this decision. o Of the remaining 8 individuals, 3 were under court evaluation. o SGSSLC had a process for reviewing those individuals who requested placement, who did not have an LAR, and who were not referred. o Of the remaining 5 individuals, a lack of consensus review was conducted for 4 individuals. It included a thorough review of the case by the committee, review and decision by the facility director, and review and comment from the assistant independent ombudsman. The APC also summarized this information in a spreadsheet. The reviews appeared to be appropriate and thorough. o 1 individual was listed as not referred due to legal/citizenship issues, however, upon further inquiry the monitoring team learned that she was now referred and would be transitioning in early November (Individual #20). • The list of individuals not being referred solely due to LAR preference contained	

		6 names (as of 5/31/13). This compared to 67, 1, 12, 5, and 8 individuals at the time of the previous reviews. o This was not an accurate count and should be completed correctly. Assistance from the QIDP department will likely be necessary. o It was surprising that more accurate data were not available because the APC began working on this on 2/13/13 and implemented a new tool on 3/1/13, according to the PAI, p. 432. • The referrals of 9 individuals were rescinded since the last review (as of 5/31/13). This compared to 4, 9, 2, 3, 5, and 4 at the time of the previous reviews. o Documentation was provided for 9 of the 9 individuals (100%) regarding the reasons for the rescinding, including ISPA notes. o 3 of the 9 were rescinded due to LAR or individual request. o 2 of the 9 had now been re-referred (Individual #194, Individual #73). o A review to determine if changes in the overall referral and transition planning processes at the facility, however, should also be conducted for the rescinded referrals. This can be done by the APC and his staff. If done and if actions were recommended, the monitoring team would look for indication of implementation of actions. o Between 5/31/13 and 8/31/13, an additional two referrals were rescinded due to behavioral problems (Individual #182, Individual #363). o The APC reported that policy and procedure were followed for rescindings, including the involvement of any LARs and/or advocates and the assistant independent ombudsman, and the independent ombudsman when appeals were pursued. No appeals resulted in an overturning of a rescinding. • 3 individuals returned to the facility after community placement (9 month period). This compared with 4, 4, 0, 2, 0, and 1 individuals at the time of the previous reviews. o Two of these occurred in December 2012, during the week following the previous onsite monitoring review. Both of these cases were noted in the previous monitoring report. A third occurred during the weeks prior to this onsite review. o A special review team was held for both. During these, details of each individual's situation were discussed. A special review team was not yet held for the third. o In addition, during these special reviews, the team listed and discussed possible changes or strategies that the APC, transition specialists, and IDT members should take into consideration as they prepared transitions for other individuals. This was good to finally see being done at SGSSLC; it was something that had been recommended in by the	

		monitoring team in all of the previous monitoring reports. Further, it was noted as a topic in the APC's staff meeting on 2/4/13 and, moreover, the results of these analyses were presented to senior management beginning in February 2013. ▪ As a result, a new process was implemented on 2/4/13, that was to include obtaining an ID for the individual as a standard CLDP item. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, who had run away from their community placements, and/or had other untoward incidents continued to be tracked, recorded, and graphed. These data were now being obtained for at least a one-year period after moving. o Of the 29 individuals who moved in the past 12 months, through 5/31/13, (and for whom information was available), 6 were reported to have had one or more untoward events (21%). ▪ It is important for the reader to understand that many individuals who are placed have histories of challenging behavioral, psychiatric, and medical issues. Therefore, it is not unexpected that these issues might occur in the community. o Of these 6, the issues with 3 (50%) were successfully resolved. Of the remaining 3, all 3 returned to the facility. o SGSSLC provided follow-up and remained involved with all 6 of the 6 individuals (100%), even past the 90-day post move monitoring period for some. This was very good to see and demonstrated the facility's commitment to each individual. o Of these, although follow-up was done with the individuals and their IDTs, an adequate review was not conducted in any of the cases to determine if changes in the overall referral and transition planning processes at the facility should be made. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. If this were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. o Four individuals were reported to still be having difficulties with their placements. Three were discussed in the previous monitoring report (Individual #119, Individual #93, Individual #292); the fourth was a more recent placement (Individual #80). Interestingly, overall, the set of individuals placed in the past 9 months were, for the most part, doing well. This was a good improvement from the time of the last review, as noted in the detailed and lengthy comments in this section of the previous report.	

		▪ The monitoring team asked the APC and his staff to give thought to what was different about this set of placements compared to the set of placements in 2012. They hypothesized that the new transition specialist was working in more detail with IDTs to help them ask more appropriate questions of providers, and help providers to more fully understand the types of supports that needed to be provided and the types of challenges presented by each individual. They also hypothesized that all of the transition specialists were doing a better job of helping individuals, LARs, and IDTs to choose appropriate providers and that IDTs were being more thoughtful about who to referral for placement. • 0 individuals had died since being placed since the last onsite review. This compared with 0 and 1 at the time of the previous reviews. A total of 3 individuals had died since 7/1/09. • 2 individual was discharged under alternate discharge procedures (see T4). The APC had made good improvements since the last review in creating a set of relevant graphs. These were contained in his QA-related documents (QAD-SAC meeting, QA reports, QI Council presentations). Moreover, he created some graphs to monitor length of time to placement because this had been an ongoing problem for the facility. Below are 15 graphs the monitoring team has suggested, with a check mark indicating which the APC had created. The full list provides additional suggestions, however, the APC, at this point, had an adequate set of data graphs. • √ Number of individuals placed each month or monitoring period • Number of new referrals each month or six-month period • √ Number of individuals on the active referral list as of the last day of each month • √ Number of individuals on the active referral list for more than 180 days, as of the last day of each month • √ Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers) • √ Number of individuals who have requested placement, but have not been referred, as of the last day of each month • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month • √ Number of individuals not referred solely due to LAR preference as of the last day of each month • √ Number of individuals who had any untoward event happen after community	

		placement each month o Cumulative number of each type of untoward event for all placements • √ Number of rescinded referrals each month or each six-month period • √ Number of returns from the community in each six-month period • √ Number of deaths in each six-month period • Number of alternative discharges (T4) • √ From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles • From T1b2 below: number of individuals who went on a community provider tour each month • The APC created additional graphs that were very good to see: o A bar graph showing the number of days from referral to placement for each individual who was placed. o A bar graph showing the number of days since referral for each individual who was on the active referral list. o A bar graph showing the number of days from the selection of a provider to the day each individual moved. <u>Other activities</u> Two other referral and placement-related activities occurred regularly at SGSSLC. One was the almost-weekly meeting of the APC and his staff. Relevant topics were discussed, such as the status of referrals and placements, records and documents, upcoming meetings, and so forth. This appeared to be a well running part of the APC's program and likely contributed to the progress made during this period. The other was the transition committee, a weekly meeting of some senior management staff with the APC and his staff. They reviewed the status of referrals when they hit 90 days, need for special review team, and within-campus transfers. The development of a transition home, mentioned in the previous report, was still in the development stage, primarily pending a series of home renovations across the SGSSLC campus. <u>Determinations of professionals</u> This aspect of 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. The monitoring team looks for indications in each professional's assessment, in the written ISP that is completed after the annual ISP meeting, and during the conduct of the annual ISP meeting.	

Ultimately meeting the requirements for this portion of T1a and for provision T1b3 will require that the APC work closely with the QIDPs and the QIDP coordinator. The APC reported that he continued to work with the QIDP coordinator.

The monitoring team requested a set of recent ISPs, attachments, and assessments. One was submitted for 12 of the homes. Eight were selected for review by the monitoring team (see above under Documents Reviewed). These were from across the SGSSLC campus, for individuals with differing levels of needed support, and facilitated by a number of different QIDPs. The ISPs were from meetings held January 2013 to May 2013.

In assessments: Assessments were available for review for all of the 8 ISPs. Of these, all of the assessments for 0 individuals (0%) included an applicable statement and/or recommendation. On the other hand, some of the assessments for all of the individuals (100%) included an applicable statement/recommendation.

Some of the assessments (nursing and vocational) used the two standardized DADS questions, which DADS was fortunately in the process of revising to make more relevant. The two questions currently asked for the professional's opinion regarding if the individual could be served in a less restrictive setting, but stopped short of requiring the professional to make (or not make) a recommendation for referral. Statements were most regularly made in the medical, nursing, vocational, and OTPT assessments. The addition of a new standardized statement/requirement will likely result in a statement being present in all assessments. Below are some specific data for the 8 ISPs:

Discipline	#assessments	# with a statement
Medical	7 of 8	5 of 7
Nursing	4 of 8	4 of 4
Psychiatry	5 of 8	0 of 5
Psychology	6 of 8	3 of 6
Dental	7 of 8	3 of 7
Vocational	8 of 8	7 of 8
Speech	7 of 8	4 of 7
OTPT	6 of 8	6 of 6
Audiology	7 of 8	0 of 7
Nutrition	4 of 8	0 of 4

Some of the professionals added some additional comment, which was good to see, such as in many of the medical assessments and some of the nursing assessments. For example, the nurse noted that Individual #362's frequent refusals to take her medication made her referral questionable.

In the written ISPs: Of the 8 ISPs reviewed, 6 (75%) included an independent recommendation from the professionals (as a group) on the team to the individual and LAR.

Of these 8, each professional's opinion was given and described in 2 (25%). In both of these, it was described very well (Individual #53, Individual #52).

Observation of ISP meetings: Of the 3 ISPs observed, 3 (100%) included an independent recommendation from each of the professionals on the team (for those present or those who had made a statement in their assessment).

Individuals referred: In reviewing the 14 CLDPs, 14 (100%) individuals and/or LARs did not oppose transition to the community.

<u>Referrals and Transitions</u>
There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. The monitoring team asked the APC and his staff specifically about:

- Difficulty finding appropriate providers: They said that the new transition specialist was spending most of her time on this (also see above) and was being successful.
- Behavioral/psychiatric issues: They reported that, overall, providers were available for group home placements. More complicated was finding appropriate adult foster care placements for individuals for whom that model was chosen (e.g., Individual #254).
- Medical: The group reported that they were able to identify providers who could support individuals who had more medical, mobility, nutritional support needs.
- Medicaid: At least one individual (noted above) had his referral delayed for a long time due to problems with his eligibility for funding. This appeared to be an unusual case that was finally receiving attention from senior management.

Funding availability was not cited as a barrier to individuals moving to the community.

Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of individuals on the active referral list via a monthly update by the APC to senior management during the Administrative IDT meeting. This was a new addition since the last onsite review.

Transitions were occurring at a reasonable pace. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The

		IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office. • Of a sample of 14 of the 14 individuals placed since the time of the last onsite review (the individuals whose CLDPs were reviewed), 4 (29%) were placed within 180 days of their referral, 6 (43%) were placed one to two months after 180 days, and 4 (29%) were placed more than one year after referral. o 3 of the 4 most recent placements occurred within 180 days. • Of the 19 individuals on the active referral list for community transition (as of 5/31/13), 7 had exceeded the 180-day timeframe (i.e., 63% were within 180 days). o This compared with 6 individuals who were referred for more than 180 days during previous monitoring review. o Of these 7, 2 individuals had exceeded one year. This compared with 0 individuals at the time of the previous reviews. o 2 of the 7 were scheduled for CLDPs in upcoming weeks. o 1 of the 7 was slated for additional efforts and attention from the transition specialist; as of 8/31/13, there was only 1 individual. o As noted above, the APC created a bar graph to clearly show the number of days since referral for each individual. o As of 8/31/13, however, there were only 4 individual who had exceeded 180 days due to placements and rescindings. The APC reported that this was going to go down to 1 (Individual #229) because 1 of the 4 was about to be placed (Individual #388), and 2 others were just rescinded (Individual #182, Individual #363). • The number of 180-day referrals was stable, but remained relatively high, as of 5/31/13, but by 8/31/13 was at its lowest since monitoring began. • There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 6 of the 8 (75 %) individuals whose CLDPs were reviewed in detail. The monitoring team surmised that the two who had gaps in activity were due to their complicated medical, ambulation, and physical nutritional management needs (Individual #229, Individual #164).	
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	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 disseminated a draft for comment in August 2013. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review. The rating for T1b is based solely on the development of adequate state and facility	Noncompliance

	require that:	policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	SGSSLC had received state training and consultation on the newest iteration of the ISP process (also see section F). Further training was expected, especially given that the state was focusing upon two other facilities to further refine this new ISP process. <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. Of the 8 CLDPs reviewed by the monitoring team, documentation indicated that the IDTs for 2 individuals (25%) included SAPs, and other supports, that were chosen with the individual's upcoming transition in mind: Individual #80 was enrolled in a community preparation class, and Individual #304 had safe eating and laundry skills in her ISP. Of the 8 ISPs reviewed, 2 were for individuals who were referred. Neither had any objectives/SAPs specifically chosen in this manner. One had goals to continue to be educated and go on tours, which didn't make sense because she had been referred. The other individual's ISP contained two very good goals (healthy cooking and self-administration of medication), though these did not appear to be chosen based upon her referral to the community. The 2/4/13 APC staff meeting minutes noted that there was discussion of objectives being created when an individual was referred. It noted that there were SAP writers who were designated to write and train DSP staff on programs and that these SAP writers should be invited by the QDDP to participate in the referral and transition process so that that this can be addressed. Further, the transition committee minutes for 4/23/13 noted that Individual #304 would have a variety of skills added to her program, though this did not end up occurring in her ISP or in her CLDP. The skills mentioned were money management, bathing, dialing a phone number, laundry, reading, self-medication, budgeting, food preparation, social skills, writing, and safe eating. During the onsite review, the APC said the he wanted this topic to become part of what they called the 14-day meeting (a planning meeting that was to occur no more than 14 days after referral), as well as part of the 90-day review (when the referral status is reviewed by the transition committee 90 days after referral). This will also require more	Noncompliance

		involvement of the QIDPs. The transition specialists could easily document these activities in a short paragraph in the CLDP. <u>Obstacles to Movement</u> Of the 8 ISPs reviewed, 6 should have had obstacles defined (the other 2 were for individuals who were referred). Of these 6 ISPs, all (100%) identified obstacles, however, only 1 (17%) clearly identified an adequate list of obstacles to referral (Individual #151). Some of the others indicated individual preference or LAR preference, but either didn't indicate the reason why this was the individual/LAR's preference (e.g., Individual #52, Individual #362), or indicated the obstacle was individual preference when there were other obstacles noted in the ISP (e.g., Individual #53). Of the 3 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 1 (33%). The two other individuals were deemed to have low understanding of community options and needed further education (e.g., tours). The monitoring team could not determine how this was an obstacle to referral. When obstacles are identified in an ISP, the ISP should also include an action plan to address/overcome any obstacles identified. The plans should be individualized, measurable, and include expected timelines. Of the other 6, there were plans to address obstacles to referral for 2 (33%). Of the 3 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 3 (100%), if one considers continuing treatment for psychological disorders to be addressing the behavioral/psychiatric obstacle to referral. Of these, 1 (33%) was adequate; for the other 2, it did not appear that going on a tour would adequately address the reason for these individuals not being referred. The APC reported that they continued to look at written ISPs and whether obstacles were clearly defined and if there was a plan to address the obstacles. This was good to see. For ISPs since January 2013, the APC's data showed that about 70% of the ISPs identified obstacles and plans to address the obstacles. It was not clear what, if any, criteria were used to judge whether the obstacles were correct, and if the plans to address the obstacle were individualized. Further, the monitoring team and APC discussed the need for more clarity regarding the metrics, for example, it was unclear if the second metric was based on a percentage of all of the ISPs or only those ISPs for which obstacles were rated as being present. <u>Preferences of individuals and LARs</u> Of the 8 ISPs, 8 (100%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style,	

		responsiveness to educational activities). Three of the 8 individuals could not adequately express a preference. The ISP indicated this and what the IDT had done to try to make this determination. Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 2 (100%), in that both were described as having low understanding; this preference appeared to have been determined in an adequate manner for 2 (100%), however, the individual's low understanding should not necessarily result in a determination that the individual would not benefit from living in a more integrated setting. Of the 8 ISPs, 8 (100%) included an adequate description of the LAR's (or family member's) preference (3) and how that preference was determined by the IDT, or indicated that there was no LAR (5). Of the 3 annual ISP meetings observed, there was an appointed LAR for 1. LAR/family member preference was discussed in 1 of these 1 meetings (100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Show that SAPs were developed specifically for helping the individual prepare for his or her upcoming transition. 2. Ensure ISPs include obstacles to referral, and some plan or action to address each obstacle that is individualized. 3. Ensure your own data are valid and reliable when assessing obstacles/plans at the individual level.	
	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.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. SGSSLC was addressing some of these activities. <u>1. Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Individualized and specifies what will be done over the upcoming year 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>: In reviewing 8 recently completed ISPs, 0 (0%) had a plan that addressed education about community options as per the above four bullets. All 6 of the ISPs, however, included some general activities, such as tours, the provider fair,	Noncompliance

		and/or community activities, and all included some reference to LAR/family, but they were not written in measurable terms and did not appear to address the individual's specific needs. For example, most referred to conducting the CLOIP, going on community outings, going on a site tour, and attending the provider fair. One specifically talked about the previous year's activity (Individual #362). It may be helpful to add some prompts or headers to the ISP shell to help the IDT address each of the above four open bullets. 2. 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 facility did hold a provider fair within the past 12 months (September 2012, described in previous report). Data and evaluations were collected from last year's fair. The APC also formed a provider fair planning group and used the data to help plan for the next provider fair, thus, meeting the standard for this item of T1b2. 3. Local Authority (LA) • Regular SSLC meeting with local LA • Apparent good communication and working relationship with LA • Quarterly meetings between APC/facility and LA • Agenda topics are relevant SGSSLC status: The facility maintained good communication and a good working relationship with the LA, participated in quarterly meetings with the LA, and ensured relevant topics were on the agenda for the LA meetings. Two meetings occurred since the last review (February 2013, June 2013). The APC provided documentation regarding these meetings. The topics were very relevant to most integrated setting practices. An annual inservice occurred in November 2012 (noted in the previous monitoring report). This standard also appeared to be met. 4. 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. New metrics from the monitoring team in the next few months will provide additional guidance	

		for this standard. 5. 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. • Tours are for individuals or no more than four people • Individual's response to the tour is assessed (describe methodology and indicators) SGSSLC status: The APC continued to work on making the system of tours manageable and appropriate for the individuals at SGSSLC. The number of tours remained about the same, that is, 13 in the last six months, compared with 16, 12, and 9 during previous reviews. Fifty-nine different individuals went on tours, and the APC now accounted for duplications in numbers, thus, making the 59 an accurate representation. The APC now collected and managed a much better set of data than ever before. This included each tour, the number of individuals scheduled, the number who attended, the number of providers they visited, and the number of staff, IDT members, and family members who attended. A description of each individual's reaction to the tour was written on a one page sheet. The APC also now listed each individual and the tours he or she went on. To make tour-related data useful to the APC, it should address the four bullets above: identify all current individuals at the facility for whom a tour was appropriate, what type of tour was appropriate, whether or not each went on a tour that was appropriate, and whether the individual's response was documented and sent to the QIDP/IDT. 6. Visit friends who live in the community SGSSLC status: Since the last onsite review, there were not visits by individuals to friends who had moved to the community. Of the 8 ISPs reviewed, visits to friends appeared to be appropriate for all, however, the monitoring team could not determine if these individuals had any friends who had moved to the community. Even so, these types of visits were not offered to any individuals. This should be a relatively simple activity to add into the activities of those individuals for whom this would be appropriate. 7. Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate SGSSLC status: Since the last onsite review, other educational activities for	

		individuals and LARs/family members did occur during at least one self-advocacy meeting and during the relatively new coffee houses with providers. Educational activities did not occur during any house meetings for individuals, and did not occur during any family association meetings. 8. A plan for staff to learn more about community options SGSSLC status: Since the last onsite review, educational activities for DSPs did not appear to have occurred at least once (other than during NEO). Since the last onsite review, educational activities for clinicians did not occur at least once. Since the last onsite review, educational activities for managers and administrators did occur at least once (for QIDPs on 1/23/13 and 2/13/13) and for the entire Administrative IDT on 2/28/13). 9. Individuals and families who are reluctant have opportunities to learn about success stories SGSSLC status: Progress was made in initial steps towards meeting this standard. The APC created an authorization form for LARs who might agree to be contacted by other LARs. His plan was to work with the QIDPs to put this into action and so that the QIDPs had another tool to use for community education and awareness, the goal being that information about successful community placements to be shared with (a) individuals who were reluctant to consider community placement and (b) LARs who reluctant to consider community placement. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop the individualized education plans described in the first item of this list of 9.	
	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	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the ISP process, through provision of recommendations in annual summaries and IDT deliberation and consensus. There was a list of all individuals, their preference if known, and whether referred for placement. To meet substantial compliance with this provision item, the facility will need to address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written assessments. o As noted in T1a, but this was not yet being done for all assessments. • 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 Based upon the written ISPs, this did not appear to be occurring	Noncompliance

	policies, procedures, and practices.	regularly, as also noted in T1a. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There was a thorough living options discussion during 0 of the 3 ISPs observed (0%) and an adequate description of a thorough discussion was evident in 4 of the 8 ISPs reviewed (50%). o It is likely that the APC's self-monitoring tool for the living options discussion inadequately captures the important aspects of a living options discussion. It might be beneficial to modify the living options observation tool to more accurately reflect the topics that need to be discussed and their quality. • 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 The set of ISPs reviewed by the monitoring team included good statements about the decision made by the entire team for 8 of the 8 reviewed (100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure a good living options discussion. 2. Include professionals' opinion in all of the annual ISP assessments and during the annual ISP meeting (also for T1a).	
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 14 CLDPs completed since the last review. This was 100% of the CLDPs reported by the APC as being completed since then. Of these 14, 8 (57%) were reviewed by the monitoring team. A set of in-process CLDPs was also reviewed. Some of the CLDPs were in the newer format, which the monitoring team found easy to read. <u>Initiation</u>: The APC reported that CLDPs were initiated within 2 weeks of referral, at the latest, however, there was no indication of when the CLDP was initiated in any of the 8 CLDPs in the sample (0%). Including the date that the CLDP was initiated/created and dates when the CLDP was updated should be helpful to the APC and transition specialists in monitoring their continued updating of the CLDPs. The transition specialists and the APC, however, said they always start the CLDP within a few days of referral and always conduct the 14-day meeting, with the date reported in the CLDP. The monitoring team felt that this was a reasonable response and based upon the availability of CLDPs for all individuals, including those newly referred, considered this metric to be met.	Substantial Compliance

		Timeliness: 11 of the 14 (80%) CLDPs included documentation to show that that ongoing activity was occurring for the individual's placement. This was an improvement from the time of the last onsite review. Two of the three that did not show ongoing activity were for two individuals who had complicated multiple medical, ambulation, and physical nutritional management needs. It may be that gaps in activity were due to difficulty finding a provider, however, there was no documentation about this. The APC and his staff added that it was also due to lack of active involvement from the IDT. They said that the IDT really needed more education about possible providers, about how the individuals' medical needs could be met (also see T1b2). On the other hand, another individual's placement took a long time, however, the reasons for the length of the transition were explained very well in the CLDP and attached documents (Individual #193). Ensuring ongoing activity towards placement and avoiding unnecessary delays was an issue in previous monitoring reviews. There appeared to be much improvement demonstrated by the APC and the transition specialists. To further support this, the APC reported to the LA at their quarterly meeting on 6/21/13 that they were trying to transition individuals within 30 days of choosing a provider. There was also a new document, Timelines for referral process, which delineated for all staff the speed at which transition activities were expected to occur. Further, the APC re-initiated a graph of the length of time (number of days) since referral for each individual on the referral list. IDT member participation: 8 of the 8 (100%) CLDPs included documentation to show that IDT members actively participated in the transition planning process (i.e., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). This continued to be a strength of the transition process at SGSSLC. Coordination with LA: 8 of the 8 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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. 0 of the 8 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all six of the activities listed in the below six bullets occurred adequately and thoroughly. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of	Noncompliance

		training required. Much progress was made in this area. o (a) who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), ▪ This was present in almost every CLDP. o (b) the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and ▪ This was indicated in some (which was a good improvement), but not all trainings. o (c) a competency demonstration component, when appropriate. ▪ This was indicated in most of the CLDPs. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was indicated somewhat in 4 of the 8 CLDPs (50%) in that there was a support for the SGSSLC psychiatrist to talk with the community psychiatrist. This support was initiated by the SGSSLC psychiatrist, not by the IDT. This was fabulous to see and was an improvement from the time of the previous review, however, there was a need for this to occur for other clinical disciplines for most of the individuals, such as psychology/counseling and PNM for Individual #193, and psychology for Individual #396. The APC said the was working to get psychology more involved in the transitioning of individuals, including having them collaborate with community psychologists prior to the individual's transition. This would be great to see and the monitoring team hopes it can occur regularly. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). This occurred in 3 of the 8 CLDPs (38%). This was done by OTPT for the three individuals who had physical/ambulation and OTPT needs. This should also occur by relevant clinicians and therapists for all individuals, or if not, there should be some rationale in the CLDP. The monitoring team realizes that at least one member of the IDT visited each site before the provider was chosen (it was good to see that was occurring), but the IDT should consider whether any clinicians should also visit the sites. • Collaboration between provider day and residential staff is ensured. This was not described in any of the CLDPs, but should be assured by the transition specialist. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not described in any of the CLDPs. The APC and his staff said that this was offered, but rarely happened, that is, was rarely called for by the IDT or requested by the provider. The monitoring team suggests that the transition specialists ask for this for those individuals for whom they feel it would be important. Once discussing this, the transition specialists pointed to one example where they had indeed done this. It was for Individual #114 because of her anxiety about transitioning. The plan	

		included the provider staff coming out to SGSSLC and for the individual to attend the provider's community day hab program a little more and more week with support and presence of SGSSLC staff whom she knew. Day of move activities: 8 of the 8 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and all 8 indicated the responsible staff member. Documentation for 2 of the 8 (25%) indicated that the activities did indeed occur. The post move monitor reported that she always made sure the day of move activities had occurred and documented it in an email to the IDT. Up to now, she had not kept this documentation, and it automatically deleted from the facility email system after 30 days. She provided examples for two individuals and said she would keep this documentation printed out for future placements. CLDP meeting prior to moving: A CLDP meeting occurred for 8 of the 8 individuals (100%). The CLDP meeting for Individual #166 was observed by the monitoring team via an audio recording of the meeting. It was led by the transition specialist Janet Jordan. She did an excellent job in making good use of the available time. The meeting lasted an hour and about 75% of it was devoted to discussing the pre- and post-move supports for the individual. The meeting was lively, had a lot of participation from attendees, including the individual. Of the seven aspects of the CLDP meeting listed below, all were evident except for #2 and #3 (which the monitoring team could not determine from the audio recording). The post move monitor participated at various times during the meeting, appropriately asking questions about the pre- and post-move supports. 1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate 3. DSP preparation occurred prior to the CLDP meeting, if appropriate to do so 4. Individual participation occurred, or was facilitated, if needed 5. There was active participation by team members 6. All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved 7. The post move monitor actively participated to ensure that supports were adequately defined and required evidence specified. During the onsite review, no other CLDP, pre-CLDP, or transition meetings occurred.	
	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 pre- and post-move supports and other pre- and post-move activities. In 8 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA,	Substantial Compliance

		community provider staff) by name, but not by title for each support. • To maintain substantial compliance, the name and the title/position of each responsible person needs to be in the CLDP list of supports. In 8 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support.	
	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.	8 of the 8 CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR (or indicated that there was no LAR) as evidenced by • Signatures on CLDP • Narratives in the CLDP	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. For 8 of the 8 CLDPs reviewed (100%), all necessary assessments were completed. For 8 of the 8 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 8 of the 8 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. Each assessment should meet the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in 6 of the 8 (75%) assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was done sufficiently 7 of the 8 (88%) of assessments. For example, the OTPT assessment for Individual #164 was very thorough and likely useful to the IDT. On the other hand, the assessment for Individual #193 insufficiently described and addressed her frequent outbursts and "blow up" when interacting with other people. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o This was not done sufficiently. • Assessments identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences.	Substantial Compliance

		o This was not done sufficiently. The assessor needs to indicate how he or she might see the supports recommended being implemented in the new settings. o For example, to repeat from section P1 regarding OTPT assessments: The supports and services may be inferred from what was in the assessment, but very few of these made specific recommendations about what would be necessary for successful community living. Even if the clinician did not believe the individual was ready at that time, recommendations as to what would be necessary for readiness as they related to PNM and OT/PT should be outlined. These needs should become a focus of OT/PT direct and indirect interventions to ensure that the individual was working toward successful community placement. To move in the direction of <u>maintaining</u> substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving. This has been mentioned by the monitoring team in the past few monitoring reports and must be improved if substantial compliance is to be maintained.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The list of pre-move and post-move supports (previously called essential and nonessential supports) were identified in the CLDPs. SGSSLC staff had made a tremendous amount of progress in developing more adequate lists of pre- and post-move supports. This was due to the work of the transition specialists under the direction and supervision of the APC. The monitoring team was pleased with this progress. The list of pre- and post-move supports should meet the following standards. • The list should be comprehensive and inclusive, demonstrated by: o Sufficient attention paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This was demonstrated in 5 of the 8 (63%) CLDPs. For example, past issues for Individual #396 and Individual #252 were dealt with in the CLDP narrative and in pre- post-move supports regarding training on their histories. The list of supports for Individual #164 and Individual #229 included supports for replacement behaviors and for the use of reinforcement systems. On the other hand, the list of supports for the other three individuals merely stated to "continue BSP." These individuals had complicated behavioral histories that were, thus, not adequately addressed.	Noncompliance

		• Individual #304 had a history of severe depression and aggression. Her SGSSLC activities included replacement behavior teaching plans, keeping her on routine, and de-escalation techniques, none of which were included as supports. • Individual #80's PBSP included a lot of information about the importance of interaction style, keeping him from being bored, looking for triggers, and teaching him to avoid problems. None of these were included as supports. • Individual #193 had severe psychiatric and behavior problems only six months prior to her move. Merely saying to continue the BSP was insufficient and did not help ensure that the provider staff would implement all of the important aspects of her BSP. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 5 of the 8 (63%) CLDPs. For example, the supports for Individual #60 listed separately many of the aspects of his SGSSLC PNMP. The supports for Individual #80, however, only were inservicing on GERD, weight, etc., but the only support was to follow his diet. His CLDP and assessments had a lot of information about ensuring he was successful with his eating and diet. For Individual #193, there were not adequate supports listed to ensure she had a proper diet and that her weight gain was addressed. Similarly, Individual #304 had a support about healthy eating, but no indication of the important components of how she was to do so. o What was important to the individual was captured in the list. ▪ This was evident in 8 of the 8 (100%) CLDPs. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 5 of the 8 CLDPs. The supports listed related to employment were adequate for 1 of the 5 (20%) (Individual #80). For the other four individuals, work appeared to be very important to their lives and likely to their success in the community, yet the supports focused on referrals to DARS and to attending day hab programs. As noted in previous reports, many individuals do not understand how long it may take for a job to be found. For example, Individual #396, Individual #193, and Individual #12 had still not found adequate jobs after 90 days in the community. Individual #396 was, not surprisingly,	

		bored at the day hab every day. The day hab provider for Individual #193, however, seemed to fill the day with other engaging activities for her. • The post move monitor was happy to report that as of 8/31/13 Individual #396 and Individual #12 now had jobs, even though it was well beyond their 90 day reviews. ▪ Obtaining an appropriate ID to be able to be employed has been an obstacle for many individuals becoming employed. This was the case for Individual #12, even though it was appropriately included as a pre-move support (i.e., the initiation of the process to obtain an ID). Because this often takes so long, it might be something to consider doing once an individual is referred for placement, rather than waiting for the CLDP meeting. This was reported to now be initiated for all individuals at the 14-day meeting. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was somewhat evident in 3 of the 8 CLDPs (38%), that is, in these CLDPs there was a support that referred to implementing the reinforcement program or system. This was a good improvement and the first time seen in any SGSSLC CLDP support lists. Better, however, would have been some detail in the support as to what the reinforcement system was. For the other 5 individuals, it was disappointing that there was no reference to reinforcement/rewards because the referrals of many of the individuals was as direct result of the progress they had made and this progress was due, in part, to the use of positive reinforcement. Having a support that merely says "continue to implement the BSP" was insufficient. o There were supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ▪ This was seen in 2 of the 8 (25%) CLDPs. This was done well for Individual #252. There were two skills for Individual #304, though based on the notes in the meeting referenced above, more would have been expected. It was surprising and unfortunate that no supports for learning new skills (or continuing skill training begun at SGSSLC) was in the support lists for the other individuals. ▪ The professionals on the IDT have an opportunity to push this type of training forward during the CLDP and transition	

		process. o There were ENE supports for the provider's <u>implementation</u> 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. ▪ Important aspects of the BSP, PNMP, etc. should have their own support to highlight their importance and help ensure that the provider carries out these important aspects. This was seen in 3 of the 8 (38%) CLDPs. Examples of what should have been included were the interactional and positive reward components of BSPs and the most important details of the PNMP and dining plans. o Topics included in training had a corresponding support for implementation. ▪ This was not evident in any of 3 of the 8 (38%) CLDPs. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately. The supports for provision of services and activities, however, were not written in a way that was measurable, so that the provider and PMM knew how much, how long, how many, etc. In other words, there was need for observable reportable outcomes and a criterion for each support. • Any important support identified in the assessments or during the CLDP meeting that was not included in the list of supports, should have a rationale as to why it was not included. o The SGSSLC staff did a nice job of presenting the discussions and deliberations that took place during the CLDP meeting. In most cases, the reader could easily understand the summarized recommendations, the discussion that took place, and the resulting supports. This was evident in 7 of the 8 (88%). The CLDP for Individual #304 was missing supports for the recommendation for the use of her AAC device. • Every support should include a description of what the PMM should look for when doing post move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o The evidence that the PMM should look for was included in all of the CLDPs (100%). A good addition was the frequent reference to a special needs checklist or check sheet. Thus, the PMM would have more to look for in addition to staff interview and direct observation. The supports, however, were missing any criteria to give guidance to the PMM. Perhaps the intent was that those items should be implemented every day 100% of the time, if so, some indication might be useful to the PMM.	

		For some supports, such as outings or family activities, a criterion, such as once per month or once per week, was included. ▪ The PMM asked the monitoring team about rating a support if the checklist wasn't available, but it appeared from staff interview and PMM observation that the support was provided. The monitoring team replied that if the CLDP called for a checklist, then it would need to be scored no. She could, however, indicate that she also conducted interviews and observations. Best, however, would be if the support included all three of these aspects in the CLDP. o The APC and PMM should improve a frequently seen support that referred to "establish care" with a PCP, psychiatrist, dentist, etc. The support usually included a list of topics that the specialist was to be informed about and address. The evidence, however, was merely that an appointment was made (in some cases) or that the visit occurred (in other cases), however, in no cases was the PMM asked to ensure that all of the topics included by the IDT in the support were presented to the specialist. This should be changed/improved. ▪ The PMM reported that she did look at the consult report. This was good to hear. The wording of the CLDP, however, should be improved, so that what is required is more explicitly described. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. o A pre-move site review was conducted for all individuals. A sample of 8 pre move site reviews were reviewed by the monitoring team (see documents reviewed) and all indicated that the pre-move supports were in place. ▪ The PMM conducted all of the pre move site reviews. She indicated that training was completed, but should provide detail indicating if all of the aspects detailed in the CLDP regarding this training occurred as per the CLDP, such as who, what, how, and documentation of competency. • Each of the nonessential/post-move supports needs to have an implementation date. o Each nonessential support in the CLDP did have an implementation date. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. At this point, the APC and transition specialists should be able to meet all of the	

		criteria for a thorough and adequate list of pre- and post-move supports. Following the above comments regarding the 8 components of a comprehensive list, and the 3 additional characteristics will move the facility towards substantial compliance.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The APC made progress in developing a QA process for CLDPs and other aspects of section T. The new activities and progress were due in large part to the progress made by the facility's QA department and described in section E. That is, the QA department now required there to be a more comprehensive QA program in each department and for each provision of the Settlement Agreement. Thus, the APC now presented data regularly to QI Council/Administrative IDT, met for a QAD-SAC monthly meeting, and wrote his part of the quarterly (and now monthly) QA report. Some of the activities that had occurred since the last review included: • A set of graphs (see T1a) were developed. The APC made much progress in this area. • Root cause analysis type reviews were conducted and being presented to senior management beginning in February 2013. These types of analyses are important to having a comprehensive QA program for section T. • The APC reported that state office was working on creating valid, reliable self-monitoring tools (however, the monitoring team has been hearing this for several years). There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. Data/information were being collected. One set of data were from the continued implementation of the three statewide tools (living options, CLDP, post move monitoring) that have been described and criticized in monitoring reports for many years. The data were not relevant or valid (i.e., did not include everything that should be included, did not measure what they portended to be measuring), yet the data from these tools were regularly presented to the QI Council/ Administrative IDT. There was, however, indication that the data were being collected reliably. Therefore, one might consider that the tools were reliable, but not valid. On the other hand, the APC reported that he now made better use of the tools by pulling out information that was most useful to them. Even so, the monitoring team could only find one example that might apply to this: the decreasing graph line of the living options tool included a narrative analyses hypothesizing that the reason for the decrease was more of a focus on professionals' determinations for referral, and assessments for transition. The monitoring team did not see any other indication of this, such as more detailed data, graphs, or tables of the pulled out useful data; corrective actions based on	Noncompliance

		data; or presentation of any good outcomes. The APC, however, collected and reported on other sets of data (the list of graphs and data in T1a). This was good to see. Data were reviewed and summarized, but there was no analysis. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a valid and reliable self-monitoring tool or set of tools. 2. Conduct an analysis and implement action plans when necessary based upon the data being collected by the department. 3. Conduct a simple quality assurance review for rescinded referrals and other negative/untoward outcomes.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The state's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting."	Noncompliance

	be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	• Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives, however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private	

providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…"

- Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).

The SGSSLC-specific portion of this report identified (long standing) problems in accurate data regarding obstacles to referral and transition. Then the APC listed six areas for intervention. The activities were not measurable, did not have any target dates, and had no identified outcomes. For the most part, the actions seemed to the monitoring team to be more of the same, that is, a continuation of the what they had been doing. One suggestion would be for the facility to try to determine why LARs were opposed to placement beyond that they were adequately educated and choose SGSSLC. This would related directly to the activities in T1b2, especially the development of individualized community living education plans/activities.

The SGSSLC-specific portion of this report should also clearly differentiate issues related to referral for placement from issues related to transitioning to the community after being referred.

The APC continued to maintain two sets of data regarding his review of obstacles at the individual level. data were taken from what was written in the ISPs. One set was a list of 68 individuals, for those who had ISPs from 1/3/13 through 6/18/13. There were 20 columns of possible obstacles to referral, including some that were sub-categories (e.g., the reason for the LAR's choice). These data showed that:

- Only one obstacle to referral was allowed to be scored, even if there was more than one obstacle (e.g., individual choice and behavioral/psychiatric issues). This flaw in the data system likely skewed the data, making it less usable to the facility and the state than it might otherwise be.
    - The APC said that this was about to change as data were being entered into Avatar.
- The largest category of obstacles, 27 (40%), were for individuals not referred due to behavioral/psychiatric reasons. This was not surprising given the types of individuals being referred to and admitted to SGSSLC. This number, however, was about twice that in the APC's annual facility report. It was unclear why.
    - There was, however, no assessment as to why the individuals were not referred, such as dangerousness to the community of self, counter to therapeutic progress the individual was making, belief that providers could not adequately support the individual, and so forth.

		• Individual's personal choice was the reason for no referral for 21 of the 68 (31%), a number similar to the annual report. About half of these individuals, however, were reported as not having adequate information about the community. The APC planned to address this for each of these individuals. o For the individuals who were reported to be well-informed, there was no information as to why they chose SGSSLC. • Similarly, 13 of the 68 (19%) were not referred due to LAR choice. There was no information as to whether the individual would have otherwise been referred by the IDT if not for LAR choice. o The spreadsheet indicated that all 13 LARs were well informed about community options, but there were no reasons given as to why they chose SGSSLC given they were informed about the community. The other set of data was also gathered by the APC. It was a review of a sample of written ISPs each month (e.g., 6 to 10), and based upon the contents of the ISP, he noted if obstacles were identified and if a plan was written to address the obstacle. His findings, as also noted in T1b1, were that about 70% of the ISPs had obstacles to referral identified and about 70% had a plan to address the obstacles (it was unclear if this meant that 70% of all of the ISPs or 70% of those ISPs that had obstacles, i.e., 70% of the 70% in this case). These data were presented to senior management from time to time, but it did not seem that any actions were taken. Further, the monitoring team's ratings of of a sample of ISPs were lower than the APCs, bringing into question the criteria the APC was using to rate the adequacy of the identification of obstacles as well as the adequacy of the plans to address those obstacles.	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the (more than) six-month period, 12/1/12 through 8/31/13. 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.	Substantial Compliance

	full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the 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	SGSSLC maintained substantial compliance with this provision item. Since the last review, 39 post move monitorings for 20 individuals were completed (from 12/1/12 through 5/31/13, additional post move monitoring was completed as required from 6/1/13 to 8/31/13). This compared with 43 post move monitorings for 20 individuals, and 34 post move monitorings for 15 individuals at the time of previous onsite reviews. The monitoring team was given documentation for 39 of the 39 post move monitorings (100%). This was comprised of 27 post move monitoring reports and ISPA documentation for 12 individuals (which was what the monitoring requested) plus 12 other ISPA documentations for 8 other individuals. Of the 39 post move monitorings, 39 (100%) were completed by the PMM, Denise Copeland. The monitoring team reviewed 27 of the 27 (100%) post move monitoring reports for 12 different individuals as well as the additional ISPA documentations. <u>Timeliness of Visits</u>: For the 20 individuals, 38 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team, of the 38 required visits, 38 (100%) were conducted and 38 (100%) were completed on time. Of the 27 post move monitoring forms reviewed by the monitoring team, all 27 (100%) included dates showing that they were completed on time. The 39th post move monitoring was done one month after the 90 day review because the IDT and PMM felt that additional follow-	Substantial Compliance

	agency.	up was needed (Individual #184). <u>Locations visited</u>: For the 27 post move monitorings reviewed, 27 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. <u>Content of Review Tool</u>: 27 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 3 of the 27 were completed using the newest iteration of the post move monitoring form. Below, the monitoring team provides five comments regarding this form. These comments have also been provided in other monitoring reports: 1. There was no explicit indication of what locations were visited by the PMM. The helpful hints document stated that all locations must be visited, but there was no requirement to report this. o The SGSSLC PMM, however, clearly indicated all of the sites she visited on each of these 3 new forms. 2. The monitoring team could not determine what evidence the PMM was to look for, and what evidence the PMM examined "to assess whether supports called for in the CLDP are in place." a. The monitoring team recommends that the post move monitoring form include these three pieces of information for each pre- and post-move support: (a) what evidence was to be reviewed, (b) what evidence was reviewed, and (c) the due date. b. Examples of evidence to be reviewed are direct observation, staff interview, provider documentation, and daily checklists completed by the provider. The PMM should then specifically indicate what he or she observed and reviewed, and whom he or she interviewed. o The PMM, however, clearly indicated, in great detail, all of the evidence she looked at, on each of these 3 new forms. 3. The monitoring team agrees with the helpful hints guidance for question 5, that is, when examining staff training, to not limit this to documentation. The monitoring team, therefore, recommends that question 5 be expanded to indicate that interview or observation of staff showed that staff were trained and knowledgeable. o The SGSSLC PMM, however, clearly indicated that she also interviewed staff on all 3 of these new forms. 4. The helpful hints document required a narrative about direct observation of the individual. The monitoring team agrees with the helpful hints item for question 11 that requires a short comment be written regarding individual and LAR	

satisfaction, and the PMM's overall opinion about the community home and day site.
    - The SGSSLC PMM, however, provided comments regarding these aspects on each of these 3 new forms.
5. In the helpful hints document, the list of negative outcomes is not an all-inclusive list. It would be helpful to indicate that these are potential negative outcomes and others that might be identified should be reported and addressed.

The post move monitoring report forms were completed correctly and thoroughly, as follows:

- The checklist was completed in a cumulative format across successive visits for all 9 (100%) of the individuals who had more than just the 7-day review.
- Supports were verified, such as by indication of the evidence examined and the results of this examination, in 27 of the 27 (100%).
    - The supports regarding training of staff were much improved, as noted above. The PMM should now provide detail in her report regarding whether she had evidence of all aspects of required training, such as who, what, how, and documentation of competency.
- There was adequate justification for findings for each support in 27 of the 27 (100%).
- Detail/comment was included in 27 of the 27 (100%). Most, but not every, support received some narrative comments.
- LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in 27 of the 27 reviews (100%), taking into account that some individuals did not have LAR or family involvement.
- An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements could easily be determined from the narrative comments provided by the PMM and/or was specifically indicated at the end of the report in 27 of the 27 (100%).

The monitoring team recommends that the PMM include the names of provider staff who were interviewed to help the reader understand which staff were interviewed during the post move monitoring. This was done in 26 of the 27 (96%).

<u>General status of individuals</u>
Based upon the monitoring team's review, of the 12 individuals who received post move monitoring, 11 (92%) transitioned very well and appeared to be having good lives. The other individual continued to exhibit problems (Individual #162).

Of the other 8 individuals for whom only ISPA notes were submitted, it appeared that 5 were doing well or had minimal problems that were being addressed adequately (62%)

		whereas the other 3 (38%) continued to have difficulties. These 3 individuals were also having difficulties at the time of the previous review. With support from the APC, IDT, and SGSSLC, all 3 individuals maintained their community placements. As discussed with the APC, a root cause type of review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a, as well as the 4 individuals noted in the above two paragraphs. Overall, however, it seemed to the monitoring team that the set of placements that occurred since the last review was the most stable and successful set of placements since monitoring began in 2010. <u>Use of Facility's best efforts when there are problems that can't be solved</u>: In 11 of the 27 (41%) post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 8 of the 12 individuals (67%). For the most part, the problems were of a moderate level, such as delays in finding a job, some aspects of PBSPs, visits from the SGSSLC IDT, and SAPs. On the other hand, sexual-related incidents occurred with two individuals (Individual #396, Individual #1) and appeared to be handled appropriately by the provider, but didn't seem to engender sufficient IDT discussion, especially given the histories of these two individuals. There was appropriate follow-up and correction for 9 of these 11 (81%) visits for 6 of the 8 individuals (75%). Although not evident in the documentation, the monitoring team asked the PMM about these two individuals. She said that the IDT for Individual #396 did meet after the 7-day review (i.e., they met for the 7-day review and then met again), and for Individual #1, she notified the transition specialist right away via email. Post 90-day follow-up was done by the PMM for 1 of the 20 individuals. <u>ISPA meetings after post move monitoring visits</u>: An ISPA meeting should occur after every post move monitoring during which a problem or concern was noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 100% of post move monitorings for which an ISPA was appropriate to have been held. Further, for all (100%) of the post move monitorings, the PMM sent an email to the transition specialists (who then sent an email to the QDDP) stating any issues that she found, giving her opinion as to whether she felt a meeting was needed, and offering the opportunity to meet if the QDDP/IDT wanted to do so.	

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.	The monitoring team observed one post move monitoring at the home of Individual #123. The PMM, Denise Copeland, again did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual Interview (as much as possible) • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information The provider was new to the San Angelo area, Angel Community Services. This was the first individual to be served by them in San Angelo. It seemed to be a good placement for the individual; he appeared to be happy and was engaged in activities with the home staff. The home staff appeared to know him very well for this 7-day post move monitoring. The monitoring team recommends that the PMM be sensitive when interviewing the staff (i.e., whether it is appropriate to talk about the individual in front of him; in this case, it was OK), and also sensitive about interviewing the individual when he is with his staff (e.g., asking him questions about if he is happy with his staff when the staff are right there). The monitoring team and the PMM talked about this following the home visit. She was very aware of this and said that she made an active decision to do as she did at this visit, which seemed reasonable to the monitoring team based upon the individual and his communicative ability. Further, the monitoring team had observed this PMM conduct more private interviews with staff and individuals during previous reviews.	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	This item does not receive a rating.	

	provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations		
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	Two individuals were discharged under this T4 provision. Both were discharged because they no longer qualified for services, one as per item (a) and one as per item (f) in the Settlement Agreement wording of T4. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summaries completed for these 2 individuals, all (100%) contained the all of the information consistent with the Centers for Medicare and Medicaid Services (CMS) requirements as follows below. The individuals were found to no longer be eligible for services. One was transferred to the care of her aunt (she was a minor) and the other and was transferred to her brother. Documentation indicated that for the 2 individuals, there was: • Documentation in the individual's record that the individual was transferred or discharged for good cause. • Reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies). • A final summary of the individual's developmental, behavioral, social, health and nutritional status. • With the consent of the individual, parents (if the client is a minor) or legal guardian, a copy provided to authorized persons and agencies. • A post-discharge plan of care that will assist the individual to adjust to the new living environment. Although the requirements of T4 were met, both individuals were discharged when they were not stable. It appeared that the facility did what it could, but the transfer was a legal action outside of the control of the facility. One of the individuals subsequently had serious behavioral issues, was admitted to a psychiatric hospital, and was now back living at SGSSLC. The other individual was exhibiting serious aggressive behavior every day up until the day she was discharged (as described in explicit detail in the discharge report). The APC said that they had not had any further contact with, or information about, the individual, so it was unknown if the behavioral issues continued and/or if her community placement had changed.	Substantial Compliance

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SGSSLC Policy: Rights of Individuals with Developmental Disabilities dated 10/12/01. o SGSSLC Policy: Guardianship dated 9/27/12 o Prioritized list of individuals without guardians who also lack functional capacity to render a decision regarding health or welfare o SGSSLC Self-Assessment and Provision Action Information for section U o ISPs for: • Individual #53, Individual #277, Individual #268, Individual #166, Individual #345, Individual #379, Individual #104, Individual #151, Individual #375, and Individual #388. o SGSSLC Section U Presentation Book o A Sample of HRC Minutes o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs o Michael Davila, QDDP Coordinator o Roy Smith, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 8/13/13 and 8/14/13 o Annual IDT Meeting for Individual #132 and Individual #379 o ISPA regarding restraints for Individual #395 o Human Rights Committee Restraint Review Meeting o Restraint Reduction Committee Meeting o Human Rights Committee Meeting o Pre-ISP Meeting for Individual #76
	Facility Self-Assessment: SGSSLC submitted its self-assessment. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. Activities engaged in to conduct the self-assessment for U1 and U2 included: • Reviewed the priority list for guardianship to ensure it was updated at least semi-annually.

	• Reviewed a sample of ISPs to determine if the ISP included discussion of the individual's ability to render a decision. • Reviewed completed section U and section F monitoring tools. The facility self-rated U1 and U2 as not in compliance. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The monitoring team agreed with the facility's compliance ratings for U1 and U2 and commends the facility for continuing to assess progress through the self-assessment process.
	Summary of Monitor's Assessment: The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs were not holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for compliance with U1. Then U2 will be the next step, which is procuring guardians for individuals assessed as high priority. 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 developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions. • 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. A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

#	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:	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The state is encouraged to finalize this policy because it should assist the facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. Steps taken to address compliance with the requirements of section U included: • The facility was using the section U and section F monitoring tools to evaluate discussion of ability to give informed consent and guardianship by the IDTs. • The HRO and QDDPs were continuing efforts to seek guardianship for individuals determined in need of guardians by the IDT. • The human rights officer worked with individuals and their IDTs to ensure protection of rights at the facility. He was actively involved at the facility and	Noncompliance

#	Provision	Assessment of Status	Compliance
	those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	served as a resource to IDTs. The facility did not have a tool to assess capacity to give informed consent. The facility was waiting for the state office to offer further direction in moving forward with compliance. A sample of ISPs and relevant assessments was reviewed to determine the adequacy of IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. The facility was doing a better job of documenting discussion regarding decision making skills, the need for training, or the need for guardianship. Three of the 10 (30%) ISPs in the sample included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare and the need for guardianship (Individual #277, Individual #166, and Individual #388). Examples that did not include evidence of adequate discussion included: • The ISP for Individual #53 did not document discussion regarding his ability to make informed decisions. He was an adult with no guardian. • The ISP for Individual #268 indicated that she "does not fully understand the nature, purpose, consequences, risks, benefits and alternatives to actions and procedures that would require informed consent." The team determined that she was a priority III for guardianship. There was no justification for why the team did not consider her as having a greater need for guardianship. • Individual #345's ISP indicated that the IDT agreed that she could not give informed consent or make decisions regarding healthcare, programming, money management, or release of records. The team did not document discussion regarding her need for guardianship. • Individual #379's ISP did not document discussion regarding the need for guardianship. • Individual #104's ISP did not document discussion regarding his ability to understand and give consent. • Individual #375's ISP summarized discussion regarding his decision making skills and ability to give informed consent. It did not, however, include discussion of his need for guardianship. • The ISP for Individual #151 did indicate that the team had determined that she was not able to give informed consent. It further noted that the family had been provided with guardianship information. There was no further discussion regarding obtaining guardianship. The facility continued to maintain a prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision. The list was not based	

#	Provision	Assessment of Status	Compliance
		on an adequate assessment process. To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that all IDTs are discussing each individual's ability to make decisions and give informed consent and then discussing the need for guardianship if the team determines that the individual does not have the functional capacity to give informed consent.	
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.	New guardianship had not been obtained for any individuals at the facility. The Human Rights Officer was working with many current guardians to renew guardianship on an annual basis. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, through the self-advocacy group at the facility. It remained an active group with a lot of participation and attendance. Much of the success of this group over the past few years was due to the thoughtful leadership, guidance, and facilitation of the human rights officer. 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. Two HRC meetings were observed. The committee engaged in good discussion regarding the restriction of rights. Compliance with U2 will be contingent on the development of an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	Noncompliance

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 recordkeeping-related policies: • Active Record Guidelines, updated 9/27/12 (i.e., no changes since last review) o SGSSLC organizational chart, undated, probably July 2013 o SGSSLC policy lists, 6/25/13 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 7/8/13 o SGSSLC Action Plans, 7/8/13 o SGSSLC Provision Action Information, 7/22/13 o SGSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/12/13 o List of all staff responsible for management of unified records o Monthly home secretary meeting minutes, January 2013 to September 2013 (8 meetings) o Description of how documents are filed, including description of a pilot program with the OTPTs to monitor that documents were given to the home secretaries for filing, 5/7/13 o List of other binders or books used by staff to record data o Description of the SGSSLC shared drive and All About Me folder, one page o Tables of contents for the active records (updated 3/22/13), individual notebooks (updated 5/15/13), and master records (undated) o Checklist of all individuals and if each aspect of unified record was updated, 7/9/13 o A 7-page spreadsheet that listed state and facility-specific policies and also showed various information regarding training (e.g., who, how, data/numbers), 6/28/13 o Description of the unified record audit process, one page o Blank audit tool for active record and individual notebook, which included six V4-related questions o Blank audit tool for master record, and blank table of contents form for master record o Blank V4 interview tool, 3 questions o Blank All About Me (shared drive) audit tool o Blank Campus Administrator Round form with questions about record presence o Blank secretary form for presence of record, with instructions for what to do if record not located. o Blank audit tool for including medical consultations and additional All About Me items o List of individuals whose unified record was audited by the URC, December 2012 to May 2013 o Completed audits for 10 individuals for March 2013 (1) and May 2013 (9) that included: • Audit tools for active record and individual notebook • Audit of master record • Shared drive/All about me electronic folder • Listing of medical consultations

	• V4 interview, three questions (for 7 of the 10) o Audit errors and recommendations for correction spreadsheet, for each individual, March 2013 (1) and May 2013 (9), including person responsible, evidence of correction, due date, date email sent, date completed, and an completion status rating o Emails showing notification of responsible persons, for the above 10 audits. o Emails when responsible persons replied to the notification emails, for the above 10 audits (not every email sent received [or required] an email response o Various graphs that summarized some aspects of recordkeeping activities and findings, for May 2013 only o Summary results of URC's monthly record audits: summaries per individual and graphs of current and cumulative months, December 2012 through March 2013, May 2013 o Summary results of secretaries' monthly record audits: summaries per individual and graphs of current and cumulative months, December 2012 through January 2013, March 2013, May 2013 o Completed medical consultation/All About Me forms for numerous individuals o Status of master record missing social security cards and birth certificates, 8/28/13 o Description of how the facility addressed the six parts of V4, and graphic summaries, and spreadsheets of home secretary checks (February 2013 to May 2013), campus administrator checks (January 2013 to May 2013), and items from section F tool (December 2012 to April 2013) o Completed V4 questionnaires, December 2012 through May 2013, 6 to 9 each month o QAD-SAC benchmark monthly meeting minutes, supplemental data, December 2012 to June 2013 o QA report for section V, February 2013 quarterly report, June 2013 and August 2013 monthly reports o Written responses to monitoring questions about items in the active record, 9/6/13, including the number of items scored on URC monthly audits (1,542) o Active records and/or individual notebooks of: • Individual #71, Individual #315, Individual #295, Individual #369, Individual #205, Individual #94, Individual #381, Individual #243, Individual #85, Individual #118, Individual #202, Individual #265 o Master records of: • Individual #63, Individual #232, Individual #379 <u>Interviews and Meetings Held</u>: o Cary Lovelace, Unified Records Coordinator o Angela Kissko, Quality Assurance Director o Various DSP, nursing, and management staff o URC presentation of recordkeeping monthly data and analysis to QI Council/Admin IDT, 9/6/13 <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o CLDP, ISP, pre-ISP meetings, and clinic meetings

	Facility Self-Assessment The content and procedures of the self-assessment remained were identical to the previous report with the exception of some expansion of V4. Therefore, the monitoring team directs the facility to the comments made in the previous monitoring report as well as to the general descriptions of how to self-assess section V, recordkeeping practices. This will also help guide what the URC puts into her action plans. For V1, the V3 URC audits comprise the majority of the self-assessment for V1. The data from those should be included in the self-assessment, separated by the three components of the unified record. In addition, the other aspects commented upon by the monitoring team in V1 should be included. For V2, self-assessment of the training information should be added. V3 should be a self-assessment of the quality review audit process, including, as reported upon by the monitoring, the frequency, quality, and reliability of the process, as well as the analysis of data/findings and implementation of any actions as a result. For V4, self-assessment for each of the six components should be included. The URC self-rated all four provisions in noncompliance. The monitoring team, however, found V1 and V3 to be in substantial compliance. Perhaps by following the above suggestions, the self-assessment can be more in line with the activities, and thus the ratings, of the monitoring team.
	Summary of Monitor's Assessment: SGSSLC continued to make very good progress with all four of the items of provision V and achieved substantial compliance with two of the provisions, V1 and V3. For each record reviewed, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement. The active records continued to improve. The monitoring team reviewed active records in each of the three units at SGSSLC. The improvements highlighted in the previous report all remained in place or were modified to be more effective. Overall, fewer documents were missing than during the last onsite review. Very few old or outdated documents were found by the monitoring team. The monitoring team did not find the records to be overly full, that is, although some of the sections might have contained documents that were ready to be purged, the monitoring team did not find the volumes to be overly filled. Overall, medical documentation continued to improve, but legibility remained a problem for some providers. An individual notebook existed for each individual. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. The individual notebooks now contained the ISP, IRRF, and IHCP.

	The URC now had a system to indicate the status of master record documents that could not be located. She was successfully focusing upon obtaining missing birth certificates and social security cards. Progress was made in the quality and management of the monthly reviews of unified records, including addressing and continuing to address the many recommendations and comments made in previous monitoring reports. There was support and responsiveness from the facility's clinical staff, DSPs, home managers, residential and unit mangers, and QA director. For instance, staff throughout the facility were responsive when notified by the recordkeeping staff about any errors found in the records and any needed corrections. All of the reviews were done in a consistent manner and were neatly and clearly documented. The URC modified her audits based upon specific recommendations in the previous monitoring report. There were written instructions that she followed regarding the conduct of the audits, definitions of items, how to score items, and so forth. The URC summarized, analyzed, and reported on her data. She also engaged in actions to correct problems based upon her data and findings. She actively participated in the QA program activities at SGSSLC, including creating a data inventory listing, a QA matrix, data graphs, narrative summaries and narrative analyses, a QAD-SAC meeting report and a monthly QA report, now 10 pages long. In addition to the monthly data and graphs, the URC created a good set of graphs that adequately showed trending across the quarter and across the past year regarding important data for the facility's recordkeeping practices. Her data allowed her to drill deeper into problems and take corrective action. For V4, the monitoring team reviewed all six with the URC. She had done a tremendous amount of work to address all six components, make decisions about what to measure, and to document that these were being addressed. A number of items were clarified during discussion while onsite.

#	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 continued to make very good progress with all four of the items of provision V. This was again due, in large part, to the work and leadership of the unified record coordinator (URC), Cary Lovelace. Ms. Lovelace was promoted and now had additional responsibilities for the entire recordkeeping department and program at SGSSLC (though she retained the job title URC). Progress was also due to the work of the home secretaries, unit secretaries, master records assistants, residential unit directors, and QA director. Also once again, the URC took very seriously the comments, suggestions, and recommendations in the previous monitoring report. State policy and facility-specific policies remained the same as during the previous	Substantial Compliance

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		review. Some of the updating of policy that the URC talked about at the last review had not yet taken place. These were good ideas that the monitoring team encourages the URC to continue to plan to do. Twelve of 12 (100%) individuals' records reviewed included an active record, individual notebook, and master record. According to the URC and a spreadsheet list that she maintained, a unified record existed for all individuals, including all new admissions. The URC maintained a list of all individuals at the facility and whether all components of the unified record existed and whether each component was updated to the latest table of contents format (all were). The table of contents and maintenance guidelines were updated in March 2013 for the active records and in May 2013 for the individual notebooks. The master record table of contents and guidelines was undated, but was the same as during the last onsite review. The changes were statewide. SGSSLC made some facility-specific modifications, following state procedure when doing so. The URC continued to teach a new employee one-hour orientation session on recordkeeping practices. She remained available to conduct various trainings for home secretaries, clinical discipline department staff, and residential unit staff, though none were reported to be needed since the last onsite review. She also met each month with the home secretaries as part of their monthly meeting. She reviewed problems, issues, progress, and any changes in recordkeeping practices. Agenda topics and notes were on topics very relevant to recordkeeping. The home secretaries (nine) continued to be supervised by the unit directors. Since the last review, the facility considered changing their supervision to the URC, and decided to keep the supervision arrangement as it was. <u>Active records</u> The active records continued to improve. The monitoring team reviewed active records in each of the three units at SGSSLC. The monitoring team spoke with a number of staff about their experience with the active records. All reported that the active records were manageable and that it was easy to find documents when needed. For example, Lynn Miller, LVN, said that she regularly used the physician orders and IPN section. She described an example where important historical information in the record regarding an individual having different size pupils allowed them to better assess him after a minor head injury had occurred. The improvements highlighted in the previous report all remained in place or were	

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		modified to be more effective. These included a monthly audit done by each home secretary of the active record of another home secretary, and conduct of an inter-rater agreement of the active record by each of the two unit secretaries. The URC was just beginning to address the monitoring team's comment in the previous report regarding ensuring that the home secretary audits were done thoroughly and not biased towards high scoring. The facility also maintained improvement of the observation notes and IPN entries. In addition, the filing by RNs and use of the medical consultation database continued, and the placement of psychology therapy notes was modified. The monitoring team's review of a sample of active reviews showed that many of the problems identified in the previous report were improved. These included: • Missing documents: Of the handful of documents that the monitoring team found missing, the URC later reported that some were no longer required, such as a PBSP for Individual #71 because it had been discontinued, and a PNMP for Individual #94 because she did not need one. One document was not yet being regular produced, that is, the quarterly medical summaries (also see section L). Even so, some documents were missing, such as the OTPT assessment for Individual #94 and the initial psychiatric assessment for Individual #205. Overall, however, fewer documents were missing than during the last onsite review. The URC also said that when there are new employees in the various clinical departments, it sometimes takes the new clinician a while to regularly produce and submit the many required documents. • Old documents: Very few old or outdated documents were found by the monitoring team. The URC commented that the new ISP process appeared to be contributing to a more timely submission of documents for the home secretaries to file. • Thinning: The URC reported that she continued to address this and that clarifying the thinning requirements was on their next home secretary meeting agenda. The monitoring team, however, did not find the records to be overly full, that is, although some of the sections might have contained documents that were ready to be purged, the monitoring team did not find the volumes to be overly filled. • Legibility of written entries: Much progress had been made, even though some entries were not written fully legibly and/or signatures were not done correctly. The URC had identified certain homes in which this was more of a problem and she had plans to provide additional training. • Overall, medical documentation continued to improve, but legibility remained a problem for some providers. Documentation in the IPN was usually in the proper format, but was inconsistently done.	

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		The monitoring team's review of active records showed that for each record, more than 90% of required documents were present, current, and substantially in compliance with the requirements of appendix D of the Settlement Agreement. The URC's quality assurance audits described in section V3 had similar findings. The monitoring team was impressed by the consistent format, contents, and presentation of the active records across the five homes from which active records were reviewed. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. For example, Media Diaz and Charlotte Alcala, DSPs in two different homes, both reported that they used the individual notebooks for charting, including recording SAP information. They also said that although the individual notebooks were in the office area, they had no problem having access to the information they needed. The individual notebooks now contained the ISP, IRRF, and IHCP. Staff did not feel that this made the notebooks to heavy or full. Rather, they said that this was information important for them to have easy access to. As also noted in section K and in V4, data in the individual notebooks were recorded up to date for all too few individuals observed by the monitoring team. <u>Other binders/logs</u>: A number of documents were kept separate from the individual notebook. This differed from home to home (e.g., intake/output logs, aspiration trigger sheets). The URC successfully addressed concerns raised by the monitoring team in the previous report by (a) putting a full page pointer note in the appropriate place in the active record that told the reader where the document was located, and (b) she included these documents in her monthly quality assurance audits of the individual notebook. <u>Master records</u> A master record existed for every individual at SGSSLC. SGSSLC maintained the same satisfactory system of managing the master records. Overall, the master records were in good shape. Every master record now had a minimum document requirement list, even though the SGSSLC master records contained many more documents than were required. The URC successfully addressed a concern raised in previous monitoring reports. That is, she now had a system to indicate the status of master record documents that could not be located. That is, she wrote notes on the minimum document requirement list.	

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		In addition, her quality assurance audits indicated that the documents most frequently missing from the master records were social security cards and birth certificates. She embarked on a task to obtain as many as possible. To that end, she wrote to the social security office and to county offices. She involved individuals by telling them what she was doing and having them sign request forms. The results were very promising; as of 8/28/13 social security card requests were submitted for 17 of the 21 missing cards, and birth certificate requests were sent for 13 of 32 missing birth certificates. The URC reported during the onsite review that the birth certificates from Tom Green County (14 of the 32) were being processed and would soon be obtained and entered into the master records. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive <u>did not always</u> also appear in hard copy in the active record and/or individual notebook. The URC continued to compare the shared drive All About Me folder to what was in the active record when she conducted the monthly quality assurance audits. She found many examples of differences, usually that a more updated document was in the shared drive. She hypothesized that the differences may have been, at least in part, due to confusion among clinicians about where to put things in the shared drive. She also predicted that this would improve because the shared drive folders were now more organized and standardized. • Because the shared drive (All About Me) was used so extensively at SGSSLC, this is an area where the URC and home secretaries should focus their efforts over the next six months. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review. Based upon the above, the monitoring found that the facility was in substantial compliance with provision V1.	
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	This provision was managed by the QA director. She continued to improve upon the spreadsheet she had created at the time of the last review. The updates included some of the suggestions from the previous monitoring report. That is, she updated the seven-page spreadsheet that listed every policy at SGSSLC and had seven columns of relevant information, such as the state policy name, number, and date; any corresponding facility policies names, numbers and dates; and five columns	Noncompliance

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	policies, protocols, and procedures as necessary to implement Part II of this Agreement.	related to facility training on these policies. Not all state policies were in place yet, though continued progress was evident. Only provisions G and H did not yet have a state policy. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Include an "as of" date on this spreadsheet so that the reader knows that the training data were valid/correct as of a certain date. Because many trainings need to be re-done periodically, the "as of" date will be important to the reader. 2. Include within the "Who provides training column" o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o type of documentation necessary to confirm that training occurred, and o where this documentation is stored and summarized.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Continued progress occurred for this provision, so much so that the monitoring team found this provision, V3, to be in substantial compliance. Progress was made in the quality and management of the monthly reviews of unified records, including addressing and continuing to address the many recommendations and comments made in previous monitoring reports. This was due primarily to the efforts of the URC, but would not have been accomplished without the support and responsiveness of the facility's clinical staff, DSPs, home managers, residential and unit mangers, and QA director. For instance, staff throughout the facility were responsive when notified by the recordkeeping staff about any errors found in the records and any needed corrections. Quality assurance reviews (audits) were conducted in five of the previous six months, that is, in every month except April 2013. The URC typically completed nine audits every month. She did nine because she wanted to do one audit for each of the facility's nine home secretaries. She did all of these audits herself. (The audits done by the home secretaries were not used to satisfy the requirement for this provision, they were used to improve the quality of the active records, which is related to provision V1, not V3.) Audits were not done in April 2013 because the URC used that month to ensure that all of the more than 200 unified records at the facility were changed over to the new table of contents format issued by state office. That was a reasonable decision. Even though this one month did not include audits, the monitoring team believes that the time was used for the betterment of recordkeeping practices at SGSSLC. Furthermore, when considering that nine audits were done in all of the other months, the total for the six month period was in excess of 30. Thus, the monitoring team considered the absence of	Substantial Compliance

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		audits for that one month to be a "temporary failure to comply during a period of otherwise sustained compliance" as allowed in the Settlement Agreement part III, paragraph D (on page 34). All of the reviews were done in a consistent manner and were neatly and clearly documented. The database of medical consultations continued to be used to assist the URC in conducting these reviews (the URC used the previous 12 months of medical consultation data to complete her audits). The review consisted of these components: • The active record and individual notebook audit tool developed shortly prior to the previous onsite review; it also contained six questions related to V4. • Checking for documentation of medical consultations for the past 12 months. • Comparing what was in the active record with what was in the All About Me electronic shared drive folder. • The master record audit tool. • Nine V4 interviews of the same clinical-management discipline for each of the nine audits (e.g., nine RNs one month, nine home managers the next month, and so forth). The first bulleted item above, the active record and individual notebook audit tool, combined the previous table of contents tool and the previous statewide section V tool. The URC rated, for every item (for which it was appropriate to do so), whether it was legible, current, complete, and so forth. This was very good to see. Further, the tool was pre-populated with NA for those items that were always NA. The monitoring team asked how many total items were rated. The URC did not know, but later did a count: 1,542 different ratings. Further, the URC modified her audits based upon specific recommendations in the previous monitoring report regarding problems with the falsification item (she modified the wording of the item), missing QDRRs (this became a topic during home secretary meetings), and QA staff always scoring lower than the URC even though the overall percentage of IOA remained high (she met regularly with the QA staff and this disparity no longer existed). The monitoring team recommends that anytime there is a disparity, once it is resolved, that the URC consider modifying her written definitions in order to reduce the likelihood of the disparity occurring with other observers. IOA continued to be collected once each quarter. The monitoring team suggested that the URC consider calculating occurrence/nonoccurrence reliability to delve deeper into any differences between raters. This is not a requirement for maintaining substantial	

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		compliance, but an activity that the URC may find to be interesting and useful. She also maintained the practices highlighted in the last report regarding making corrections in the record when errors could easily be fixed while including those errors in her data count, and completing the audit tools by hand and then entering the data into her computerized spreadsheet that allowed her to count, track, and follow-up on every recommendation (errors were called recommendations at SGSSLC). The URC maintained a very high standard. For example, a single instance of an illegible entry in the observation notes resulted in that item (legibility of observation notes) being scored as "no." The URC had written instructions that she followed regarding the conduct of the audits, definitions of items, how to score items, and so forth. These were used by the QA staff who conducted IOA and could be used by other staff or by any future URCs. Once the audit was completed and the URC had entered the data into the computer, emails were sent to appropriate responsible persons and included a due date and what evidence was needed to show that the recommendation was corrected. For the most part, evidence was submitted to the URC either via email or as a copy of the document. The URC followed recommendations for two months. Supervisors were notified of any that were not completed by that time. The monitoring team talked with the URC about doing periodic checks as to whether the corrections were actually made (e.g., if a missing document was actually placed into the active record) for a sample of the corrections. She immediately added to her process to include having the home secretaries sign a tracking form when the corrected document is submitted tot hem for filing, and including follow-up within the home secretaries' monthly active record audits. The URC summarized, analyzed, and reported on her data. She also engaged in actions to correct problems based upon her data and findings. She actively participated in the QA program activities at SGSSLC, including creating a data inventory listing, a QA matrix, data graphs, narrative summaries and narrative analyses, a QAD-SAC meeting report and a monthly QA report, now 10 pages long. She attended and participated in monthly QAD-SAC meetings, and presented each month at the QI Council/Admin IDT meeting. The initiative of the URC combined with the support of the QA department helped the facility move to substantial compliance with this provision. She created a set of graphs and tables to summarize the audit results each month: • Total number of recommendations per home, and total for the facility o Typically, there were approximately 25 recommendations (items scored "no") per active record/individual notebook. Given that there were	

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		1,542 items scored, this was a relatively small number. Even so, the URC conducted analyses and implemented actions where problems were found (see below). o The URC's audits identified the same types of problems found by the monitoring team (see V1). • Total number of these recommendations that were corrected within 2 months • Recommendations and corrections presented by unit. • The above data presented in tabular, bar graph, and pie graph formats. In addition to the monthly data and graphs, the URC created a good set of graphs that adequately showed trending across the quarter and across the past year regarding important data for the facility's recordkeeping practices. Data points were graphed since October 2012 and presented in a monthly QA report that was also presented to QI Council/Admin IDT. Narrative summation and analyses were included for every graph. • Master records: number of recommendations and the number of these that were for missing social security cards and birth certificates. • Findings from the active record/individual notebook/V4 tool showing percentage scores. • Findings from the active record/individual notebook/V4 tool, separated by: o Active record volume 1 versus volumes 2-4 o 13 different quality components (e.g., legibility, current, complete, documents are accurate/consistent with state guidelines) • Comparison of what was in the All About Me electronic folder versus what was in the active record • Percentage of recommendations corrected by the end of two months o The URC was very happy to report that 100% were corrected for both June 2013 and July 2013. • Presentation of recommendations that were not corrected separated by: o clinical-management discipline department o residential home • Various data related to V4 o Results of home secretaries checking for the presence of active records and if not present, if they were signed out correctly. o Data from the section F monitoring tool regarding whether the active record was present at ISP and other meetings, and used if needed. o Subset of data from the active record/individual notebook/V4 audit regarding whether SAP data sheets and other progress notes were fully completed in the active record. o The URC's rating of the IPNs. o The URC's scoring of the V4 interviews	

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		Her data allowed her to drill deeper into problems and take corrective action. For example, legibility problems occurred more often in certain homes. She identified one home in which this was the case and conducted additional training and worked with the home manager and unit director. Another example was focusing upon missing social security cards and birth certificates. Another example was focusing upon the All About Me electronic shared drive folders. Some of these activities became official CAPs and were tracked to completion by the QA department. Others were tracked via the Admin IDT follow-up process. The monitoring team was fortunate to observe the URC's monthly presentation to QI Council/Admin IDT during the onsite review. She competently and professionally presented her data. There was good discussion and participation from attendees. The URC asked for assistance regarding some areas that her data indicated were problematic. In this instance, it was regarding complete signatures in the observation notes and IPNs. There was much good discussion, resulting in the facility director appointing the residential director to come up with a proposal to bring back to the group during a subsequent Admin IDT meeting.	
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.	In previous monitoring reports and during previous onsite reviews, the monitoring team detailed the six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URC. She had done a tremendous amount of work to address all six components, make decisions about what to measure, and to document that these were being addressed. For example, she incorporated some of the data and information needed for V4 into her V3 audits, she created data for the V4 components, and she included V4 data and information in her QA activities, including her QA report and presentations to QI Council/Admin IDT. Some of the work she had been doing, however, was not directly lined up with the six items of this provision. This was cleared up during discussion while onsite, especially regarding items #2 and #6. The facility was in substantial compliance with one of the six items. However, much good progress occurred and it is likely that further progress will be evident over the next six months. Below, the six areas of this provision item are presented, with some comments regarding SGSSLC's status on each.	Noncompliance

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		1. Records are accessible to staff, clinicians, and others The URC and the facility approached this aspect of V4 in a number of creative ways. These included: • Home secretaries conducted a check of the presence of the active records every day that included recording if a missing record was properly signed out. • Campus administrators did this same check during hours later in the night. • The URC included a check of the presence of the active records when doing each of the nine monthly audits. The URC summarized and presented the data in her monthly QA reports and presentations. Her data indicated that records were often not present, however, about two thirds of the time, they were signed out properly. The facility was engaged in corrective actions to address this. There was an in depth discussion during the URC's presentation at Admin IDT during the onsite review. The Admin IDT members raised questions when it was discovered that the record of an individual who was hospitalized was sent to home 516 (as appropriate), but because it was not signed out properly, it was scored as missing three times a day for all 13 days of her hospitalization, resulting in what some Admin IDT members considered to be an invalid spike in the data that appeared to indicate 39 records were missing. In addition, the monitoring team observed that: • A sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Both a current ISP and IHCP were available in 11 of 16 (75%) individual notebooks in the sample. • All volumes of active records for individuals listed in the Documents Reviewed section above were readily accessible and followed the facility's table of contents. • The monitoring team reviewed onsite records for Individual #23. All volumes of the active record were readily accessible and followed the facility's record organizational content table of contents. • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • The active records were available to the habilitation clinicians (OT, PT, SLP). This was good to see because most of their IPNs were handwritten and completed at the time of the contact. • The active records were available to the physicians.	

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		2. Data are filed in the record timely and accurately The URC was not yet addressing this item. In this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). Even so, the URC was assessing this during the monthly audits, that is, when she indicated whether a document was in the record, up to date, and in the right place. The information from these reviews could be used to satisfy this requirement, too. That is, the URC should pull the data from the audits regarding documents in the active record being up to date. The monitoring team observed that: • Data provided by the facility indicated that 127 of 218 (58%) ISPs developed in the past year were filed more than 30 days after the annual ISP was held. • Direct therapy was documented on a treatment note and filed in the Habilitation Therapy section of the active record, whereas monthly summaries and assessments were consistently in the IPNs. This was an appropriate system so as to provide key information for access by other team members. • The monitoring team, when reviewing onsite records for Individual #23, found many documents to be in place, such as evidence of admission records, nursing assessments, and immunization records. • Medical documents appeared to be filed timely and accurately. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The URC correctly looked to see if a variety of data and tracking sheets were completed after being filed in the active record. She did this while conducting her nine audits and then she included the data in her QA reports and presentations. She also needs look to see if these sheets are up to date in the current month's individual notebook and report on that, too. The monitoring team observed that: • In looking at whether behavior data were recorded in a timely manner, 44% of data cards reviewed had timely data. This should be improved upon. • There was improvement in the presence of intake and output, trigger sheets, on the individual care flow tracking record which recorded information about the individual's activities of daily intake, provision of fluids, and observations of the aspiration. • Data sheets were not typically utilized for direct therapy, but most of the IPNs	

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		and monthly summaries reflected measurable data relative to the established objectives of intervention. 4. IPNs indicate the use of the record in making these decisions (not only that there are entries made) The URC noted that she was awaiting guidance from state office regarding criteria for evaluating the IPNs. In the interim, she assessed and reported on whether the IPNs appeared to contain complete documentation, if there was follow-up to injuries and illnesses, and if all disciplines appropriate for the individual were making regular entries. She collected data on this and included it in her QA reports and presentations. The monitoring team observed that • Nursing staff reported to the monitoring team that the active record was used in making care, treatment, and training decisions, however, most nursing entries were driven from a complaint by the individual or from a staff person. The entries focused on the event or complaint, and rarely contained historical data or information from prior assessments. • Data were not consistently utilized to determine medication efficacy. In order for psychiatrists to make evidence-based driven decisions, for an individual with a seizure disorder prescribed AED medication to target both epilepsy and a psychiatric condition, staff inclusive of the psychiatrist must routinely utilize records (seizure frequency/graph) in making treatment decisions. • The psychiatrists documented findings in the comprehensive psychiatric evaluation according to Appendix B, or in the form for psychiatry clinic including a psychiatric interim note, and Quarterly Psychiatric Medical Review. 5. Staff surveyed/asked indicate how the unified record is used as per this provision item The URC implemented the staff interview in a creative and efficient manner. That is, each month, she chose a clinical or management category (e.g., RN case managers, home mangers) and conducted the V4 interview with that staff person for each of the nine audits. Thus, over the course of multiple months, she had sampled from a range of clinical and management staff at the facility. She graphed her results and included them in her QA reports and presentations. The majority of her ratings were positive. The monitoring team also found • During randomly chosen medication observations, and during interviews with nursing staff, the monitoring team asked RN and LVN staff how they used the individuals' record to assess, plan, implement and evaluate care. The nurses reported they review the individuals' medication administration record, physician orders, Physical Nutritional Management Plan, and Integrated	

#	Provision	Assessment of Status	Compliance
		Progress Notes (IPN) to ensure medications were administered in accordance with the physician orders. • The medical director reported that he wanted to change the process regarding signature sheets. The URC and medical director should work collaboratively on this topic. • This component of V4 was in substantial compliance. <u>6. 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> The intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. The URC addressed this by including questions on the section F observation tool to look at whether the active record was available at ISP meetings and whether the records were used for discussion or as a reference. The monitoring team clarified the intent of this item (#6) while onsite with the URC. In addition to ISP meetings, there are other meetings where it is important for the facility to ensure the presence and availability of records. The monitoring team found the following: • Records were present for all of the pre-ISP and ISP meetings observed by the monitoring team. • For Individual #23, the active record was located and utilized during the an acute care event to review historical data, make decisions about care and treatment, and ensure sufficient health notifications to the Infection Control Nurse. • During an IDT meeting the record was present and referred to when referencing current status for Individual #132 identified skin integrity issues. • The active records were available during the PNMT meeting for reference and documentation as required. • Records were available during psychiatry clinic, staff referred to the records, and reviewed documentation. • A lack of similar diagnostics across disciplines in the unified record that was not addressed by the IDT until prompting from the monitoring team. • Pertinent records were <u>not</u> present during discussions in the Medication Review Committee or Polypharmacy Committee meetings. These specific cases were	

#	Provision	Assessment of Status	Compliance
		identified to be presented and discussed and, therefore, should have been available for staff review during the meeting. The staff stated they did not know the details of the case because the record was not present in these meetings regarding the individual being reviewed. • Active records were used during pneumonia review, but did not have the results of a recent MBSS for one individual.	

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
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
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
AROM	Active Range of Motion
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
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
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
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
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
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
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
CMQI	Continuous Medical Quality Improvement

COS	Change of Status
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
DBW	Desirable Body Weight
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
DNP	Doctor of Nursing Practice
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPN	Dental Progress Note
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
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
EC	Environmental Control
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
EOC	Environment of Care
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
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
GIB	Gastrointestinal Bleed
GIFT	General Integrated Functional Training
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)
IA	Intelligent Alert
IAR	Integrated Active Record
IC	Infection Control
ICA	Intense Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
ID	Intellectually Disabled
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
IHCP	Integrated Health Care 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
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
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
LLL	Left Lower Lobe
LOC	Level of Consciousness
LOD	Living Options Discussion
LOI	Level of Involvement
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
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MDRO	Multi-Drug Resistant Organism
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
NFS	Non Foundational Skills
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
OH	Oral Hygiene
OHI	Oral Hygiene Index
OIG	Office of Inspector General
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
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
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
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
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior

PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
PNE	Pneumonia
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PO	By Mouth (per os)
POC	Polypharmacy Overview Committee
POI	Plan of Improvement
POT	Post Operative Treatment
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	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
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
PUSH	Pressure Ulcer Scale for Healing
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

QIDP	Qualified Intellectual Disabilities Professional
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
RLL	Right Lower Lobe
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
SBO	Small Bowel Obstruction
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
SIS	Second Injury Syndrome
SIT	Skin Integrity Team

SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
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
TCA	Texas Code Annotated
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TFT	Thyroid Function Tests
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSHA	Texas Speech and Hearing Association
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
UR	Unified Record
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VAP	Vascular Access Port
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old