United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: February 17-21, 2014

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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

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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.

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

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.

Restraint

- Although the facility remained out of compliance with five of eight provision items in section C, definite progress towards compliance had been made, including substantial compliance with five of the seven items in C7.
- There were 306 restraints used for crisis intervention involving 60 individuals between 8/1/13 and 1/31/14. Individual #395 accounted for 49 (16%) of these restraints. Eight individuals at the facility had 10 or more restraints during the past six months, while 21 (33%) of the 60 individuals involved in restraint had only one restraint.
- There were 56 instances of dental/medical restraint from 8/1/13 through 1/31/14 involving 28 individuals.
- The facility reported that two individuals at the facility wore protective mechanical restraints for self-injurious behaviors. Observations at the facility confirmed that other individuals were wearing protective mechanical restraints not included in data presented for section C.
- To move forward, the facility should focus on providing meaningful training opportunities and active engagement during the day, documenting protective medical restraints in compliance with the state policy, and ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines.

Abuse, Neglect, and Incident Management

- Of 760 allegations, there were six confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, 27 confirmed cases of neglect, and no confirmed case of exploitation. The facility reported that 58 other serious incidents were investigated by the facility during this period.
- There were a total of 1930 injuries reported between 6/1/13 and 11/31/13. These included 25 serious injuries resulting in fractures or sutures. Although there was a decrease in the total number of injuries, there was an increase in serious injuries. Injury trends were being generated by individual and were made available to IDTs for planning.
- While the incident management and quality assurance departments were placing a greater focus on trends and systemic issues that contributed to incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. Individuals at the facility continued to remain at risk for harm due inadequate planning and follow-up to incidents by IDTs.
- Five of the 22 provisions remained in noncompliance:
    - D2a: The facility failed to appropriately report all serious incidents as dictated by state policy.
    - D3e: The facility was not ensuring that all investigations were completed within 10 days unless an extension was approved by the facility director due to extenuating circumstances. Additionally, not all investigations included appropriate recommendations for corrective action.
    - D3g: The facility review process did not ensure that deficiencies or areas of further inquiry in the investigation and/or report were addressed promptly.

- D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring.
- D.4: The facility was still not adequately developing action plans to address trends. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented.

Quality Assurance

- The QA program at SGSSLC continued to make progress. Systems continued to evolve and improve.
- The data list inventory was 71 pages long, contained 22 topic areas and was managed in a database that was easy to read and update. 20 of the 20 provisions of the Settlement Agreement (100%) were included. The QA plan matrix was 14 pages long and the items lined up with the data listing inventory. There were items for all 20 sections (100%).
- The QA director and SAC continued to develop and improve monthly Face to Face meetings. The SAC and her staff kept excellent minutes of these meetings. The QA director and SAC continued to use a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory).
- All 20 sections (100%) appeared in a QA report at least once each quarter in the last six months. Most every section had narrative, however, most narratives were descriptions of the data, of the problem identified by the data, and of what they were going to do (regardless of whether it related to a cause). What was missing was an analysis of the causes of the problem, not just a description of their occurrence.
- There were 9 CAPs. The monitoring team reviewed all 9 CAPs and found them to be inadequate because the overall goal/purpose of the CAP was not clearly stated, the CAP was not worded in a measurable manner that related to the goal/purpose, and the action steps were not written in observable terms with criterion. Additions need to be made to the CAPs document format and improvements need to be made in the content of that format.

Integrated Protections, Services, Treatment, and Support

- The facility had chosen to focus on assessment submission and attendance at the annual IDT meetings by all relevant team members to move towards compliance with section F. The monitoring team agreed that these two areas should be priorities to ensure that IDTs are developing comprehensive ISPs.
- Additional activities that the facility had engaged in included:
  - Three QIDPs assumed ISP facilitator roles and received additional training on meeting facilitation skills.
  - QIDPs were trained by the APC on the community living determination process.
  - QIDPs were trained by the Rights Officer Assistant on determining supports versus restrictions when completing the rights assessment.
  - Training was provided to all IDT members on writing measurable goals and objectives. RN case managers received additional training on writing objectives for the IHCPs from the RN supervisor.

- Two annual ISP meetings were observed during the monitoring visit. Both were lengthy (four hours) and did not result in a plan that would ensure meaningful programming and supports. The facility needs to request additional training from the state office to move forward with developing and implementing comprehensive ISPs.
- All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review.
- IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection.
- 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.

Integrated Clinical Services

- There was no measurable progress in this area. The clinical disciplines continued to work on ways to deliver services in an integrated manner, but the facility struggled with the development of an effective means to measure integration.
- Facility staff understood that participation in meetings alone was not adequate evidence of integration. To that end, the facility was developing tools to demonstrate that the meetings were generating plans and recommendations that were implemented and facilitated integration of services.
- For provision G2, there was no progress. It appeared that staff did not understand the documentation requirements for this provision. An audit tool was developed that captured the requirements, but audits had not been completed. The IPN entries did not meet the documentation requirements.

Minimum Common Elements of Clinical Care

- There was very little progress seen and that was not unexpected given the facility made significant changes related to this provision. For more than a year, the facility's QA nurse had served as the section H lead. In November 2013, the medical director assumed the lead.
- There was progress in provision H1 as the facility continued to monitor the timeliness of the various assessments. H2 remained in substantial compliance.
- The November 2013 QA report indicated that no data for provisions H3-H7 were presented and audits were not conducted or scheduled. The self-assessment reflected that monitoring was temporarily suspended.
- The suspension was unfortunate because the facility had made good progress in H1 and previous compliance reviews provided evidence that the fundamental work needed to move forward with this provision was in progress.

At-Risk Individuals

- The monitoring team observed the risk identification process at two ISP meetings and noted some progress made. IDTs were engaging in better discussion regarding risk levels. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions.
- Supports were not being monitored and revised as needed to address risks identified. Teams were not consistently documenting the completion of assessments and implementation of recommendations.
- As noted throughout this report the monitoring team has concerns related to the accurate identification of risk factors for individuals and the processes that the facility had in place to address those risks.

Psychiatric Care and Services

- SGSSLC was in substantial compliance with J1. There had been tremendous turnover in the psychiatry staff, however, new staff, including a new psychiatrist leader were recently hired.
- 81% of the individuals (177) were receiving services via psychiatry clinic.
- There were deficiencies with regard to timeliness of quarterly psychiatric medication reviews. There was a paucity of combined assessment and case formulation; only 34% of comprehensive psychiatric evaluations per Appendix B had been completed. Psychiatry did not routinely attend meetings regarding behavioral support planning for individuals assigned to their own caseload, and was not consistently involved in the development of the plans.
- The facility must ensure that following the pretreatment sedation review, a consensus is obtained with regard to the administration of a particular medication, 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.
- SGSSLC had instituted a monthly polypharmacy meeting, however, this meeting was chaired by psychiatry clinic, but instead should be led by pharmacy. The psychiatric providers had not begun authoring clinical polypharmacy justifications for review.
- The facility made progress in the area of informed consent; 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

- There were several improvements since the last review, resulting in one additional item rated in substantial compliance (K9) and maintenance of the other items (K2, K3, K5, K7, K8, and K11) that were in substantial compliance. Improvements included continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written; documentation that PBSPs were consistently implemented within 14 days of receiving consent; and improvements in the quality of the PBSPs.

- Areas in need of additional improvement included ensuring that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors and reviewing the procedures for collecting IOA, treatment integrity, and data collection timeliness data. The facility also needed to ensure that replacement/alternative behaviors are collected and graphed for all individuals with PBSPs, ensure that current data are consistently available and graphed at interdisciplinary meetings to foster data based decisions, ensure that when an individual is not making expected progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred, and 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.

Medical Care

- There was minimal progress seen in the medical department. One area with improvement, however, was staffing. Physicians continued to have very little participation in the ISP process, attending only two meetings over an eight-month period. Attendance at ISPAs was not tracked. Even though attendance was poor, there were anecdotal accounts that the primary care providers were very accessible to the IDTs and staff and, overall, worked well with other disciplines.
- Generally, individuals received basic medical care. There was documentation that annual assessments were completed along with routine annual labs and screenings.
- There were many issues related to the medical care provided to individuals with more complicated medical issues. Individuals with numerous chronic medical conditions were treated with standing orders without physician notification. Based on the record sample, individuals were not being assessed as required following hospitalization and emergency department evaluations. In some cases, the medical staff was conducting phone consults with SGSSLC nursing in lieu of actual evaluations following return from the hospital.
- Pneumonia management needed additional work. At some point, a decision was made to no longer track individuals with metabolic syndrome even though it is a risk factor in subsequent development of type 2 diabetes and/or cardiovascular disease. It appeared that there were some individuals with metabolic syndrome who were undiagnosed.
- There continued to be no effective means of integrating neurology and psychiatry and the need for joint evaluation was observed in the sample of neurological records reviewed.
- The external and internal medical reviews were completed as required. There continued to be problems with implementation of the corrective action plans. Mortality reviews were conducted, but significant delays were seen in the completion of two of the reviews. The medical department did not develop a medical quality program and was not tracking any data related to hospitalizations or disease management.

Nursing Care

- The Nursing Department continued to make progress. When selecting samples for self-audits, the department should also include the low risk population, as it should be recognized that the assignment of low risk does not rule out the eruption of a serious health conditions.
- The 12 last completed Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed (using a monitoring tool similar to the tool currently used by the facility) and had an overall compliance of 73%.
- The Nursing Department should ensure individuals who have acute changes in their mental health/health status are sufficiently assessed, and there is a plan of care in place that includes applicable instructions/training for staff. The Nursing Department should provide practice opportunities that assist nurses in developing Acute Care Plans and their associated staff instructions.
- All Nurse Managers were housed in one main building, away from the units where the nurses they supervised provided the day to day nursing procedures (e.g., assessments, sick call, administration of medication). A standard was not in place by the Nursing Department, where RN Nurse Managers were empowered to adjust their Monday through Friday schedule for conducting random unannounced supervisory visits on different shifts, including weekends.
- The monitoring team attended one of the facility's Nursing Administration Meetings. The meeting was productive as the Nurse Managers were involved in problem solving and data collection. The Nursing Department established standing meetings with the Medical Director and worked collaboratively to ensure standardized care and services were individualized.
- The Hospital Liaison continued to make improvements with the Hospital Liaison activities, which included being proactive in the Partners Meeting held between the hospital and facility. The Infection Control Preventionist reviewed and revised 50% of the facility's infection control policies.
- The Nursing Department made improvements to its practice of 24-hour chart review process to now include all units.
- The facility continued to evaluate/assign risk as to whether or not the individual actually had an event and/or a negative outcome from the event, rather than a continuum of screening for risk that focus on prevention
- CLDP discharges/transition summaries did not, but need to contain accurate data to assure the provision of quality of care.
- Based on a review of 45 medication pass observation for 15 individuals, conducted during monitoring team visit, there was negligible progress in following accepted standards when administering medications.

Pharmacy Services and Safe Medication Practices

- The new pharmacy director reported that a great deal of effort was devoted to the logistics of providing basic pharmacy services. Changes in staffing and a lack of a clinical pharmacist for several months had worsened the existing deficits.
- Overall, there was some progress seen in the provision of pharmacy services. The monitoring team could appreciate that the department seemed positioned to move forward in most areas, but simply had not had enough time to do so.

- There was documentation of communication between the pharmacists and providers, but this documentation was inadequate and fluctuated monthly. The Intelligent Alerts were implemented, but the reports generated were limited to three medications.
- The QDRRs that were completed were quality evaluations, but there were serious issues related to compliance with timelines. At the time of the review, 40% of individuals had current evaluations.
- The facility did not have an adequate system to review psychotropic polypharmacy and there was no consensus on how that would be achieved. Eleven percent of the population was identified as diabetic, but it appeared that there may have been individuals with metabolic syndrome that remained undiagnosed.
- There were numerous problems related to completion of the MOSES and DISCUS evaluations. The facility continued to have under-reporting of ADRs based on documents reviewed and there was no training done to address this. DUEs were completed, but the reviews will need a considerable amount of work to meet an acceptable standard.
- The facility's medication variance system remained problematic.

Physical and Nutritional Management

- Substantial compliance was maintained for provision O1. Strengths included regular attendance by the IDT members and Dr. Jolivet. The team seemed to have established key clinical indicators that noted when specific actions were to be implemented.
- The PNMT was encouraged to track the occurrence of health issues to ensure that timely referral to the team was possible. They had taken this a step further and were tracking and trending these issues across the facility and presented in Administrative IDT meetings, as well as others. They are to be commended for recognizing the importance of this process and taking action to implement their current process.
- There were overall improvements related to mealtimes noted. The mealtime coordinator system had been implemented, but there were many logistical issues to be worked out and extensive training for these staff.

Physical and Occupational Therapy

- Substantial compliance was maintained for P.1 and continued efforts to improve the content of assessments and timeliness were noted.
- The facility was very close substantial compliance in P.4, with a needed focus on consistency of effectiveness monitoring. It was positive that the facility tracked the effectiveness of plans and programs, but based on this review, they did not appear to be consistently completed in a timely manner. In addition, documentation of direct services was absent or very limited.
- There were few intervention plans and SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries. Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report with regard to content.

- Attendance at ISPs needed to be more consistent with the determinations by the IDT and supports and services needed to be more consistently reflected in the ISP document. The Essential Elements guide used by the therapists, appeared to be effective during the meeting, but did not result in consistent documentation of PNM and OT/PT supports and services.

Dental Services

- A great deal of progress was seen and the facility was on the brink of achieving substantial compliance. Removal of the barriers will involve additional collaboration and further integration with other clinical services. The dental director continued to be involved in all aspects of the clinic's operation. The clinic's full time registered dental hygienist served as the facility's lead for the Settlement Agreement. She was responsible for much of the logistics related to Settlement Agreement activities.
- There were a number of accomplishments noted in this review: (1) compliance with annual assessments was increasing, (2) oral hygiene ratings were improving (3) compliance with obtaining radiographs was significantly increased and (4) the number of missed appointments decreased.
- There were also some areas of importance that will need attention. The facility did not have a comprehensive set of policies and procedures related to the use of TIVA in the facility. Record reviews indicated that the appropriate monitoring was not completed. The facility utilized post sedation standards and not the post general anesthesia standards.

Communication

- There was continued, steady progress in all aspects of provision R. Efforts to improve the content of communication assessments were evident. Standardized assessment formats were implemented consistent with the state formats. Instructional guidelines were revised to ensure inclusion of all essential elements. Self-audits were conducted with reliability checks conducted by the lead SLP. Though improvements were noted, on-time completion of assessments continued to be problematic.
- There were a number of communication plans and SAPs in place for individuals with communication needs and also for those individuals with behavioral concerns in combination with severe communication deficits. Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report, with regard to content.
- Numerous references to the need for cause and effect, as a prerequisite to benefit from AAC, were unfortunately frequently noted. For example, in one case, the individual did not respond to requests for identification of pictures and this was used as the rationale for not providing AAC.

- Assessments were not consistently completed 10 days prior to the ISP. The content of assessments was substantially improved with compliance with the 23 essential elements averaging approximately 97%. The staff and leadership are congratulated on this significant achievement.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were several improvements since the last review. These included improvements in the quality of SAPs, in collaboration between behavioral health services and the dental department, and in program developers writing of replacement behaviors plans. The monitoring team also found improved initiation of a day programming attendance project, the percentage of SAPs that were clearly based on assessment results, and the percentage of individuals working on SAPs in the community.
- The facility needs to ensure that each SAP contains all of the required components and that SAP data are accurately recorded. The facility also needs to document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans, and establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- There was progress in the detail included in many of the CLDPs, the reduced length of time individuals waited for transition, and the continued transition and placement of individuals into the community.
- 8 individuals had been placed in the community since the last onsite review. 18 individuals were on the active referral list. Of the 22 or so individuals who moved in the past 12 months, 2 had one or more untoward events that occurred within the past six months (9%). Of these 2, 0 (0%) were successfully resolved or managed; both returned to live at the facility. In addition, 2 other individuals returned to the facility after less than 1.5 years in the community. The APC and the facility continued to fail to do a thorough analysis of these failures in order to make improvements to the referral and transition processes at the facility.
- CLDPs were developed for each individual who was referred. A CLDP meeting was conducted during the onsite review and was observed by the monitoring team. The individual was very engaged during the meeting, though there was little participation from team members.
- Discharge assessments were completed for all relevant disciplines, however, they did not focus upon the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings.
- The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive.
- Post move monitoring continued to be implemented as required. 39 post move monitorings for 14 individuals were completed since the last onsite review.

Guardianship and Consent

- This provision received no monitoring based upon the parties' agreement due to limited or no progress.

Recordkeeping Practices

- SGSSLC maintained substantial compliance with two of the provisions, V1 and V3.
- 10 of 10 (100%) individuals' unified records reviewed included an active record, individual notebook, and master record. 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.
- Nine reviews (audits) were conducted in each of the previous six months. All were done in a fairly consistent manner, and were neatly and clearly documented. Inter-rater agreement reliability checks were occurring regularly.
- The system of conducting the audit, listing all errors (which were called recommendations), emailing to the responsible person, and following up on each error (for two months and with timed prompts) continued in the same manner as described in some detail in previous monitoring reports. This continued to be a very good system that was easy to understand.
- The number of errors was decreasing over the past year and the number of errors that were corrected had increased.
- The URC was very creative and thoughtful in coming up with specific activities, data, and criteria for each of the six areas of V4.

Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints #00.1
o SGSSLC Policy: Management of Inappropriate Behaviors 2/10/06
o SGSSLC Policy: Restraint Notification Process 3/31/11
o SGSSLC Policy: Use of Restraints 4/14/11
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 Section C QA 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
o List of all injuries that occurred during restraint
o SGSSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o Sample #C.1: 22 records of physical or chemical restraint used in a crisis intervention for seven 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 incidents in the sample were:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#329</td><td>Physical</td><td>11/17/13 @ 4:41 pm</td></tr>
<tr><td>#329</td><td>Physical</td><td>11/17/13 @ 4:37 pm</td></tr>
<tr><td>#329</td><td>Chemical</td><td>11/17/13 @ 5:20 pm</td></tr>
<tr><td>#329</td><td>Physical</td><td>11/9/13 @ 11:19 am</td></tr>
</table>
</td></tr>
</table>

#329	Chemical	10/29/13 @ 1:33 pm
#329	Physical	10/21/13 @ 8:46 am
#243	Chemical	10/22/13 @ 4:45 pm
#243	Physical	10/21/13 @ 2:31 pm
#243	Physical	10/21/13 @ 6:50 pm
#243	Chemical	10/15/13 @ 4:40 pm
#243	Physical	10/10/13 @ 11:48 am
#243	Chemical	10/10/13 @ 11:50 am
#395	Physical	9/24/13 @ 9:04 am
#395	Chemical	9/19/13 @10:00 pm
#395	Physical	9/19/13 @ 1:20 pm
#395	Physical	9/18/13 @ 1:25 pm
#395	Physical	9/13/13 @ 1:41 pm
#209	Physical	11/27/13 @12:53 pm
#9	Physical	11/26/13 @ 5:32 am
#142	Physical	11/26/13 @4:25 pm
#142	Chemical	11/27/13 @ 1:45 am
#241	Chemical	11/5/13 @ 4:45 pm

- Sample #C.2 was documentation for a selected sample of 20 staff:
  - their start dates,
  - the dates they were assigned to work with individuals,
  - their training transcripts showing date of most recent:
    - PMAB training and
    - Training on the use of restraint.

- Sample #C.3 was a sample of documentation for pretreatment sedation chosen from the last 10 medical/dental restraints including 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 desensitization plan.

Individual	Restraint type
#144	11/4/13
#38	11/21/13
#251	11/21/13
#251	11/14/13
#238	11/25/13

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was 72. Sample size was eight, 11% of the chemical restraints. 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 behavior health specialist and physician prior to the use of the restraint. For the following:

Individual	Date
#243	10/22/13
#243	10/15/13
#243	10/10/13
#395	9/19/13
#329	11/17/13
#329	10/29/13
#241	11/5/13
#142	11/27/13

- Sample #C.5: Restraints off-campus.

Individual	Date
#395	9/24/13
#329	10/21/13

- 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:
  - PBSPs, crisis intervention plans, and individual support plan addendums (ISPAs) for:
  - Individual #243, Individual #370, Individual #209, Individual #329, and Individual #58

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

Individual	Restraint type
#346	Kevlar gloves

<u>Interviews and Meetings Held</u>:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Dana Robertson, Provision Coordinator
- Liz Love, Behavioral Health Specialist
- Jalown McCleery, Incident Management Coordinator
- Vanessa Barrientez, QIDP Coordinator
- Roy Smith, Human Rights Officer

	Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 2/17/14 and 2/19/14 o ISP preparation meeting for Individual #354 and Individual #337 o Annual IDT Meeting for Individual #55 and Individual #331 o Restraint Reduction Committee Meeting
	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 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 POI Coordinator for section C was responsible for the self-assessment process. She engaged in a thorough self-assessment process that included a review of all restraints, ISPs, and other IDT documents regarding the use and review of restraints, and data collected by the facility regarding restraints. Not only did she consider the presence of documentation, she also commented on the quality of documentation in terms of meeting state mandates and Settlement Agreement provision requirements. For each item not rated in substantial compliance, measureable actions steps were developed to address those items. The facility assigned a self-rating of substantial compliance to C2, C3, C6, and two items in C7. The monitoring team agreed with the facility's findings regarding each provision of C, and also found three additional items of C7 to be in substantial compliance.
	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 306 restraints used for crisis intervention involving 60 individuals between 8/1/13 and 1/31/14. The number of restraint incidents had increased since the last onsite review when it was reported that there had been 287 restraints during the review period. Individual #395 accounted for 49 of the 306 (16%) restraints used for crisis intervention. Eight individuals at the facility had 10 or more restraints during the past six months, while 21 (33%) of the 60 individuals involved in restraint had only one restraint. A log of all dental/medical restraints provided by the facility included 56 instances of dental/medical restraint from 8/1/13 through 1/31/14 involving 28 individuals. The facility reported that two individuals at the facility wore protective mechanical restraints (PMRs) for self-injurious behaviors. Observations at the facility confirmed that other individuals were wearing protective mechanical restraints not included in data presented for section C. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting

	compliance with the requirements of section C. Observations in the homes and day programs and interviews with staff were conducted the week of the monitoring visit to gain additional information. Although the facility remained out of compliance with five of eight provision items in section C, definite progress towards compliance had been made, including substantial compliance with five of the seven items in C7. The POI Coordinator had developed a self-assessment process similar to the process used to assess compliance by the monitoring team. She was well aware of the barriers to achieving progress and was focused on addressing those issues. To move forward, the facility should continue 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. The monitoring team noted very little progress in IDTs developing plans that would lead to meaningful programming for individuals. • 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.

<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 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.</td><td>According to a list of all restraints implemented at the facility (Document II.6),
<table>
<tr><th>Type of Restraint</th><th>December 2012 – May 2013</th><th>August 2013-January 2014</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>207</td><td>234</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>80</td><td>72</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>1</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>287</td><td>306</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>72</td><td>60</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>14</td><td>19</td></tr>
<tr><td>Medical/dental pretreatment restraints</td><td>46</td><td>56</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental treatment</td><td>16</td><td>28</td></tr>
<tr><td>Protective mechanical restraints</td><td>3</td><td>2 individuals</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Prone Restraint a. Based on facility policy review, prone restraint was prohibited. b. Based on review of other documentation (list of all restraints between 8/1/13 and 1/31/14) prone restraint was not identified. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 8/1/13 and 11/31/13. Sample #C.1 was a sample of 22 restraints for eight individuals, representing 7% of restraint records over the last six-month period and 13% of the individuals involved in restraints. The sample included 14 physical restraints and eight chemical restraint. Sample #C.1 included three individuals with the greatest number of restraints, as well as five 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 eight individuals, zero (0%) showed use of 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: • f. In 22 of the 22 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 22 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 22 (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 22 of the records (100%), 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. All restraint checklist indicated that staff used PMAB skills and strategies included in the individual's PBSP prior to implementing restraints. Specific interventions were not described, so it was not possible to assess if staff used a full range of strategies included in the PBSP prior	

#	Provision	Assessment of Status	Compliance
		to the implementation of restraint. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 22 restraints, involving seven individuals, 22 (100%) were approved restraints. k. In 19 of 22 of these records (86%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. As noted throughout this report, it was not evident that individuals were engaged in meaningful programming based on preferences and assessed needs. There was still a high number of refusals to attend programming at the facility. PBSPs reviewed tended to focus on rewarding compliance for individuals attending non-functional programming rather than modifying programming to meet the needs of individuals at the facility. For example, individuals were rewarded for attending the workshop, though work assignments were not based on functional vocational assessments that identified work preferences or prioritized vocational skills training. Analysis of resulting behavioral incidents focused on the individual's failure to comply, rather than on the facility's failure to provide adequate supports and training opportunities. For the sample reviewed, • Individual #142 did not have a current ISP in place. His ISP was dated 10/23/12. A list of all ISPs for all individuals at SGSSLC (Document V.10) indicated that the IDT met on 10/9/13 to update his plan. The resulting ISP had not yet been filed. • Individual #209 did not have a current psychiatric or psychological assessment for the team to use when developing her ISP. She did not have a PBSP in place. 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 reported that there were two individuals subjected to restraints classified as protective mechanical restraints (PMRs). Both of those were used to prevent injury from self-injurious behaviors. The facility was not collecting data in regards to protective mechanical restraints classified as "medical" protective devices by the facility. It was not evident that IDTs were engaging in adequate discussion to ensure that these devices were the least restrictive intervention necessary. For example, Individual #241 was wearing a helmet to prevent injury during seizures. His ISP did not adequately address use of his helmet or team discussion regarding less restrictive supports that had been tried and ruled out as not effective.	

#	Provision	Assessment of Status	Compliance
		Plans should be developed to include a description of the individual's risk, the type of restraint to be used, the restraint's maximum duration, and when to apply, remove, and monitor the restraint. IDTs should document that less restrictive restraints have been discussed and determined to be ineffective at reducing or mitigating the documented risk. 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 all individuals have updated plans that include behavioral intervention strategies to minimize the use of restraint based on current assessments. 2. Ensure that all IDTs are holding adequate discussion regarding the use of protective mechanical restraints. IDTs should document consideration of less restrictive interventions. 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.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 14 physical restraint records involving the six individuals in Sample #C.1 were reviewed. Two individuals in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individuals involved in physical restraint who had a Crisis Intervention Plan (Individual #243 and Individual #395), five of seven (71%) 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. The two restraints that did not follow release criteria in the CIP were released because staff could not maintain the correct hold. b. For the four individuals who did not have Crisis Intervention Plans, seven of seven (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. Based on this review, the facility was in substantial compliance with C2.	Substantial 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 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:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	• 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 20 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: • 20 of the 20 (100%) had current training in RES0105 Restraint Prevention and Rules. • 16 of the 17 (94%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training • 20 of the 20 (100%) had completed PMAB training within the past 12 months. • 16 of the 17 (94%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, six direct support professionals answered the following questions correctly: • Describe specific intervention techniques in the PBSP to avoid restraint for _____ (name of individual assigned to support) (100%); d. In 22 of the records (100%), 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.	
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	a. Based on a review of 22 restraint records (Sample #C.1), in 22 (100%) there was evidence that documented that restraint was used as a crisis intervention. See C1f. b. All individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for eight individuals in the sample, 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) (100%). c. In addition, facility policy did not allow for the use of <u>non-medical</u> restraint for reasons other than crisis intervention, except for protective mechanical restraints for SIB.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual shall include treatments or strategies to minimize or eliminate the need for restraint.	d. In 22 of 22 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. The facility reported that one individual (Individual #68) was restrained contrary to the "Do Not Restrain" list. Staff were retrained on his risks and appropriate interventions. e. The facility reported that 56 restraints were used to complete routine medical appointments from 8/1/13 through 1/31/14. In 56 of 56 restraints, there was no evidence that the restraint used was in contradiction to the individual's medical orders according to the "Do Not Restrain" list. f. In 22 of 22 restraint records reviewed in Sample #C.1 (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 from Sample #C.3 for individuals for whom restraint had been used for the completion of medical or dental work: • g. Zero (no documentation submitted) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent. • h. One (25%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. o Individual #238's ISP stated that he did not need pretreatment sedation for routine appointments. He received pretreatment sedation on 11/25/13. o Individual #38's ISP did not include strategies to minimize the use of pretreatment sedation. o Individual #251's ISP noted that he did need pretreatment sedation, however, the IDT did not discuss strategies to minimize the need for pretreatment sedation. • i. Zero (no documentation submitted) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs to provide documentation to the monitoring team to show that the HRC has approved all medical/dental restraints prior to implementation and that the IDT has discussed the use of restraint and strategies that might reduce the need for future restraints.	

#	Provision	Assessment of Status	Compliance
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	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. Twenty 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 face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 22 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 22 out of 22 incidents of restraint (100%) by an adequately trained staff member. • e. In 20 out of 22 instances (91%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The exception was: o Individual #395 dated 9/19/13 (late) o Individual #9 dated 11/26/13 (late) • f. In 22 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 22 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 22 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 15 (68%) of the instance of restraint. Exceptions were: o Individual #329 on 1117/13 o Individual #329 on 11/9/13 o Individual #329 on 10/29/13 o Individual #395 on 9/19/13 at 10:00 pm o Individual #395 on 9/19/13 at 1:20 pm o Individual #209 on 11/27/13 o Individual #9 on 11/26/13	Noncompliance

#	Provision	Assessment of Status	Compliance
		• k. Monitored and documented vital signs in 21 (95%). The exceptions were: o Individual #329 on 10/29/13 • l. Monitored and documented mental status in 21 (95%). The exception was: o Individual #329 on 10/29/13 The facility data summary indicated that problems with the completion of nursing assessments within required timeframes were, in part, due to late notification by restraint monitors. Restraint monitors were responsible for notifying nursing staff of the need for an assessment. The facility was focusing on earlier notification of restraint monitors when a restraint occurred. Based on documentation provided by the facility, five restraint incidents had occurred off the grounds of the facility in the last six months. A sample of two restraint incident was reviewed (sample #C.5). • m. Conducted monitoring within 30 minutes of the individual's return to the facility in two out of two (100%). • n. Monitored and documented vital signs in two (100%). • o. Monitored and documented mental status in two (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months, • p. In five out of five (100%), the physician specified the schedule of monitoring required or specified facility policy was followed; and • q. In ___ out of ___ (n/a), the physician specified the type of monitoring required if it was different than the facility policy. r. In three out of five of the medical restraints (60%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Exceptions were: • Individual #144 on 11/4/13 – monitoring by the nurse was not continued with the frequency or duration ordered by the physician. • Individual #251 on 11/14/13 – monitoring by the nurse was completed with the frequency ordered by the physician. 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: • PMRPs are developed for individuals with protective mechanical restraints. • A licensed healthcare professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the	

#	Provision	Assessment of Status	Compliance
		start of the restraint.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 22 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 22 (100%), continuous one-to-one supervision was provided; • b. In 22 (100%), the date and time restraint was begun; • c. In 22 (100%), the location of the restraint; • d. In 22 (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 22 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • f. In 22 (100%), the specific reasons for the use of the restraint; • g. In 22 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 22 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 21 (96%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The restraint checklist for Individual #329 dated 10/29/13 at 1:33 pm did not describe the individual's behavior during observation following a chemical restraint. o j. In ____ (n/a) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint. The longest physical restraint in the sample was 13 minutes. o k. In _____ (n/a), 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. • l. In 22 (100%), the level of supervision provided during the restraint episode; • m. In 14 of 14 physical restraints (100%), the date and time the individual was released from restraint; and • n. In 22 (100%), 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. In a sample of 22 records (Sample #C.1), restraint debriefing forms had been completed for 22 (100%).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		p. A sample of five individuals subject to pretreatment sedation for medical treatment was reviewed (Sample #C.3), and in five of five (100%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. Exceptions were: Sample #C.4 was a subsample of eight chemical restraints included in Sample #C.1. q. In eight (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the behavior specialist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met.	
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 15 individuals were placed in restraint more than three times in a rolling 30-day period. This was a slight improvement compared to the last review when 19 individuals were placed in restraint more than three times in a rolling 30-day period. Five of these individuals (i.e., Individual #243, Individual #370, Individual #209, Individual #329, and Individual #58) were reviewed (33%) 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 #329, Individual #370, and Individual #58 did not have crisis intervention plans. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in substantial compliance because the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of all five (100%) individual's adaptive skills and biological, medical, and psychosocial factors, and actions to address those factors. For example, Individual #243's ISPA reflected a discussion that her diagnosis of schizophrenia likely contributed to her dangerous behaviors that provoked restraint. Additionally, the ISPA indicated that she would be referred to the psychiatrist to attempt to better manage her schizophrenia. In order to maintain substantial compliance with this provision item, the minutes from at	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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.	
	(b) review possibly contributing environmental conditions;	This item was rated to be in substantial compliance because the minutes from all five (100%) of the ISPA meetings reviewed following more than three restraints in a rolling 30-day period reflected a discussion of potential contributing environmental factors, and if these factors were hypothesized to contribute to restraints, a plan to address them. For example Individual #58's ISPA minutes documented that the team did not believe that environmental factors contributed to her dangerous behavior that provoked restraints. In order to maintain substantial compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review possible contributing environmental conditions, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as being in substantial compliance because the minutes from all five (100%) of the ISPA meetings reviewed following more than three restraints in a rolling 30-day period reflected a discussion of potential antecedents to the behaviors that provoked restraint, and when antecedents were identified that may contribute to restraint, a plan to address the antecedents. For example Individual #209's ISPA meeting minutes indicated that the treatment team hypothesized that not getting her way was an antecedent to physical aggression, which sometimes resulted in restraint. The team referred her to individual counseling to assist with finding ways to address her anger issues. In order to maintain substantial compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review potential environmental antecedents, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Substantial Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated in substantial compliance because the minutes from all five (100%) of the ISPA meeting minutes reviewed following more than three restraints in a rolling 30-day period reflected a discussion of the variables that may be maintaining the behaviors provoking restraints, and when hypothesized to be contributing to the behaviors provoking restraint, a plan to address them. For example, Individual #370's ISPA meeting minutes discussed that the team hypothesized that she often engaged in	Substantial Compliance

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		aggression to avoid an undesired situation. The ISPA minutes also indicated that her replacement behavior, designed to provide an acceptable way for Individual #370 to avoid situations, was not consistently implemented by the DSPs. Consequently the team recommended that the DSPs be re-trained in the use of the replacement behavior. In order to maintain compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings reviewed following more than three restraints in a rolling 30-day period should reflect a discussion of the variables maintaining the dangerous behavior that provokes restraint. The ISPA minutes should also reflect an action to address this potential source of motivation for the target behavior that provokes restraint.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Not all individuals reviewed had a crises intervention plan. Therefore, this item was judged to be in noncompliance. 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), • All five (100%) of the PBSPs reviewed (100%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, • 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. Two (Individual #243 and Individual #209) of the five individuals reviewed (40%) had a crisis intervention plan. The following was found: • For both of the crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • For one (Individual #243) of the crisis intervention plans reviewed (50%), the maximum duration of restraint authorized was specified (the facility later reported that the crisis intervention plan contained this information), • For both (100%), the designated approved restraint situation was specified, and • For one (Individual #243) of the crisis intervention plans reviewed (50%), the criteria for terminating the use of the restraint were specified (the facility later reported that the crisis intervention plan contained this information).	Noncompliance

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		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 PBSP and a crisis intervention plan, and that at least 85% of PBSPs and crisis intervention plans are complete as defined above.	
	(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	Although there were improvements, this item is rated as noncompliance because only 80% of the individual's reviewed had treatment integrity data. For four (Individual #243, Individual #58, Individual #329, and Individual #370) of the five individuals reviewed (80%) there was 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). Individual #209 did not have integrity data. This was an improvement from the last review when integrity data were available for only 40% of individuals reviewed. In order to achieve substantial compliance with this provision item, SGSSLC needs to ensure that at least 85% of individuals with more than three restraints in a rolling 30-day period have treatment integrity data that indicates that at least 85% the PBSPs were implemented as written.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	This item continued to be rated in substantial compliance. All five of the ISPAs reviewed (100%) documented that the PBSPs were reviewed. In order to maintain substantial compliance with this provision item, 85% of the individuals who were placed in restraint more than three times in a rolling 30-day period should have evidence (in the ISPA) of a review, and revision when necessary, of the current PBSP.	Substantial 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.	The facility had a restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the behavior specialist, unit directors, and IMRT. The facility was now noting recommendations and errors in restraint implementation and documentation. Follow-up to recommendations was documented and attached to the restraint checklist. A sample of documentation related to 22 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 15 (68%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the	Noncompliance

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		Restraint Checklist and/or Debriefing Form. The exceptions were: o Individual #329 on 11/17/13 at 5:20 pm o Individual #329 on 11/9/13 o Individual #329 on 10/29/13 o Individual #329 on 10/21/13 o Individual #209 on 11/27/13 o Individual #9 on 11/26/13 o Individual #142 on 11/26/13 • b. In 15 (68%), 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. The exceptions were: o Individual #329 on 11/17/13 at 5:20 pm o Individual #329 on 11/9/13 o Individual #329 on 10/29/13 o Individual #329 on 10/21/13 o Individual #209 on 11/27/13 o Individual #9 on 11/26/13 o Individual #142 on 11/26/13 • c. In 22 (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 22 (100%), the review conducted by the restraint monitor and/or behavior specialist 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. The restraint monitor, behavior specialist, and/or the unit director documented recommendations from their review for the restraints in sample #C.1. Follow-up to recommendations was documented for all (100%) recommendations. • f. Of the four referred to the team, in three (75%) appropriate changes were made to the individuals' ISPs and/or PBSPs. o The restraint monitor recommended development of a CIP for Individual #209 following a restraint on 11/27/13. There was no documentation to show that a CIP was developed or that the team met to determine that a CIP was not needed. • A review of restraint documentation in the sample indicated that IDTs were following up on other recommendations (i.e., retrain staff on CIP, referral to the	

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		psychiatrist). Based on this review, the facility was not in substantial compliance with review requirements. A review process was in place, however, the facility needs to ensure that review occurs within three business days and recommended revisions are made to the ISP and/or ancillary plans.	

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: Client Injury Reports and Injuries of Unknown Source Reports revised 11/21/13 o SGSSLC Policy: Incident Management revised 11/21/13 o SGSSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation revised 1/28/13 o SGSSLC Policy: Protection of Individuals from Serious Self-Harm in Acute Situations revised 9/18/13 o SGSSLC Policy: Spurious Allegations of Abuse/Neglect/Exploitation revised 5/30/13 o Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit Meeting Minutes for the past six months o QA/QI report for the past two quarters o Abuse/Neglect/Exploitation Trend Reports for the past two quarters o Injury Trend Reports for the past two quarters 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 6/1/13 o All injury report for the past six months for any individual sustaining a serious injury o Injury audits conducted from June 2014 through November 2013 o List of all ANE allegations since 6/1/13 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 (7) o A description of activities related to the reduction of incidents and injuries at the facility o A sample of individual trend reports o ISP and ISPAs for Individual #300 o ISPs for Individual #328, Individual #55, Individual #183, Individual #57, Individual #251, Individual #194, Individual #327, Individual #203, Individual #99, and Individual #271. o Documentation from the following completed investigations, including follow-up:

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42934677	Physical Abuse	Unconfirmed	11/14/13 8:02 am	11/14/13 1:56 pm	11/21/13
#42934412	Physical Abuse	Unconfirmed	11/13/13 8:36 pm	11/14/13 2:05 pm	11/21/13
#42933362	Physical Abuse	Unconfirmed	11/13/13 9:43 am	11/15/13 6:05 pm	11/20/13
#42933675	Physical Abuse Sexual Abuse	Unconfirmed (2)	11/13/13 12:29 pm	11/13/13 2:17 pm	11/19/13
#42933611	Emotional/Verbal Abuse Physical Abuse	Unconfirmed Referred Back	11/13/13 11:52 am	11/15/13 11:30 am	11/18/13
#42933021	Neglect (2)	Unconfirmed (2)	11/12/13 10:18 pm	11/13/13 2:39 pm	11/19/13
#42917012	Neglect (2)	Unconfirmed (2)	10/29/13 2:16 pm	10/30/13 9:53 am	11/6/13
#42914322	Physical Abuse	Confirmed	10/26/13 4:50 pm	10/27/13 2:06 pm	11/4/13
#42893858	Neglect Physical Abuse	Confirmed Confirmed	10/8/13 3:30 pm	10/9/13 1:43 pm	10/24/13
#42883348	Physical Abuse	Confirmed Referred Back	9/28/13 10:35 am	9/28/13 2:43 pm	10/15/13
#42938273	Neglect	Referred Back	11/18/13 6:24 am		11/19/13
#42934665	Emotional/Verbal Abuse	Referred Back	11/14/13 7:31 am		11/17/13
#42926824	Sexual Incident	Referred back	11/7/13 1:13 am		11/12/13
#42922151	Neglect	Referred back	11/2/13 3:45 pm		11/5/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
UIR #14-6334	Serious Injury	1/2/14 Unknown	1/2/14 11:30 am	1/8/14	
UIR #14-6282	Serious Injury	12/7/13 7:30 pm	12/17/13 11:30 am	12/30/13	

UIR #14-6187	Serious Injury	11/10/13 1:00 pm	11/10/13 2:25 pm	11/18/13	
UIR #14-6176	Serious Injury	11/1/13 6:16 pm	11/1/13 6:40 pm	11/12/13	
UIR #14-6153	Serious Injury	10/23/13 1:03 pm	10/23/13 2:03 pm	10/29/13	
UIR #14-6112	Choking	10/5/13 8:16 am	10/5/13 8:52 am	10/15/13	
UIR #13-5859	Death	6/23/13 11:42 pm	6/24/13 12:31 am	1/9/14	

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Dana Robertson, Provision Coordinator
- Liz Love, Behavioral Health Specialist
- Jalown McCleery, Incident Management Coordinator
- Vanessa Barrientez, QIDP Coordinator
- Roy Smith, Human Rights Officer
- Section I discussion with departmental leads

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 2/17/14 and 2/19/14
- ISP preparation meeting for Individual #354 and Individual #337
- Annual IDT Meeting for Individual #55 and Individual #331
- Restraint Reduction Committee Meeting

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. For example, for D2i, the facility had developed an audit system to ensure that all injuries were consistently documented and reported for investigation when warranted. Injury audits were reviewed for compliance with the requirement to have an adequate injury audit system in place. The facility's review of its own performance found compliance with 20 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with two of the seven provision items reviewed (due to the streamlined monitoring procedures in place for this section). The monitoring team did not confirm compliance with the requirements of D2a, D3e, D3g, D3i, and D4. The facility self-assessment indicated that the facility was in compliance with D3e, D3g and D3i. While the monitoring team agreed that progress had been made with these provisions, the facility was not yet in substantial compliance. Ratings for D2a and D4 were the same in the self-assessment and in the monitoring team's review (i.e., noncompliance). The facility should note findings by the monitoring team for each provision found not to be in substantial compliance and consider further review of those provisions using similar methods used by the monitoring team. The focus of the review should be on the quality of recommendations and follow-up to issues noted during the investigation process and positive outcomes in reducing the number of incidents and injuries at the facility.
	Summary of Monitor's Assessment: According to a list provided by SGSSLC, DFPS conducted investigations of 760 allegations at the facility between 7/1/13 and 11/31/13, including 257 allegations of physical abuse, 239 allegations of verbal/emotional abuse, 33 allegations of sexual abuse, 238 allegations of neglect, and 13 allegations of exploitation. Of the 760 allegations, there were six confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, 27 confirmed cases of neglect, and no confirmed case of exploitation. The facility reported that 58 other serious incidents were investigated by the facility during this period. There were a total of 1930 injuries reported between 6/1/13 and 11/31/13. These 1930 injuries included 25 serious injuries resulting in fractures or sutures. This indicated an overall decrease in the number of injuries reported the previous six-month period, although there was an increase in serious injuries. Injury trends were being generated by individual and were made available to IDTs for planning. While the incident management and quality assurance departments were placing a greater focus on trends and systemic issues that contributed to incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. Individuals at the facility continued to remain at risk for harm due inadequate planning and follow-up to incidents by IDTs. Behavioral incidents continued to be a contributing factor to the high number of incidents and injuries at the facility. During the week of the monitoring visit, it was noted that few individuals were engaged in meaningful programming through much of the day. Vocational opportunities were limited and pay was too low to be considered an incentive for most individuals to attend work regularly.

	The parties agreed that there would be no monitoring for 15 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. During this review, the monitoring team found the facility to be in substantial compliance with two out of seven provisions of section D that were reviewed. Provision items found not to be in compliance were: • D2a: The facility failed to appropriately report all serious incidents as dictated by state policy. • D3e: The facility was not ensuring that all investigations were completed within 10 days unless an extension was approved by the facility director due to extenuating circumstances. Additionally, not all investigations included appropriate recommendations for corrective action. • D3g: The facility review process did not ensure that deficiencies or areas of further inquiry in the investigation and/or report were addressed promptly. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented. The incident management department was providing incident and injury trend information to residential units and individual IDTs. The process remained in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring. IDTs will need additional training on analyzing and addressing trend information.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		

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	(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. According to a list of all abuse, neglect, and exploitation investigations provided in response to document request III.18, there were 760 allegations of abuse, neglect, or exploitation investigated by DFPS at the facility between 6/1/13 and 11/31/14. From these 760 allegations, there were: • 237 allegations of physical abuse including, o 6 confirmed o 183 unconfirmed o 20 unfounded o 13 inconclusive o 8 referred back for further investigation o 7 other • 239 allegations of verbal/emotional abuse including, o 2 confirmed o 166 unconfirmed o 11 unfounded o 10 inconclusive o 35 referred back for further investigation o 9 other • 33 allegations of sexual abuse including o 0 confirmed o 23 unconfirmed o 7 unfounded o 2 inconclusive o 1 referred back for further investigation • 228 allegations of neglect including, o 27 confirmed o 68 unconfirmed o 12 unfounded o 14 inconclusive o 103 referred back for further investigation o 14 other (including pending outcomes and merged cases)	Noncompliance

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		• 13 allegations of exploitation
		  o 3 unconfirmed
		  o 10 referred back for further investigation.
		
		According to a list provided by the facility, there were 58 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included:
		• 20 serious injuries/determined cause,
		• 5 serious injuries from peer-to-peer aggression,
		• 1 serious injury/undetermined cause
		• 17 sexual incidents,
		• 1 choking incident,
		• 3 suicide threats,
		• 0 encounters with law enforcement,
		• 7 unauthorized departures, and
		• 4 deaths
		
		From all investigations since 7/1/13 reported by the facility, 21 investigations were selected for review. The 21 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 (14 cases).
		• Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (7 cases).
		
		Metric 2.a.1: Based on the monitoring teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.
		
		Metric 2.a.2: According to SGSSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements.
		
		Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements.	

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		Metric 2.a.4: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 14 investigation reports included in Sample #D.1: • Metric 2.a.6: 13 (93%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. The exception was: o DFPS #42893858 – witnesses did not immediately report the incident to DFPS. Both staff were retrained on reporting procedures following the incident. • Metric 2.a.7: Fourteen (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 12 of 14 (86%) indicated the facility director or designee was notified of the incident within one hour. ▪ The UIR for DFPS case #42926824 indicated that the director was notified prior to the incident. It was not possible to determine when he was actually notified in this case. ▪ The director was not notified within an hour in regards to DFPS #42934665. o 11 of 12 (86%) indicated OIG or local law enforcement was notified as required by the facility policy when appropriate. ▪ DFPS #42925624 was the investigation of a case involving a rape allegation. The individual involved reported to her behavioral health specialist, a DSP, the nurse and two campus administrators that she had been sodomized. The individual had no history of making false rape allegations. The incident was not reported to law enforcement and she was not sent for a sexual assault exam until the following morning at 10:00 am when she continued to complain of pain. o 14 of 14 (100%) documented that the state office was notified as required. o Two of three (66%) documented that DADs Regulatory was notified as required. ▪ Notification did not occur within 24 hours in DFPS #42922151.	

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		• Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, two UIRs (67%) included recommendations for corrective actions. o DFPS #42893858 – witnesses did not immediately report the incident to DFPS. Both staff were retrained on reporting procedures following the incident. o For DFPS case #42926824, the facility recommended retraining the AODs and EDOs on the need to call a critical incident team meeting when allegations involve rape. o The director was not notified within an hour in regards to DFPS #42934665. No recommendations were made regarding late reporting. Based on a review of seven investigation reports included in Sample #D.2: • Metric 2.a.9: Six (86%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. o UIR #14-6187 indicated that the facility director/designee was not notified within one hour of the incident. • Metric 2.a.10: Six (86%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. o UIR 13-5859 was the investigation of a death. The incident was coded as 6b Death (not unusual). The individual was a 55 year old woman with no acute health problems. The cause of death was determined to be an acute combined drug intoxication. The death should have been reported to DFPS when evidence in the investigation suggested negligence in her care and supports might have contributed to her death. • Metric 2.a.11: For the unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders did include recommendations for corrective actions. o UIR #14-6187 included a recommendation to retrain the AOD on reporting requirements. o The administrative review of UIR #13-5859 did not address the fact that it was never reported to an outside entity though there was reasonable suspicion that negligence by the facility staff contributed to the individual's death. Metric 2.a.12: 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.	

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		Metric 2.a.13: Based on a review of 21 investigation reports included in Samples #D.1 and #D.2, 21 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. In response to document III.35 for a list of staff who failed to report a serious incident or failed to report in a timely manner, the facility submitted a list of seven employees involved in six incidents who failed to report to the appropriate entities in a timely manner. All seven staff were retrained on reporting procedures. The facility was not in substantial compliance with the reporting requirements of D2a regarding reporting requirements for unusual incidents. 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: • 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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial 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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	documentation indicating completion of such training.		
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(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 10 ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #328, Individual #55, Individual #183, Individual #57, Individual #251, Individual #194, Individual #327, Individual #203, Individual #99, and Individual #271. • Nine (90%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exception was the ISPs for Individual #203. 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	Substantial Compliance

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		had a problem with staff. The facility was in substantial compliance with this item.	
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures (SGSSLC Policy: Client Injury Reports and Injuries of Unknown Source Reports revised 11/21/13) defined sufficient procedures to audit whether significant injuries are reported for investigation. Metric 2.i.2: The facility conducted audits at least semi-annually, during the preceding 13 months. The facility was conducting monthly injury audits for selected homes. All Client Injury reports generated from the selected home, along with Shift Logs, Integrated Progress Notes, and Switchboard Entry Logs were reviewed for the selected time period.	Substantial Compliance

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		Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. Auditors reviewed Integrated Progress Notes, Staff Observation Notes and Shift Logs, and Client Injury Data Reports, for documentation of any injuries the individual might have incurred during the time period reviewed. The auditor then looked for a corresponding injury report or investigation if the injury was from an unknown source or in an unusual (suspicious) location on the body. • Audits included good documentation of findings including graphs, charts, and comprehensive narratives describing findings. • Auditors included recommendations for corrective action when warranted. Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all reported injuries at the morning unit meetings and any serious injuries at the daily IMRT meeting. • Completed an investigation on all serious injuries. • Compiled Quarterly data reports to identify trends in injuries. Metric 2.i.4: In ___ of ___ (n/a), significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate and immediately investigated. (none found). The audits did find that a client injury report was not completed for all injuries noted in shift logs and IPNs. The audits included recommendations to address any injuries not documented as required by facility policy. For example, the November 2013 audit noted that client injury reports were completed for 83% of the injuries noted in shift logs, IPNs, and switchboard logs. Staff in the homes audited were retrained on reporting and correct documentation of injuries. Evidence that retraining was completed as recommended was submitted to the risk management department. The facility had an adequate injury audit system in place to ensure that all significant or suspicious injuries were reported for investigation.	

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D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations included in sample #D.1 noted the date and time of initial contact with the alleged victim. (The four investigations referred back to the facility for further review were not used in this sample). o Contact with the alleged victim occurred within 24 hours in eight of 10 (80%) investigations. Exceptions were DFPS cases #42933362 and #42933611. o Documentation showed that some type of investigative activity took place within the first 24 hours in all cases (100%). This included gathering documentary evidence and making initial contact with the facility. • For investigations in sample #D.1, eight of 10 (80%) were completed within 10 calendar days of the incident. Extensions were filed for two investigations. The investigations not completed within 10 days: o Case #92893858 was submitted on the 16th day (witness not available for interview). o Case #42883348 was submitted on the 17th day (witness not available for interview). • All 14 (100%) resulted in a written report that included a summary of the investigation findings. • In seven of eight (88%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Five of those cases resulted in a referral back to the facility for further 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%). • Four of seven (57%) indicated that the investigator completed a report within 10 days of notification of the incident. o UIR #14-6282 was completed on the 13th day. No extension was filed. o UIR #14-6176 was completed on the 12th day. No extension was filed. o UIR #13-5859 involved a death on 6/24/13. It was completed on 1/9/14. Extensions were not filed. The investigation was halted for OIG to investigate. • Five of seven (71%) included appropriate recommendations for follow-up action to address the incident. o UIR #14-6112 was investigation of a choking incident. The	Noncompliance

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		investigation indicated that the IDT met following the incident and recommended a swallow study be completed. The investigator noted that further evaluations were scheduled, but did not include the swallow study as a recommendation for follow-up. There was no follow-up completed to ensure that evaluations were completed and any resulting recommendations were implemented. o UIR #14-6334 was the investigation of a serious injury of undetermined cause. It was discovered that Individual #116 had a fractured tibia when an x-ray was obtained due to ongoing complaints of leg pain. The physician was able to determine that the fracture occurred between 9/30/13 and 12/31/13 by comparing x-rays of her leg from those two dates. Evidence in the investigation included documentation that the individual fell on 10/12/13 and was noted to be walking with a limp. On 10/14/13, notes indicated that she refused to walk at all and began crawling/scooting on the floor. She was given a walker that she continued to use. There was no evidence she was referred to her physician to rule out a serious injury following her fall even though she continued to complain of leg pain and required the use of a walker to ambulate. Her IPNs for December 2013 were included in the investigation file. The notes indicated that she continued to complain of leg pain and was treated for pain by nursing staff on 12/13/13, 12/15/13, 12/16/13, 12/20/13, 12/22/13, and 12/23/13. She again went to the nurse complaining of leg pain on 12/31/13 at 9:15 am. The nurse noted swelling and discoloration to her leg and gave her medication for pain. At 12:30, she went back to the nurse stating, "My leg hurts. It always hurts, but it hurts bad now. I want pain killer, please!" She was again given pain medication and told to elevate her leg. She saw the nurse again at 1:30 pm with complaints of dizziness and at that time the doctor was notified. The doctor then saw her and ordered an x-ray of her leg. The investigator did not note or make recommendations regarding the failure of nursing staff to refer Individual #116 to her physician following multiple complaints of leg pain prior to 12/31/13 or to address the fact that her PNMP was never updated when she was given the walker on 10/14/13. The facility was not in substantial compliance with the requirement of D3e.	

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	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(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	Metric 2.g.1: 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. Metric 2.g.2: The facility policy required that any further inquiries or deficiencies be addressed promptly.	Noncompliance

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	and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Metric 2.g.3: The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements). • Metric 2.g.4: The facility Incident Management Review Team (IMRT) did note any problems with any of the investigations in the sample. • Metric 2.g.5: The monitoring team did not identify problems with regard to sections D.3.e and/or D.3.f. Based on a review of the facility's IMRT data, for n/a (__%), the facility IMRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. o DFPS #42926824 was referred to OIG for investigation. The OIG investigator concluded that there was no evidence of criminal activity. This was, in part, due to the facility nurse's assessment indicating no injury had occurred. The OIG report stated that if additional evidence that a crime had occurred was found, the facility should notify OIG. The sheriff's department ordered a sexual assault exam the following morning, which showed the presence of semen and anal trauma. The facility did not submit this information to OIG for further investigation. • Metric 2.g.6: The facility returned no cases in the sample to DFPS for reconsideration (for n/a (--%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry). The IMC reported that cases were returned to DFPS when the facility did not agree with findings or had further concerns. The monitoring teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. 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, • 14 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 14 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In five out of seven investigation files reviewed (71%), there was evidence that the supervisor had conducted a review of the investigation report	

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		to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. o As described in D3e, for UIR 14-6334, the investigator did not note or make recommendations regarding the failure of nursing staff to refer Individual #116 to her physician following multiple complaints of leg pain prior to 12/31/13 or the failure of her PT to update the PNMP when she began using a walker. The IMRT did not note any deficiencies with the investigation. o UIR 13-5859 was the investigation of a death. The incident was coded as 6b Death (not unusual). The individual was a 55 year old woman with no acute health problems. The cause of death was determined to be an acute combined drug intoxication. The death should have been reported for outside investigation when evidence in the investigation suggested negligence in her care and supports might have contributed to her death. This was not noted in review by the IMRT. The facility was not in substantial compliance. To move forward, the facility will need to ensure that any deficiencies or areas of further inquiry in the investigation and/or report are addressed promptly.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	Metric 3.i.1: 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. Metric 3.i.2: The facility continued to track follow-up to recommendations in the daily IMRT meeting minutes. The meeting minutes included a date that recommended action was completed, but no evidence that a review was completed (to ensure protections were effective and/or continued to be implemented). A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of six cases: • Four DFPS cases: #42914322, #42893858, #42883348, #412922151; and • Two facility investigations: UIR #14-5187 and #14-1724	Noncompliance

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		Metric 3.i.3: For three out of three (100%) of the DFPS investigations (DFPS cases #42914322, #42893858, and #42883348) and one of one (100%) facility investigation (UIR#14-6187) reviewed in which disciplinary action was warranted, 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: Metric 3.i.4: For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. Metric 3.i.5: For zero out of six investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility did not have a system to track outcomes from investigations. Based on identified issues with the implementation of recommendations and desired outcomes, the facility remained out of compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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	Metric 4.1: 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.	Noncompliance

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	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: • Metric 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did contain recommendations for corrective actions. The IMC reported that she reviewed data monthly, quarterly, and annually with the Risk Manager and made recommendations to address trends based on data analysis. Additionally, • Quarterly reports were submitted to the Administrative IDT and Quality Assurance Council. • When serious injuries occurred or individuals were identified as having a high number of injuries, a copy of individual injury data and trends were sent to the IDT and a special review was requested. Action plans resulting from these reviews were submitted to the Risk Manager to monitor effectiveness of the plan. • A/N/E and unusual incident trend reports were provided to each unit director for additional analysis. • The risk management department was providing data and trending graphs to ISP facilitators for review at annual IDT meetings at least 14 days prior to the meeting. Metric 4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans (CAPs) were developed. The QAQI Council had CAPs in place regarding incidents and injuries. As noted below, it was difficult to determine what specific action had been implemented, how it was being monitored, and what data were used to determine the efficacy of the plan. Metric 4.8: Even when appropriate to do so, corrective action plans were not always developed both for specific individuals and at a systemic level. None of the investigations in the sample reviewed demonstrated that when a trend of similar incidents or injuries was identified, an adequate corrective action plan was developed and outcomes were tracked. Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion.	

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		Metric 4.10: The trend reports/minutes did not review, as appropriate, the effectiveness of previous corrective actions. Based on a review of resulting action plans included in quarterly trend reports and documentation related to implementation: • Monthly and quarterly trend reports did include action plans with specific outcomes related to trends identified. However, trend reports were extremely lengthy and hard to follow in terms of tracking efficacy and status of action steps developed. • Action steps were included to address both systemic and individual trends. Often, however, action steps were generic referrals to the unit or the IDT. From that point, it was difficult to assess the status of action steps. • A subsample of action steps developed from the November 2013 trend report and were reviewed to determine the facility's progress with metrics 4.11, 4.12, and 4.13. Metric 4.11: Zero action plans included in the monthly trend report (0%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. • The November 2013 trend report in regards to injuries included recommendations for seven individuals that were identified as having the greatest number of injuries during the month and/or quarter. The recommended action was the same for each individual. Each stated "PST should review provided data and reevaluate the action plans in place for effectiveness, more steps should be added to help reduce and eliminate these types of injuries." In each case, the PST was listed as the responsible person and 1/17/14 was assigned as the due date. • ISPAs were attached to the trend report to show that IDTs met to discuss trends. • Four of seven of the ISPAs indicated that current supports were adequate and no new recommendations were made. Supports were added or revised for the other three individuals, however, it was not evident that the team engaged in a thorough discussion that resulted in a revision to supports that would have a significant impact on preventing further injury. For example, Individual #52's IDT met to discuss her trend of injuries. The team noted that she was "highly medicated and had polypharmacy side effects causing her to walk unsteadily." The team noted that she had been given knee pads and elbow pads for protection from injury, but was no longer wearing them. She stated that she had lost them. The team recommended replacing her protective equipment and	

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		reminding her to get out of bed slowly and ask for help when needed. The team did not discuss further assessment regarding her being "highly medicated" and unsteady. Metric 4.12: For zero of the action plans reviewed (0%), the plan had been timely and thoroughly implemented. • ISPAs were attached to the monthly trend report documenting IDT meetings to review trends for each individual identified by the IMC. Although IDTs met within the timeline required by the IMC, documentation did not include the status of implementation when supports were revised. Metric 4.13: For zero action plans (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. The following example is from the set of investigations reviewed where the facility did not adequately address trends identified by the incident management department. The facility continues to have a high number of incidents and injuries related to behavioral incidents. DFPS #42933611 involved an allegation of emotional/verbal abuse reported by Individual #300. DFPS referred several rights issues back to the facility to further investigate. The individual was reportedly unhappy over her diet, living arrangements, and lack of work, thus, she reported the allegation of abuse to DFPS. The UIR indicated that she had been involved in 41 similar investigations over the past year. The facility investigator made one recommendation for the IDT to meet to discuss the individual's request to transfer to another home. There was documentation that the team met with Individual #300 three weeks after the incident and that she no longer wished to move. The case was closed and no further follow-up was recommended. The investigation checklist indicated that adequate programming and supports were not a factor in this investigation. A review of Individual #300's ISP, ISPAs, and PBSP revealed that she frequently made unfounded allegations against staff when she was upset or frustrated with staff and her supports. Her PBSP noted that she did best when she was supported in a structured environment with planned programming. She indicated that she did not like to work in a noisy environment. Spending her time constructively and earning money were important to her. Her long-term goals were to live and work in the community. Her employment goal was to "provide meaningful employment based on her personal preferences." Her ISP indicated that the team continued to address	

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		work refusals through her PBSP and SAPs to improve her attendance at the sheltered workshop where she was primarily engaged in monotonous, non-challenging tasks, such as shredding paper and bundling silverware. The IDT had not addressed her work preferences or attempted to build on her vocational skills in any meaningful way. She was a young, very independent woman with many skills that would transfer well into more challenging employment. Additionally, the IDT agreed at her annual IDT meeting on 5/15/13, that community placement was appropriate for her. An action step was implemented to meet with the transition specialist to begin the referral process for community placement. ISPAs did not document that the team had moved forward with the referral process or continued to work towards supporting her preference to live in the community. A review of all documentation in this case indicated that Individual #300's dissatisfaction with supports and services that were not meeting her needs were a contributing factor in a large number of incidents at the facility. The IDT had not adequately addressed the root cause of these incidents and revised supports to prevent further incidents from occurring. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed, 2. Specific staff are assigned to monitor and document implementation, and 3. A date is set to review efficacy of the plan and make revisions when needed. The facility should consider streamlining its trend reports based on priority issues identified jointly by the IM and QA departments. Corrective action plans should provide clear documentation that recommendations are implemented, monitored, and tracked for efficacy. See section E for additional recommendations regarding the format and review of trend reports to address investigations and incidents.	
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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	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.		

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names o SGSSLC facility-specific policies: • Quality Assurance Process, #2.1.23, 4/14/11, updated 1/30/14 • QA plan (narrative), #2.1.23.a, 11/30/12, updated 1/30/14 • QA CAP tracking, #2.1.23.b, 4/14/11 and 4/19/12, not updated • Policy/procedure approval and review committee, 1/4/11, 11/29/12, not updated o SGSSLC organizational chart, January 2014 o SGSSLC policy lists, January 2014 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 12/1/13 o SGSSLC Action Plans, 1/28/14 o SGSSLC Provision Action Information, most recent entries for the most part were 9/9/13 o SGSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/17/14 o SGSSLC DADS regulatory review reports, September 2013-January 2014 o List of all QA department staff and their responsibilities, November 2013 o SGSSLC QA department meeting notes, (none held) o SGSSLC data listing/inventory, hard copy, 2/19/14 o Annual schedule for review of each Settlement Agreement provision, undated o SGSSLC QA plan narrative, 1/30/14 o SGSSLC QA plan matrix, 1/30/14 o Table showing percentage agreement of comparisons across data listing/inventory, QA matrix, and QA reports, for November 2013 and January 2014; sample scoring sheet for November 2013 o Set of blank tools used by QA department staff (1) o Sets of completed tools used by QA department staff (none) o QA director's program audit analysis, monthly, September 2013 to January 2014 o Sets of graphs of the QA department activities (included in QA reports) o Trend analysis report, for four components, last two quarters, (the traditional four trend analysis no longer used at SGSSLC; the data were fully incorporated into the sections C and D QA program reporting system) o Monthly QAD-SAC-1:1 meetings (i.e., face to face meetings), cover pages for all 20 sections November 2013 to January 2014 (3 months) o Monthly QA-SAC-1:1 meetings, cover page and attachments for all 20 sections, January 2014 o Handouts for two QA-SAC-1:1 meetings observed by the monitoring team o 15-item 4-page guide to 1:1 meeting topics

	o SGSSLC QA Reports, monthly, August 2013 to January 2014 (6) o Sample schedule for presentation topics for QI Council, February 2014 o QAQI Council minutes, at least monthly 9/12/13 to 2/20/14 (5 months, 22 meetings) • Handouts and agenda for meeting during onsite review, 2/20/14 o PIT, PET, work group reports • Various documents for four PITs: assessment quality, assessment implementation, HCCE, and active treatment o SGSSLC Corrective Action Plan documents • Open/active CAPs report, 38 pages, 2/8/14 • Closed CAPs report, 95 pages, 2/8/14 • CAP tracking sheet (none) • Data regarding CAPs (in QA reports) o Facility newsletters, (none) <u>Interviews and Meetings Held</u>: o Michael Fletcher, Director of Quality Assurance o Misty Mendez, Settlement Agreement Coordinator o Roy Smith, Human Rights Officer, Zula White, Human Rights Office Assistant, Janet Smith, Assistant Independent Ombudsman, Jalown McCleery, Incident Management Coordinator o Charles Njemanze, Facility Director <u>Observations Conducted</u>: o Face to face section meetings, section I 2/17/14, section D 2/20/14 o QI Council Admin IDT meeting, 2/20/14 o Self-advocacy meeting, 2/18/14 o Clinical services meeting, each afternoon
	Facility Self-Assessment The self-assessment was much improved from the last review in that it contained many more activities and these activities lined up more with the monitoring team's report than ever before. Given that this report has alpha-numerically labeled the metrics, this should provide further guidance to the QA director for his next self-assessment. That is, the QA director could use these metrics in his own self-assessment. If so, however, he should be sure to read all of the detail provided within the report for each metric because there is important supplemental information provided. The facility self-rated itself as being in noncompliance with sections E1 and E2. The monitoring team agreed. The facility self-rated E3 in noncompliance, but the monitoring team found it to be in substantial compliance. Sections E4 and E5 were determined to be in noncompliance prior to the onsite review.

	Summary of Monitor's Assessment: The QA program at SGSSLC continued to make progress. Systems continued to evolve and improve (as one would expect to see in any QA program). The data list inventory was 71 pages long (compared to 53 pages at the last review), contained 22 topic areas and was managed in a database that was easy to read and easy for the SAC and QA director to update. 20 of the 20 provisions of the Settlement Agreement (100%) were included. The QA plan matrix was 14 pages long. It was well organized and the items lined up with the data listing inventory. There were items in the QA plan matrix for 20 of the 20 sections (100%). The QA director and SAC continued to develop and improve monthly Face to Face meetings. The SAC and her staff kept excellent minutes of these meetings. The QA director and SAC continued to use a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory). Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once each quarter in the last six months. Most every section had narrative, however, most narratives were descriptions of the data, a description of the problem identified by the data (e.g., a certain home or individual), and a description of what they were going to do to address the problem (regardless of whether it related to a cause). What was missing, however, was an analysis of the causes of the problem, not just a description of their occurrence. The sections that came closest to doing so were M, N, Q, R, and V. The QI Council meeting (called the Administrative IDT meeting) met almost every week and continued to run very well. There were 9 CAPs. The monitoring team reviewed all 9 CAPs and found them to be inadequate because the overall goal/purpose of the CAP was not clearly stated, the CAP was not worded in a measurable manner that related to the goal/purpose, and the action steps were not written in observable terms with criterion. Additions need to be made to the CAPs document format and improvements need to be made in the content of that format.

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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 make progress. Systems continued to evolve and improve (as one would expect to see in any QA program). The QA director for many years, Angelo Kissko, was promoted to a new job at the facility, about half way through the six months since the last review. A new QA director, Michael Fletcher, was appointed in December 2013 and was becoming familiar with the details of the QA program at SGSSLC. He worked closely with the Settlement Agreement Coordinator, Misty Mendez.	Noncompliance

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		All of the other members of the QA department remained the same. The staff assigned to the SAC, however, had grown and now contained six people in addition to the SAC. They were Alicia Vaughn, Connie Whorton, David Ann Knight, Albert Fierro, Jennifer Quisenberry, and Marsha Jones. <u>Policies</u> a. 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, #003.1: Quality Assurance, dated 1/26/12. The monitoring team's comments on the state policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated more than two years ago, edits may be needed. State office should consider this. b. There were not SGSSLC facility policies that adequately supported the state policy for quality assurance. Facility policies for quality assurance were being updated. Some had been updated; others were to be updated. One policy, called Quality Assurance Process, was, for the most part, a re-statement of the state policy. This is not necessary to do. Most of the QA program's description was in the QA narrative, which was also designated as a facility-specific policy. The QA director needs to determine if additional facility policies are needed to guide implementation of the QA program at SGSSLC. <u>Quality Assurance Data List/Inventory</u> c. There was not yet a complete and adequate data list inventory at the facility. The data list inventory was 71 pages long (compared to 53 pages at the last review), contained 22 topic areas (two were not Settlement Agreement related, sections O and P were combined into one topic, and section S was split across two topics), and was managed in a database that was easy to read and easy for the SAC and QA director to update. 20 of the 20 provisions of the Settlement Agreement (100%) were included. Of the 19 inventories (O and P were combined, and the two S-related were reviewed as one), 19 (100%) included data that could be used to identify trends as required in the wording of section E1; 17 (89%) included a wide range of data; 19 (100%) included what appeared to be key indicators; 19 (100%) described the data being collected; and 11 (58%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used, with a rationale). Some items were notated to be a process or an outcome indicator. This was good to see and will likely be expanded over the next six months. The monitoring team was pleased to see that the section E content was directly measuring implementation of many aspects of the QA program itself, as it should be.	

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		The facility continued to improve the process for reviewing and evaluating the data list inventories. Up to this point, the inventories were reviewed at the monthly face to face meetings between the section leader, QA director, and SAC. The QA director and SAC now had a specific schedule to review Settlement Agreement provision items during each month's meeting to ensure that data were being collected to address each one. Further, rather than reviewing the data inventory during QI Council meeting, they formed a QI Board that was scheduled to meet semi-annually to review the listings. They did this because presentation of the inventories during regular QI Council meetings did not lead to thoughtful discussion and participation, in part, because it occurred during an already lengthy meeting. The QI Board was designed to allow the smaller group of participants to solely focus upon these inventories. The facility needs to demonstrate that each data listing is complete, that is, that (a) it includes all relevant data items (and that no important data items are missing), (b) each data item is indeed being collected by the section leader, (c) each is available for presentation if requested, and (d) data are being used as per the wording of this Settlement Agreement provision. As discussed during the onsite review, this information might be included in the data listing inventory database or perhaps within the face to face meeting cover page. d. The data list inventory was current. 18 of the 19 lists (95%) were updated within the past six months. Dates ranged from October 2013 through February 2014. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was current, complete, and adequate. <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 February 2014 QA matrix. The SGSSLC QA plan matrix was 14 pages long. It was well organized and the items lined up with the data listing inventory. The QA director and SAC were now assessing the correspondence of what was in the QA matrix compared to what the section leader presented in the QA report. They did this section by section and found an overall correspondence of 76% in November 2013 and 83% in January 2014. It was very good to see that the facility was conducting this data-based comparison.	

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		Overall, the facility was using the QA matrix as it was intended, that is, to be a subset of the data listing, such that it correctly shows which data are to be presented in the QA report and to QI Council along with more detail on how the data were to be collected, reviewed, and managed. f. There were items in the QA plan matrix for 20 of the 20 sections (100%). The items represented a set of key indicators for n/a of the 20 (--%). A rating of whether these items were key important indicators was not made by the monitoring team because the QA director, SAC, and the department heads were working on assessing the content of each data listing to ensure that each one included <u>all</u> key indicators (each section included a number of indicators already, see metric c. above), so that key indicators for each section could be chosen for the QA matrix. g. Of the 20, both process and outcome indicators were identified for 0 of the 20 (0%) in the QA matrix. The monitoring team was impressed, however, to see that the QA director, SAC, and the department heads were, for some sections, beginning to identify whether indicators were process or outcome indicators. By including this categorization in the QA matrix (rather than only in the data list inventory), the reader can determine if both types of indicators were included. h. Of the 20, in 20 (100%), the indicators provided data that <u>could be</u> 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." • The QA director should describe, for each section (perhaps in the QA matrix and/or in the face to face meeting cover sheets) how data <u>were being</u> collected and presented to identify trends across the variables described in the wording of E1. i. The QA matrix did not include all self-monitoring tools/self-monitoring procedures. It should 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 along with a rationale. The QA matrix listed what appeared to be self-monitoring tools for 7 of the 20 sections (35%). j. All data that QA staff members collected were listed in the matrix. At SGSSLC, this was one tool: the QA program audit. The QA director continued to write a short monthly report based upon the results of this tool, along with results of any satisfaction surveys. This report only noted items that were not included elsewhere within the QA program; this was good to see.	

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		k. All of the items in the QA matrix did also appear in the QA data list inventory. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. The monitoring team selected a sample for review as follows: for five sections: C, F, J, R, and T: face to face meeting cover sheets for three months (one quarter: November 2013 to January 2014), data and graphs submitted during the face to face meeting for January 2014, and the QA report for each of these five sections for six months (August 2013 to January 2014). For the next review, the QA director should indicate if the items in the QA matrix were: l. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). • The reconciliations conducted in November 2013 (76%) and January 2014 (83%) addressed the above metric. The facility's presentation, however, should state how many/the percentage of the sections met this standard. • The monitoring team's review of the sample described above found different numbers than reported in the QA director's 76%/83% table. The monitoring team and the QA director should review this together during the next review. o C: there was a face to face meeting two of the three months; there were 7 items in the matrix, but only 2 were reported on in the January 2014 report. o F: there was a face to face meeting two of the three months; there were 11 items in the matrix, and all 11 were reported on in the January 2014 report. o J: there was a face to face meeting two of the three months; there were 4 items in the matrix, but only 3 were reported on in the January 2014 report. o R: there was a face to face meeting three of the three months; there were 6 items in the matrix, but only 4 were reported on in the January 2014 report. o T: there was a face to face meeting two of the three months; there were 16 items in the matrix, but only 2 were reported on in the January 2014 report. m. Reviewed or analyzed by the QA department and/or the department section leader. • This was likely reported to the QA department by the section leader during the face to face meetings. The QA director and SAC could easily report on this. • The monitoring team's review of the sample described above found that there was some review of the data by the department section leader for 4 of the 5 in	

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		the sample (all but section T). A determination of the quality of this analysis is done in section E2 below. n. Conducted/implemented as per the schedule. • The QA director and SAC said that the reconciliations conducted in November 2013 (76%) and January 2014 (83%) met the above metric, however, the monitoring team's understanding was that the reconciliations compared the presence of each QA matrix item in the QA report, not whether the items were implemented as per the plan (which at SGSSLC was included in the description within the data list inventory, not within the QA matrix [which was an acceptable place for it to be]). • The monitoring team's review of the sample described above found that sections F and R (40%) provided sufficient detail regarding implementation and sample size in the matrix/inventory. o. Received QA department assistance in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. • This likely occurred during the face to face meetings. The QA director and SAC could easily report on this. • The monitoring team's review of the sample described above found that the QA department provided assistance during each of the face to face meetings. Self-Monitoring Tools For the next onsite review, the QA director should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: p. 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. q. 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. r. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. s. 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.	

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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. In this section (E2,) the monitoring team's findings were based upon the data that were included in face to face meetings documentation, in QA reports, and in QI Council meeting minutes. That is, the determination of whether the data presented by each department were correct (i.e., lined up with what was in the QA matrix) was done in section E1 above and was found to be in need of much improvement. Based upon the QA reports: a. Data from the QA plan matrix for 20 of the 20 (100%) sections of the Settlement Agreement were summarized, (note that there was not full correspondence between what data were in the QA matrix and what data were in the QA reports), and most had graphed data showing trends over time. Few, however, analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. See more detail in metrics f. to h. below. <u>Monthly QAD-SAC meeting with discipline departments</u> The QA director and SAC continued to develop and improve upon these meetings. They were now called Face to Face meetings, which was a more descriptive term than the previous benchmark meeting label. Further, the meetings now occurred every month for all section leaders (up to this point, a meeting was not held if the section leader was due to make his or her quarterly QI Council presentation). In addition: • The SAC and her staff kept excellent minutes of these meetings. They were maintained on one page per each meeting. The page also had a column on the left side that indicated the performance (yes/no/na) for the many metrics of quality assurance performance that the QA director and SAC had established. • As described in the previous report, many section leaders were conducting their own QA meetings with their own department staff. This was good to see. The occurrence of a departmental QA meetings was now one of the items monitored in the face to face meetings as part of the facility's data on implementation of the QA program at SGSSLC. • The QA director and SAC continued to use a set of metrics to measure each department's performance on a number of QA-related activities (e.g., updating of data list inventory). They developed a 15-item set at the time of the last review, but had backed off it at this time due to its complexity, especially regarding the definition of an "analysis" of the data. The QA director and SAC were planning to again revise and update this set of metrics. • The monitoring team observed two face to face meetings: for sections I and D.	Noncompliance

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		The monitoring team suggests that the section leaders use the meeting to take the time for a thoughtful review and analysis of their data rather than merely making a presentation of the data to the QA director and SAC. It may be that not all of the data are verbally discussed due to time constraints (though all would be in the document), only those that would benefit from it. b. Since the last onsite review, a meeting occurred at least twice for 19 of the 20 (95%) sampled sections of the Settlement Agreement (all but section U), and all five topics below were conducted during 37 of the 46 (80%) meetings that occurred (during the November 2013 to January 2014 meetings). • 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. The QA director and SAC collected data on each section leader's participation and completion of a variety of QA activities (recorded on the monthly face to face meeting cover pages). These data were included as part of the section E QA data inventory and QA matrix, and were reported in the QA department's face to face meetings, QA report, and QI Council presentations. The data showed that not all of the activities monitored in metrics b., c., d., and e. were engaged in all of the time (i.e., data similar to that found by the monitoring team). c. Since the last onsite review, during 37 of the 46 (80%) meetings, data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during 37 of the 46 (80%) meetings, data were reviewed and analyzed. For the purposes of this metric, the monitoring team rated this as acceptable if there was review and discussion of data. The quality of the "analysis" was not considered. e. Since the last onsite review, during 39 of the 46 (85%) 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.	

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		QA Report The SGSSLC QA report was assembled at the end of the month, following the completion of all of the month's presentations at QI Council and face to face meetings. The information in the QA report was what was presented at QI Council. f. In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the last six months (100%). g. Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once each quarter in the last six months. • Of the 20 sections, 15 appeared in six of the last six months' QA reports. Three others appeared in five of the six (N, K, and I; however, one of the K reports was identical to a previous month's, and two of the I reports were identical to the previous month's report). Two others appeared in four of the six (E, U). • If one considers 20 sections for six months totals a possibility of 120 presentations, SGSSLC QA reports contained 113 presentations, well above the criterion. h. Of the 20 sections of the Settlement Agreement that were presented quarterly, 0 (0%) contained all of the components listed below. That being said, the QA reports were consistent from month to month, and contained a great deal of well-presented data and narrative. • 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 - Four sections reported use of a self-monitoring tool (D, I, J, U). The others did not. - A short rationale (two or three sentences) for the absence of a self-monitoring tool should be included in those sections of the report. • 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 - 19 sections presented a variety of other key indicators and important data (all except section U, which used a self-monitoring tool only). Most sections had numerous key indicators (e.g., F, N, Q); some had only a few (e.g., C). - Many of the sections showed improvement (and growth) in the	

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		indicators in the report over the course of the six months (e.g., J, L, M). - Some sections broke down some of the data some of the months by home and shift (C, D), home (J, Q, R), discipline (F, V), and skills (O). • Narrative analysis - Most every section had narrative, however, most narratives were descriptions of the data, a description of the problem identified by the data (e.g., a certain home or individual), and a description of what they were going to do to address the problem (regardless of whether it related to a cause). - What was missing, however, was an analysis of the causes of the problem, not just a description of their occurrence. The sections that came closest to doing so were M, N, Q, R, and V. The monitoring team has the following comments for the QA director and SAC as they continue to improve upon the SGSSLC QA program: • For the narrative analysis: o The section leader should look at the causes and reasons behind the data in addition to looking at where and when problems might be occurring. o Many of the actions described in these QA reports were to do more training and collect more data. Although often appropriate actions, they may or may not be related to the causes and reasons. o The QA director and SAC might include a template for the section leader that prompts one paragraph for a summary of the data and a separate paragraph for the analysis of the data. For example, this was done for section L in the January 2014 report. o Although the QA director and SAC were not using the 15-item criterion list to score section performance, they could use the analysis item from this list to help guide their discussion during face to face meetings. • Quarterly versus monthly entries: Each section did a quarterly presentation. Some sections also did a monthly presentation. The monthly presentations were a subset of the quarterly presentations. The monitoring team recommends that a simple single line be added to the beginning of each section of the QA report to indicate if that section, for that month, was a quarterly presentation or a monthly presentation. • Section D: The section D portion of the QA report was too long. It ranged from 40 to more than 50 pages in each report and thereby comprised about 25% of the entire QA report. The topics of section D (incident management, ANE, unusual incidents, injuries) are very important and likely will take up more of the report and more of QI Council's time than most other sections. However, the	

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		monitoring team found that the length and detail made it impossible to determine what were the key points for the QI Council to attend to. Further, there was much description of data and of problems (including lots of detail about specific individuals), but little analysis of the data. One exception was in the October 2013 report when the writer hypothesized that problems in maintaining assigned levels of supervision contributed to injuries and incidents. o The monitoring team suggests that the QA director, SAC, and section D leader work together to make a QA report that is more useful to the QI Council and to the reader. <u>QAQI Council</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 the monthly QI Council meetings from 9/12/13 to 2/20/14 (5 months, 22 meetings). At SGSSLC, the QI Council also went by the name Administrative IDT. Sometimes, during an Administrative IDT, a detailed clinical review was done. This was called a Clinical IDT. None occurred since the last onsite review. Overall, this meeting was running very well at SGSSLC. i. There was not an adequate description of the QAQI Council in the QA plan narrative or in a separate QI Council policy or procedure document. j. Since the last onsite review, the QAQI Council did meet at least once each month. k. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. l. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. m. Minutes (and attachments/handouts) from 22 (100%) of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (indicators, self-monitoring) were presented, (b) the data presented were trended over time and (c) comments and interpretation/analysis of data were presented. (Though the quality of the interpretation/analysis needed improvement as noted in metric h.) n. Minutes from 22 (100%) QAQI 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.	

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		Corrective Actions Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. The CAPs system, however, remained in development and was not incorporated into the typical activities of the facility and the section leaders (i.e., not in the same way that the data listing inventories, QA matrix, QA report, and QI Council meetings were). A training was conducted by the QA director at the 10/3/13 Admin IDT meeting, but did not result in more use of the CAPs program. The monitoring team reviewed the two CAPs management documents: open CAPs and closed CAPs. At this time, there were 9 open CAPs for 6 sections. This compared with 43 CAPs for 12 sections at the time of the previous review. Further, at this time, 4 of the CAPs were for psychology section K, and one each for sections C, G, J, M, and T. This was a marked difference from the last review when nursing and habilitation accounted for almost all of the CAPs. Each CAP had approximately three or four action steps that comprised it. (Note that the facility submitted 5 CAPs for section K, but one was a duplicate: PBSP data to be submitted in the AAM folder on a timely basis.) o. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP. There are likely a variety of criteria and a variety of sources. p. Therefore, when considering the full set of CAPs, the monitoring team could not determine if they were chosen following the written description, policy, or procedure (0%). • Not every provision will always require a CAP, but at SGSSLC, not all departments were participating in the CAPs system. The monitoring team reviewed all 9 CAPs and found them to be inadequate because the overall goal/purpose of the CAP was not clearly stated, the CAP was not worded in a measurable manner that related to the goal/purpose, and the action steps were not written in observable terms with criterion . The monitoring team did its best to rate the following metrics, but overall, additions need to be made to the CAPs document format and improvements need to be made in the content of that format. q. Of the 9 CAPs reviewed by the monitoring team, 3 (33%) appeared to appropriately address the specific problem for which they were created. • These were the ones for sections C, J, and M. • The monitoring team could not determine what problem was being addressed by the G, K, and T CAPs. The K CAPs did not have an overall CAP outcome/goal at all.	

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		• There was no criterion to judge when/if the overall CAP was being met. None (0%) had a criterion attached to the overall CAP. The monitoring team suggests that the QA director consider each CAP to be an objective and, therefore, each would contain an observable/measurable outcome, conditions under which the outcome should occur, and a criterion/criteria. Based on these 9 CAPs: r. 9 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. There were from 3 to 7 actions for each CAP. s. 9 (100%) included the anticipated outcome of each action step. • 0 of 9 (0%) included specific criteria to judge if the outcome of each action step was met. Most were not written in a behavioral objective type format with the observable behavior, conditions, and criteria clearly described. t. 9 (100%) included the job title and name of the person(s) responsible. u. 9 (100%) included the time frame in which each action step must occur (i.e., a due date).	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 9 CAPs, which represented 100% of the total: a. 9 (100%) included documentation about how the CAP was disseminated b. 9 (100%) included documentation of when each CAP was disseminated, and • Some of the J actions, however, addressed when the action would be implemented rather than when the CAP was disseminated. c. 9 (100%) included documentation of to whom it was disseminated, including the names and titles of the specific persons responsible.	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 parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands. The monitoring team refers the QA director and SAC to the four metrics for this provision as they continue to develop their QA program.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands. The monitoring team refers the QA director and SAC to the five metrics for this provision as they continue to develop their QA program.	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 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 #354 and Individual #331 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #328, Individual #55, Individual #183, Individual #57, Individual #251, Individual #194, Individual #327, Individual #203, Individual #99, Individual #271, Individual #267, Individual #217, Individual #58, Individual #77, and Individual #338. <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 Vanessa Barrientez, QIDP Coordinator o Roy Smith, Human Rights Officer o Vicky Hinojos, Residential Director o Section I discussion with departmental leads o Dana Robertson, Provision Coordinator o Liz Love, Behavioral Health Specialist o Jalown McCleery, Incident Management Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 2/17/14 and 2/19/14 o ISP preparation meeting for Individual #354 and Individual #331 o Annual IDT Meeting for Individual #55 and Individual #331

	Facility Self-Assessment: The self-assessment had been updated on 12/1/13 with recent activities and assessment outcomes. The QIDP Coordinator was responsible for the section F self-assessment. SGSSLC continued to use the statewide section F monitoring tool to assess compliance with section F. The facility had also developed a staff interview/observation tool used in conjunction with the statewide audit tool. The facility continued observing ISP meetings, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. These are the same type of activities that the monitoring team looks at to assess compliance. The facility self-rated itself as being out of compliance with all provision items in section F. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. For example, the monitoring team and the facility each found problems with meeting attendance, timely submission of assessments, and ensuring that action plans were developed to address assessment recommendations.
	Summary of Monitor's Assessment The facility had chosen to focus on assessment submission and attendance at the annual IDT meetings by all relevant team members to move towards compliance with section F. The monitoring team agreed that these two areas should be priorities to ensure that IDTs are developing comprehensive ISPs. Additional training had been provided to staff responsible for implementing the ISP. This was positive to see, however, plans were still not comprehensive to ensure that all supports needed were in place. Additional activities that the facility had engaged in included: • Three QIDPs assumed ISP facilitator roles and received additional training on meeting facilitation skills. • QIDPs were trained by the APC on the community living determination process. • QIDPs were trained by the Rights Officer Assistant on determining supports versus restrictions when completing the rights assessment. • Training was provided to all IDT members on writing measurable goals and objectives. RN case managers received additional training on writing objectives for the IHCPs from the RN supervisor. Two annual ISP meetings were observed during the monitoring visit. Both IDTs were struggling with the statewide ISP planning process and what the resulting outcome should be. Both meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports. The facility needs to request additional training from the state office to move forward with developing and implementing comprehensive ISPs. IDTs need additional training on how to develop integrated action plans based on assessment recommendations that incorporate the individual's preferences. IDTs need guidance on setting priorities for training and developing measurable objectives with clear directions for staff designated to implement plans.

	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 are available to all team members for review. • The facility needs to continue to track submission of assessment by discipline prior to the annual ISP meeting and address any trends of late submission with the specific department responsible for submission. • IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • 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.

#	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 two ISP meetings and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. The assignment of having ISP facilitators lead the discussion was a new process for the IDTs. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, the CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, QIDP monthly reviews, the individual's daily schedule, and ISP Preparation Meeting documentation, as available. A sample was requested of the most recently developed ISPs from each residence on campus, and 15 were submitted for review. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. The QIDP Coordinator confirmed that QIDPs facilitated the teams, including team	Noncompliance

#	Provision	Assessment of Status	Compliance
		meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP was the team leader and responsible for ensuring team participation. A QIDP Coordinator oversaw the QIDP Department. The facility had 16 QIDPs. Three had recently been designated as ISP facilitators. These facilitators were responsible for facilitating the annual IDT meetings. The facility utilized the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills. Thirteen of 16 (81%) QIDPs had been deemed competent in facilitation skills. The ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the ISP facilitators in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the ISP facilitators used this template to draft portions of the ISP prior to the meeting. The facilitators 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. Based on observations of meetings held the week of the onsite review and review of related documentation, facilitation of team meetings was continuing to improve. However, there were still a number of barriers to ensuring that the team developed a comprehensive ISP that integrated all needed services and supports. Barriers included, but were not limited to: • Assessments were still not consistently completed and available to IDT members prior to annual IDT meetings. • It was not evident that all team members were either present at meetings, or, if not physically present, had the opportunity to provide adequate input prior to the meeting. • It was not evident that data were consistently gathered and analyzed, and then used to revise or develop new supports. 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. For example, as described in K4, PBSPs and/or supports were not consistently modified when the individual outcomes were not achieved.	

#	Provision	Assessment of Status	Compliance
		At both ISP meetings observed, the QIDP was not able to summarize progress towards outcomes that the team developed the previous year. Additionally, the QIDP was unaware of how each of the individuals spent a majority of the day. This raised concerns regarding whether or not the QIDP was adequately monitoring services and supports. Having an adequate monthly review process in place would significantly reduce the length of ISP meetings. Both meetings observed the week of the monitoring were over four hours in length. A majority of the discussion was in regards to the status of current outcomes. Very little progress had been made towards outcomes for both individuals. Because data were not available regarding implementation, team members were not sure what the barriers to progress were for many of the outcomes. As a result, both IDTs agreed to continue outcomes that had not been achieved without a significant revision of supports to address barriers. For example, Individual #354 had an outcome to participate in activities that he enjoyed in the community to increase his community awareness. The QIDP reported that he had not left the facility to go into the community for over a year. The team agreed to continue the outcome without an adequate discussion of barriers to implementation of the outcome. With an adequate monthly review process in place, outcomes could be revised prior to the annual IDT meeting when individual's completed outcomes or failed to make progress. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, 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 or when outcomes had been completed. To move forward, the facility needs to focus on ensuring that ISP facilitators and QIDPs are competent in meeting facilitation skills. Then, ensure that QIDPs are monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a lack of implementation, change in status, or a lack of progress.	
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	DADS Policy #004.1 described the Interdisciplinary Team (IDT) 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	to identify assessments to be completed prior to the annual ISP meeting. The QIDP Coordinator was tracking attendance by relevant IDT members monthly. Data were presented at QA/QI meetings and distributed to each department. The QIDP Coordinator reported that this had been effective for increasing overall attendance at annual ISP meetings. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for August 2013-January 2014. Attendance remained low for some disciplines, notably so for the psychiatrist, PCP, dietician, and dental services.	

Team member	Aug	Sept	Oct	Nov	Dec	Jan
Individual	76%	100%	95%	88%	94%	61%
LAR	75%	80%	100%	100%	67%	88%
Family/Advocate/DIS	75%	71%	67%	50%	29%	86%
DSP	93%	94%	77%	88%	94%	87%
QIDP	100%	100%	100%	100%	100%	100%
Behavioral health spec./BA	100%	94%	100%	94%	100%	100%
Psych Assistant	100%	100%	100%	75%	100%	95%
RN	100%	100%	100%	100%	100%	100%
Occupational Therapist	100%	100%	80%	100%	86%	100%
Physical Therapist	86%	100%	100%	100%	86%	100%
Speech Therapist	100%	100%	100%	100%	100%	100%
Audiologist	0%	N/A	100%	N/A	100%	N/A
Dietician	67%	100%	80%	100%	75%	56%
Primary Care Provider	0%	0%	33%	100%	75%	56%
Psychiatrist	33%	20%	67%	100%	25%	14%
Dental Services	100%	0%	50%	50%	100%	33%
Pharmacy	0%	0%	N/A	0%	0%	N/A
Vocational Services	92%	91%	100%	100%	100%	87%
Session Psych	100%	100%	75%	33%	67%	63%
Cultural Services	100%	89%	100%	80%	60%	88%
Program Developer	100%	100%	91%	100%	100%	91%
Home Manager	100%	100%	100%	100%	100%	100%
LA Designated	100%	100%	0%	100%	100%	50%
Contract LA	88%	100%	100%	100%	91%	100%
School District	N/A	N/A	0%	N/A	N/A	N/A
Transition Specialist	100%	100%	100%	N/A	N/A	N/A

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in seven of eight (88%) of the annual meetings in the sample (i.e., full attendance by relevant participants occurred in 12% of

#	Provision	Assessment of Status	Compliance
		the ISPs). The sample was Individual #99, Individual #267, Individual #271, Individual #194, Individual #55, Individual #57, and Individual #183. Individual #271's ISP was developed by an appropriately constituted IDT. Those that were not included: • At the annual ISP meeting for Individual #99, relevant team members identified at the pre-ISP meeting that did not attend the meeting included the physical therapist and day program staff. • Key team members not in attendance at Individual #267's annual ISP meeting included her family, his PCP, psychiatrist, and day program staff. • Key team members not in attendance at Individual #194's annual ISP meeting included the physical therapist, dietician, and transition specialist. • Individual #55 did not attend his annual ISP meeting. • Individual #183's family, psychiatrist, dental staff, LA, and pharmacy staff did not attend her annual meeting. • Key team members not present at Individual #57's annual IDT meeting included his family, DSP, and psychiatrist. • Individual #338's LAR, dietician, dental staff and day program staff were not present at his meeting. In zero of seven ISPs (0%), for any team members not physically present at the IDT meeting, was there evidence of their participation in the development of the ISP. At both pre-ISP meetings observed, for Individual #337 and Individual #354, the QIDP and other team members encouraged active participation by the individual. They frequently asked for input throughout the meeting. Individual #331 attended her annual ISP meeting and provided some input, however, the team did little to encourage her participation in planning. Individual #66 did not attend his annual ISP meeting. The ISP facilitator reported that he was resting in his bed. Additional effort needs to be made to ensure that each individual is a part of the planning process. The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. Relevant team members should be identified at the pre-ISP meeting; then the facility should use that information to track actual attendance by relevant team members at the ISP meeting. When team members cannot attend the meeting, the ISP should note efforts to get input from those team members prior to the annual meeting.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient	DADS Policy #004.1 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.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>quality to reliably identify the individual's strengths, preferences and needs.</td><td>The facility was gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of discipline specific assessments for November 2013 through January 2014 indicated that assessments were not routinely submitted prior to ISP planning meetings. The chart below shows assessment submission rates for that time period.

<table>
<tr><th>Discipline</th><th>Nov</th><th>Dec</th><th>Jan</th></tr>
<tr><td>Audio</td><td>100%</td><td>100%</td><td>64%</td></tr>
<tr><td>Behavioral Health</td><td>73%</td><td>69%</td><td>52%</td></tr>
<tr><td>Dental</td><td>60%</td><td>88%</td><td>82%</td></tr>
<tr><td>Functional Skills Assessment</td><td>67%</td><td>56%</td><td>48%</td></tr>
<tr><td>Nutritional</td><td>73%</td><td>81%</td><td>83%</td></tr>
<tr><td>OT/PT</td><td>100%</td><td>100%</td><td>85%</td></tr>
<tr><td>Aspiration/pneumonia</td><td>100%</td><td>no data</td><td>100%</td></tr>
<tr><td>Pharmacy</td><td>33%</td><td>6%</td><td>35%</td></tr>
<tr><td>Physical</td><td>93%</td><td>69%</td><td>96%</td></tr>
<tr><td>Psychiatric</td><td>7%</td><td>15%</td><td>24%</td></tr>
<tr><td>Nursing</td><td>80%</td><td>100%</td><td>87%</td></tr>
<tr><td>Speech</td><td>100%</td><td>71%</td><td>55%</td></tr>
<tr><td>Vision</td><td>83%</td><td>73%</td><td>87%</td></tr>
<tr><td>Vocational</td><td>69%</td><td>58%</td><td>63%</td></tr>
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A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample was Individual #194, Individual #55, Individual #183, Individual #271, Individual #338, Individual #57, Individual #267, Individual #99, Individual #77, Individual #251, Individual #328, Individual #58, and Individual #217.
• Individual #194 did not have an updated speech assessment.
• Individual #55's did not have a current psychological assessment or psychiatric evaluation.
• Individual #183's nutritional evaluation was completed after the ISP date.
• Individual #338 did not have an updated psychological or vocational evaluation.
• Individual #57 did not have an updated psychiatric evaluation or functional skills assessment. His structural functional assessment was not updated 10 days prior to his annual ISP meeting.
• Individual #267's psychological and functional skills assessments were completed after his ISP date. His vocational assessment was completed the day before his annual meeting and he did not have an updated psychiatric assessment.
• Individual #99's ISP Preparation document included a request for a PT assessment. One was not completed prior to his annual meeting. His dental</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		assessment was not dated. • Individual #77 did not have a medical exam, or psychiatric assessment. • Individual #217 did not have an annual physical exam, psychological, or speech assessment. In nine of 13 (69%), the team considered what assessments the individual needed and would be relevant to the planning process. The team defined the assessments that were needed for the annual meeting during the ISP Preparation meeting. No assessment listing was found in the ISP Preparation Meeting documentation for Individual #271. Individual #58, Individual #251, and Individual #328 did not have an ISP Preparation document. In zero of nine (0%), the team obtained the needed relevant assessments. None of the individuals in the sample had <u>all</u> assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Assessments from various disciplines were reviewed to determine if the assessments were submitted and if they included recommendations that were adequate for planning. Assessment should provide information/recommendations that would guide the IDT to support the individual and develop a comprehensive plan to help the person learn or develop a skill, achieve an outcome, or address a medical or behavioral issue. Findings were: <u>Behavioral Health Services</u> Generally, behavioral assessments did identify the individual's strengths, preferences, and needs. PBSPs included a list of preferences that were used in the PBSPs. Assessments generally provided recommendations that guided the IDT to support the individual and develop a plan to help the person learn a new skill or address a behavioral issue. Additionally, several SAPs reviewed were based on individual preference (see examples in S2). On the other hand only 75% of individuals had preference assessments (PSIs) available to the team at least 10 days prior to the ISP. <u>OT/PT/Communication</u> OT, PT, and speech assessments did identify the individual's strengths, preferences, and needs. There was a specific section in each therapy assessment that identified the individual's interests and preferences (100% of the assessments reviewed in section P and R contained this). The therapists consistently made recommendations related to existing or new SAPs to integrate identified skills (motor and communication, or specialized strategies) into the instructional guidelines developed by the program developers.	

#	Provision	Assessment of Status	Compliance
		In the case of Individual #208, for example, the SLP recommended that a SAP be developed to increase her use of the communication picture book and schedule. In the case of Individual #120, it was recommended in the OT/PT assessment that his safe eating SAP be revised to include him laying his utensil down after one bite and picking it up after he had swallowed and cleared the previous bite. This was based on his success in completing five of six steps in this SAP. A SAP related to learning to cut her food was recommended for Individual #194 to further avoid choking due to taking large bites. She was able to continue with a regular diet, but this SAP addressed identified safe eating concerns. Assessments did provide recommendations that would guide the IDT to support the individual and develop a plan to help the individual learn or develop a skill, achieve an outcome, or address a medical or behavioral issue. Individual #78 presented with a progressive diagnosis of COPD and was losing his breath support for adequate connective speech at intelligible volumes. The SLP provided both voice therapy and AAC device training to ensure that he had a method to communicate effectively with others when his voice could not be heard. <u>Nursing</u> The Nursing Department recently made a change to their Nursing Assessment format. The changes included adding a new section entitled Recommendations, but the Nurses had not been sufficiently trained or had enough time to gain experience when completing the Annual Comprehensive Assessments to arrive at recommendations. The Comprehensive Nursing Assessments did not consistently identify the individual's strengths, preferences, or needs. For example, Individual #127's preferences did not include how he participated in his own health care. Additionally, his assessment did not provide recommendations that would effectively address the frequency of incidents related to falls and alterations in skin integrity. Two ISP Preparation meetings were observed. The IDT completed a checklist at both meetings indicating what assessments would need to be completed prior to the annual ISP meeting. 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.	

#	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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. As described in F1c, assessments required to develop an appropriate ISP meeting were not always done in time for IDT members to review each other's assessments prior to the ISP meeting. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and then information from assessments is used to develop plans that integrate all supports and services needed by the individual. In zero of two (0%) ISP meetings observed, recommendations from assessments were used to develop plans that would provide a broader range of experiences and lead to the development of new skills. Both IDTs had developed draft outcomes prior to the ISP meeting. IDTs were reluctant to consider new outcomes even though assessments had been completed after the initial recommendations for outcomes were made at the ISP Preparation meeting. For example, at Individual #331's meeting, • The team spent a lot of time discussing vocational supports. Although the team acknowledged that she had a current vocational assessment with a list of recommendations, findings from the assessment were not used to develop outcomes or supports. The IDT reported that she had a job shredding paper, but refused to work most of the time. She reported that the shredder was broken, so she was unable to work. The IDT did not appear to be aware of this and had no data to support her refusals to work. The team was prepared to continue her work objectives without consideration of her preferences or recommendations in her vocational assessment. • In discussing her progress over the past year, several team members agreed that her behavior was "better." The team had determined that her behavior was a barrier to community placement the previous year. But, again it was noted as her only barrier to living in the community. The team made a determination without reviewing her behavioral assessment or recommendations from that assessment. Behavioral data were not presented to support the IDT's decision. The IDT agreed that her behavior needed to be "better" before she could be referred for community placement. Measurable outcomes were not developed based on assessment information. Individual #66's assessments identified his support needs and preferences, however, his IDT failed to use the information to develop meaningful supports and programming. For example,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The team agreed that he enjoyed going to church. He had an outcome the previous year to attend church at the facility. The QIDP reported that he was able to attend about six times last year. The team acknowledged that he rarely had opportunities to leave his home. The team continued this outcome, however, did not identify barriers to his attending church and develop appropriate supports to address lack of implementation. • His IDT also noted that he enjoyed wind on his face and the sound of birds. Rather than develop functional goals for going outside, the team came up with ways to provide those sensory experiences in his room (i.e., a fan blowing on his face, recordings of bird sounds). Although these would be nice ancillary activities, the team needs to explore providing those experiences in a less restrictive setting with appropriate supports. At both ISP Preparation meetings observed, the IDTs did a better job of identifying support needs in relation to building on preferences. For areas where the team was not sure what supports were needed, they recommended further assessment prior to the annual ISP meeting. The adequacy of integration of recommendations into the ISP for specific disciplines is discussed in detail in other sections of this report. Findings for section K indicated that functional assessments were consistently of high quality and used to develop PBSPs to address behavioral issues. On the other hand, findings from S2 indicated that only 67% of SAPs reviewed were based on clear needs identified in assessments. None of the five recent nursing assessments reviewed contained statements that were used to develop appropriate protections, services, and/or supports for the individual. For example, Individual #329 was a new admission and had an omission for completing the recommendations section. Individual #66 had an omission for completing the recommendation section. Again this as most likely due to the new form, as stated in F1c. OT/PT and communication assessments provided the necessary information to develop the PNMP, which is the primary document for staff instructions related to mealtime and physical assistance by staff. Communication strategies were also added to these plans. When a referral was made to the PNMT, the existing risk ratings were reviewed with the IDT and these were modified based on identified needs due to the change in status that resulted in the referral (Individual #180, Individual #98, Individual #59, Individual #203, and Individual #78). Supports and strategies were added and modified based on these.	

#	Provision	Assessment of Status	Compliance
		When assessments were completed after the annual IDT meeting, it was not evident that the IDT met to review the assessment and incorporate recommendations into the ISP. For example, • Individual #338's ISP indicated that vocational staff would complete an assessment of his work skills, his home manager would assess his water safety skills, and the program developer would assess his reading skills and yoga skills. There was no evidence that the assessments were completed or that changes were made to his ISP to address assessment findings. • Individual #57's ISP included outcomes for the home manager to complete her section of the FSA and the program developer to complete her section of the FSA. Additionally, the ISP directed that after the FSA was completed, it would need to be printed and filed in the active record. There was no indication that the team would meet to review the FSA and incorporate recommendations into the ISP. • Individual #182's ISP included an outcome for the speech therapist to complete a communication assessment. There was no evidence that the assessment had been completed or recommendations used to develop supports. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and 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).	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample size) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. In the new ISP format, discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with a consensus opinion by team members from various disciplines. Any barriers to community placement were to be addressed in the ISP. See section T regarding the quality of discipline specific determinations. None (0%) of the individuals in the sample were offered a range of opportunities to participate in meaningful activities in the community. None (0%) of the individuals in the sample had adequate access to the use of community services and community supports (i.e., hair salons, gyms, banks, churches, pharmacies). None (0%) of the ISPs in the sample indicated that the individual was adequately integrated into the community (has friends who are not paid to be in his/her life and are	Noncompliance

#	Provision	Assessment of Status	Compliance
		not disabled, regularly participates in activities in the community and engages with others in the community, has memberships, hobbies, and interests, works/volunteers, or contributes to the community in some way). There was no focus on providing additional opportunities for individuals to participate in day programming in the community. The facility did not have options for individuals to receive day habilitation in the community. Minimal formal training was occurring in the community. Eight ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #183, Individual #251, Individual #77, Individual #91, Individual #55, Individual #267, Individual #57, and Individual #338. None (0%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for all individuals 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 #518 had community based outcomes to "go to town" twice a month and "have scheduled shopping trips" twice each quarter. • Individual #55 had one community based outcome to "be provided the opportunity to participate in a preferred activity." There was no focus on providing supported employment or volunteer opportunities in the community for individuals at the facility. Vocational outcomes did not address developing work skills that would lead to employment in the community. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. None (0%) of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	
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:		

#	Provision	Assessment of Status	Compliance
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a summary of progress) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. 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 engaged in a discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting, and developed plans to include the individual's preferences throughout the day. Teams were not adept at using preferences to build on new training opportunities for individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to preferences were often general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. Lists of preferences in the ISPs in the sample reviewed were individual specific. 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. Preferences were used to develop outcomes for participation in preferred activities, but training was not based on prioritized preferences in the ISPs reviewed. Appropriate supports were developed when IDT members identified needs or barriers to achieving outcomes in some cases. For example, behavioral plans were developed to address refusal with routine dental procedures, and increases in restraints. Functional assessments and PBSPs generally included individualized measurable treatment strategies based on identified needs. However, a review of SAPS for S2 showed that only 67% of SAPs were based on clear needs identified in assessments. 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,	Noncompliance

#	Provision	Assessment of Status	Compliance
		joining community groups focused on specific 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 occasionally listed as a possible training site for outcomes, training was not designed specifically for functional training in the community. As noted in F1e, outcomes for training offered opportunities for visits in the community, but few were focused on gaining specific skills. IDTs did little to develop community integration strategies that included the 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 focus 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;	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample size) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. 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. As noted in F1e, none of the ISPs reviewed included measurable outcomes to address barriers to community placement. The monitoring team found that outcomes were not written in a way that staff could measure progress towards completion and/or that plans did not provide enough information to ensure consistent implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. For example, • Individual #183 had an outcome to "continue going to the workshop." There were no staff instructions to indicate what type of work he would do, what training would occur, what supports would be needed, or what barriers might need to be addressed. There was not enough information to ensure consistent implementation. He had another outcome that stated he "will complete his daily hygiene with staff help." Again, the outcome did not indicate what he needed to do to complete his daily hygiene or what supports would be needed by staff. • Individual #327 had an outcome that stated "swimming activities." There was no further information to direct staff on what type of swimming activities he	Noncompliance

#	Provision	Assessment of Status	Compliance
		would be involved in or what staff support was needed. • Individual #77 had an outcome to continue employment. Again, there were no instructions on how staff should implement the outcome and what criteria would be used to determine progress or regression. • Individual #203 had an outcome that stated that she would continue to participate in leisure activities. The outcome did not indicate what level of participation would be considered a successful attempt, what level of support staff would need to provide, or what barriers might need to be addressed. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and I also address the writing of measurable strategies to address health care risks. For OT/PT supports, individualized measurable goals/objectives/treatment strategies based on identified needs were developed primarily through the PNMP, though direct therapy was provided on a limited basis. Although the Comprehensive/Quarterly Nursing Assessments and their associated Integrated Health Care Plans contained goals, more often the goals were not realistic/holistic or included sufficient interventions to meet their identified health care needs. For example, Individual #47's IRRF, Comprehensive Nursing Assessment, and associated IHCP documents stated she was At Risk for respiratory compromise. None of the documents provided necessary supports to assist the individual in minimizing her use of tobacco products. 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 parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. The development of action plans that integrated all services and supports was still an area with which the facility struggled. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		the IDT prior to annual meetings. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. None of the SAPs in the sample reviewed incorporated individualized strategies developed using therapy and behavioral assessments available at the time of development. As noted, many assessments were updated after the development of the SAPs. It was not evident that teaching strategies were revised when updated assessments were submitted after the annual ISP meeting. It was not evident that existing SAPs included steps that the team had identified through the assessment process that would be needed to accomplish the outcome. 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 IHCP. For the most part, these continued to be stand alone plans. There was very little integration noted among disciplines. 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. Observation at annual ISP meetings and pre-ISP meetings indicated IDTs were making little progress towards integrating protections, services, and supports into one comprehensive plan. Each discipline continued to report independently on each particular assessment/plan related to their own discipline. Minimal discussion occurred to attempt to integrate supports among disciplines. For example, at the annual ISP meeting for Individual #331, the speech therapist had recommendations to facilitate better communication. She suggested to the behavioral therapist that they could work together to integrate communication and behavioral strategies. The behavioral therapist was resistant to this idea because she already had action steps to address behaviors developed. This would have been a great opportunity to integrate recommendations from both assessments into functional outcomes based on the individual's preferences since both were identified as barriers to achieving her outcomes. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and measurable outcomes.	

#	Provision	Assessment of Status	Compliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. <u>Method for implementation</u> As discussed in F2a2, some 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. A review of ISP outcomes and action steps for • Individual #99 (living options, relationships, leisure) • Individual #57 (living options, relationships, vocational) • Individual #327 (living options, community integration) • Individual #183 (relationships, independence, employment) For of zero of 11 (0%) outcomes reviewed, action plans were specific and relevant to assisting the person in achieving his/her outcome, including steps the team had identified through assessment that will be needed to accomplish the outcome. Three of 35 action steps were written in terms of measurable action that the individual would perform to complete the objective. Many of the action steps were written in terms of what staff would do rather than what the individual needed to do to achieve the outcome. For example, Individual #99 had an action step for staff to look into (guitar) lessons in the community. This should have been one support strategy needed for an outcome related to his taking guitar lessons in the community. Similarly, Individual #57 had an action step for the team to meet to discuss reinforcers for his attendance at work. Again, this should have been a support strategy rather than an action step related to the individual achieving his vocational outcome. IHCP action steps were generally brief statements of action to address the risk or references to additional plans (i.e., PNMT, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention. As previously noted, each discipline will need to ensure that assessments are completed prior to the annual ISP meeting to ensure training strategies are developed using current recommendations from each discipline.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Time frame for completion A sample of ISPs was reviewed to verify that outcomes included a time frame for completion. All (100%) included projected completion dates. In most cases, however, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. As noted above, many of the action steps were related to things that staff had to do rather than what the individual needed to do to complete the outcome. In those cases, a completion date was assigned for staff to complete tasks. Staff responsible All SAPs and IHCPs in the sample included designation of which staff /discipline 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 parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. 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. 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 in key areas of their lives. For example, outcomes did not address increasing independence in routine household activities, such as laundry, yard work, and meal preparation. None (0%) of the ISPs in the sample included adequate 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were general in nature and did not address barriers to working in 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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. 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 type of data to be collected and the frequency of implementation were to be in 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. For the sample described in F2a4, 29 of 35 action steps included the frequency of implementation. Most action steps indicated how often the action step should be implemented in terms of weekly, monthly, quarterly, or annually. In six instances, frequency included terms such as "when scheduled." Program developers should list frequency in concrete terms, even specifying the day of the week and time for training when feasible to ensure consistent implementation. One of 35 action steps included clear direction for documenting implementation and progress. The facility continued to use very broad terms for when and how to document progress (i.e., progress note, monthly review).	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	The parties agreed the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. As noted in F1, adequate assessments were often not completed prior to the annual	Noncompliance

#	Provision	Assessment of Status	Compliance
	outcomes, services, supports, and treatments are coordinated in the ISP.	meetings. When assessments were recommended by the team, it was not evident that 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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. A small sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. The QIDP Coordinator reported that the recent assignment of ISP facilitators to the IDTs should have positive impact on the timely submission of ISPs. The monitoring team reviewed data in regards to ISPs held August 2013 and September 2013. A list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). • Data provided by the facility indicated that 30 of 33 (91%) ISP meetings were held within 365 days of the previous ISP meeting. • 23 of 33 (70%) of the ISPs were filed within 30 days of development. As noted in other sections of this report, the monitoring team found that outcomes were not always written in measurable terms, so that those monitoring the plan could determine when progress was made or if the outcome was completed. Additionally, teaching and support strategies were not comprehensive enough to ensure that staff knew how to implement the outcome and provide appropriate supports based on assessment recommendations. 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 outcomes should be written in clear, measurable terms. 2. Teaching and support strategies should provide a meaningful guide to staff responsible for plan implementation. 3. ISPs should be accessible to staff within 30 days of the development of the plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	The parties agreed the monitoring team would not conduct monitoring for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with 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	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 utilized the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills. Thirteen of 16 (81%) QIDPs had been deemed competent in facilitation skills. During the week of the monitoring visit, two annual IDT meetings were observed. At the two meetings observed, ▪ Meetings were very lengthy, yet very few revisions were made to current supports. When outcomes had not been met, both IDTs either continued the outcome with little changes in supports or discontinued the outcome without considering more appropriate action steps to teach the identified skill. ▪ There was still minimal integrated discussion among team members. Each discipline reported on discipline specific areas and suggested supports and action plans relevant to his/her own assessment. The IDTs will need additional training on developing integrated action plans based on information from assessments. ▪ Outcomes and action steps were not necessarily developed based on priorities established for the individual. ▪ Teams were still struggling with using strengths and preferences to provide new	Noncompliance

#	Provision	Assessment of Status	Compliance
	updated competency- based training when the plans are revised	training opportunities with a focus on developing new skills. ▪ IDTs were still struggling with developing measurable objectives to track progress or regression. QIDPs were still learning to use the new statewide ISP format to develop the ISP. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at SGSSLC. It would be beneficial for the facility to seek additional outside training and consultation from the state office on developing person-centered ISPs. All new employees were required to complete Supporting Vision, the statewide training on the ISP process. Data collected by the training department for new employees completing this training showed 94% of all new employees completed training in June 2013, 88% in July 2013, 96% in August 2013, 97% in September 2013, 100% in October 2013, and 87% in November 2013. Individual specific training was provided to staff on implementing ISPs for each individual supported. Staff instructions were provided to DSPs as a guide to implementing supports. Staff instructions, however, 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, particularly in regards to risks and behavioral strategies for individual that they were assigned to support. It was evident that the facility had provided additional training to DSPs on individualized plans. 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.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the	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 all records reviewed. The monitoring team commends the facility's efforts at ensuring that ISPs are accessible to all staff designated to implement the plan, however, it will be necessary to ensure that plans are revised when warranted to gain substantial compliance with this provision. IDTs were still not ensuring that plans were monitored for efficacy and revised when outcomes were met or when there was regression or lack of progress towards outcomes. To ensure compliance with the requirement that ISPs were held within 365 days (30 days for new admissions) and filed within 30 days,	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility Superintendent grants a written extension.	• Scheduling of ISPs was monitored by the QIDP Coordinator Assistant. • QIDPs were required to provide justification and obtain approval from the SSLC Director for any ISPs that did not meet timeliness requirements. • Secretaries were responsible for tracking receipt of completed ISPs and providing that information to the QIDP Coordinator Assistant. Tracking information was entered into a log for data collection. The facility reported a decrease in the timely filing of newly developed ISPs over the six month review period due changes in the QIDP department related to the appointment of three new ISP facilitators. The QIDP Coordinator predicted that the appointment of ISP facilitators would have a positive long range impact on ensuring that plans were developed within appropriate timeframes and revised when needed. The monitoring team reviewed data in regards to ISPs held August 2013 and September 2013. A list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). • Data provided by the facility indicated that 30 of 33 (91%) ISP meetings were held within 365 days of the previous ISP meeting. • 23 of 33 (70%) of the ISPs were filed within 30 days of development. An adequate review process will need to be in place to ensure that supports are revised as needed. As previously noted, at both ISP meetings observed, the IDT acknowledged that little progress had been made on most outcomes and some outcomes were not implemented for the previous year. The IDT should have met prior to the annual meeting and revised outcomes and supports when no progress was noted. For example, Individual #331 was not participating in her vocational outcome or attending sessions as planned at her annual IDT meeting the previous year, consequently, it was difficult to determine how she was spending her days. The IDT should have met prior to her annual meeting to develop alternate programming or review supports that were barriers to her participation in planned programming. Similarly, Individual #354 had made little, if any, progress on his outcomes. His staff also reported that he participated in very little meaningful programming throughout the past year. IDT members reported that limited staff and his health were barriers to achieving his outcomes. Again, the team should have met prior to his annual meeting to revise supports and ensure that he had opportunities to participate in programming during the day. The facility needs to continue to focus on ensuring that an adequate review process is developed and that plans are revised when outcomes are met, individuals experience a change of status, there is a lack of progress towards the accomplishment of outcomes, or when regression is noted.	

#	Provision	Assessment of Status	Compliance
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 parties agreed the monitoring team would not conduct monitoring for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands.	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 SGSSLC Section G Self-assessment o SGSSLC Section G Action Plan o SGSSLC Provision Action Information o SGSSLC Sections G Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily 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 David Ann Knight, RN 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. The self-assessment was very limited. There were two activities for provision G1: sample of ISPs was reviewed for attendance by the clinicians and habilitation services reviewed a sample of ISPs to determine if clinical services were integrated into the ISPs.

	For Provision G2, the facility presented the data from the medical audits. However, as noted in previous reviews, the audit questions did not adequately cover the requirements of this provision. Other activities were listed as "0 of 30" sample indicating that no monitoring was completed. In moving forward, the monitoring team recommends that the medical director read the comments and recommendations of this report. Future self-assessment should include items that are similar to those listed reviewed by the monitoring team. 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 medical director served as the facility lead for this provision. However, the medical compliance nurse appeared to serve in the role as functional lead since he had served as lead for quite some time. There was no measurable progress in this area. The clinical disciplines continued to work on ways to deliver services in an integrated manner, but the facility struggled with the development of an effective means to measure integration. Facility staff understood that participation in meetings alone was not adequate evidence of integration. To that end, the facility was developing tools to demonstrate that the meetings were generating plans and recommendations that were implemented and facilitated integration of services. For provision G2, there was no progress. It appeared that staff did not understand the documentation requirements for this provision. An audit tool was developed that captured the requirements, but audits had not been completed. The IPN entries did not meet the documentation requirements. There was no monitoring for this provision. Therefore, the lack of appropriate documentation was not recognized.

#	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 continued to seek methods to measure integration of clinical services. At the time of the compliance review, the facility measured ISP attendance of clinicians and participation of clinicians in the various clinical meetings and committees. Habilitation therapies was also auditing ISPs to ensure that clinical services were integrated into the plans of the individuals. Data submitted by the facility for ISP attendance are summarized in the table below.	Noncompliance

#	Provision	Assessment of Status	Compliance

ISP Attendance 2013 (%)						
	Jun	Jul	Aug	Sep	Oct	Nov
Medical	NA	0	0	0	25	0
Psychology	90	88	94	100	100	100
Psychiatry	20	0	33	0	29	NA
Nursing	82	95	100	100	100	100
Dental	50	75	60	0	0	0
Pharmacy	0	0	0	NA	0	0
Physical Therapy	100	100	75	100	100	100
Occupational Therapy	NA	75	66	100	75	100
Speech Therapy	100	78	89	100	100	100
Dietary	NA	66	57	66	57	100

ISP attendance was discussed with the medical director and medical compliance nurse because it is the fundamental planning event for the life of the individual. It also provides a significant opportunity to plan for the delivery of services in an integrated manner. Yet, it was clearly documented that key clinical disciplines were not participating in these meetings. The medical director reported that moving forward, this would be addressed.

The medical compliance nurse indicated that the facility was no longer using meeting attendance as the sole measure of integration. The facility was planning to measure the effectiveness of meetings by determining if the recommendations generated by the meetings were implemented. To that end, the Integrated Clinical Services Tool was developed. The tool was not implemented at the time of the review.

The medical director provided several examples of integration such as the IMRT, unit meetings, and Pneumonia Review Committee.

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:

- Daily Provider Meetings – The facility conducted daily provider meetings at the end of the day to discuss the events of the past 24 hours. All of the clinical disciplines participated in this meeting, which was facilitated by the medical staff. Discussions covered medical, psychiatric, dental, and behavioral issues. Further discussion can be found in section L1.
- Medical Nursing Meetings – This meeting was conducted weekly with the medical and nursing staff to discuss specific clinical issues.
- The monitoring team attended several committee meetings throughout the week of the compliance review. Many of these meetings included collaborative clinical discussions. Details related to the following committee meetings are found in the various sections of this report:

#	Provision	Assessment of Status	Compliance
		o Infection Control Committee o Pharmacy and Therapeutics Committee o Pneumonia Review Committee o Skin Integrity Committee o PNMT o PBSP Committee • Speech clinicians collaborated with psychology and the program developers to integrate individualized communication strategies into new and existing programs. • Psychology and dental clinic worked together to address barriers to dental treatment for those individuals who refused treatment. • As noted in the report, while information about various topics (e.g., 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 integrated document (i.e., nursing, psychiatry, psychology, and pharmacy). Unfortunately the psychiatric quarterly evaluations were not always completed in a timely manner Several areas offered great opportunities for improvement: • ISP Attendance - As note above, data submitted by the facility indicated that attendance by the medical, pharmacy, dental and psychiatry providers was poor. • Dental behavioral rehearsal plans were implemented, but the status of the plans was not adequately communicated to the clinic staff. The status of the behavioral rehearsal plans was unknown at the time of the compliance review. Treatment in dental clinic was awaiting the outcome of these plans, so it was important for the clinic staff to know the progress of the individuals. • There was no effective integration of neurology and psychiatry. • Since June 2013, only 18% of the pretreatment sedation forms were completed by the IDT thus indicative that the IDT failed to review details of individuals who received pretreatment sedation. Additionally, the pretreatment sedation review forms that were completed did not include the documentation of a consensus decision with regard to the use of a particular medication. <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:	

#	Provision	Assessment of Status	Compliance
		1. The medical director should address the concerns outlined in the comments above. 2. The facility should implement the Integrated Clinical Services Tool to determine how effective it will be at measuring integration of clinical services. 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 facility did not utilize the state developed consultation tracking database. It was reported that nursing services maintained a spreadsheet to track appointments. The medical department secretary also tracked appointments. A total of 40 consults in the record sample that were completed after June 2013 were reviewed: • 15 of 40 (38%) consultations were summarized by the medical providers in the IPN within five working days • 0 of 40 (0%) IPN entries included the required elements related to agreement/disagreement and IDT referral The primary providers were required to provide adequate information to the consultants. The physicians continued to utilize the consultation form to document agreement or disagreement with the recommendations of the providers as well as the need for referral to the IDT. Entries were also made in the IPN, however, the IPNs reviewed included very cursory notes, none of which met the requirements of the Settlement Agreement as defined by state policy. The medical director did not appear to be absolutely clear on the requirements of this provision. This was surprising because the medical compliance nurse had developed (but not implemented) an audit tool that targeted the exact IPN requirements that were discussed during the September 2013 compliance review. Those requirements were outlined in the recommendations of the monitoring teams' report. Adding to this lack of clarity was the guidance provided to auditors completing the external/internal medical audits. Question #45 stated "Are medical/surgical consultation recommendations addressed in the IPN within five business days after the consult recommendations are received?" The guidance section stated "Documentation from provider as to why consultation recommendations were not addressed within five business days should be in the integrated progress note (i.e., provider on vacation)." This question is not intended to determine if the explanation for failure to address the recommendation is documented in the IPN. Question #45 simply assesses the basic requirement to address the consult in the IPN within five business days. Unfortunately, this question does not address the	Noncompliance

#	Provision	Assessment of Status	Compliance
		additional requirements cited in state policy regarding the need to summarize the findings, state agreement/ disagreement, and determine the need for IDT referral. The addition of those elements would provide useful information, to existing quarterly internal audits, without adding the burden of additional tools and reviews. The medical department did not conduct any monitoring of this requirement. Therefore, the medical director was unaware of the extent of the deficiencies in this area and clinical outcomes related to the deficiencies. Consultation referral and clinic tracking are discussed in further detail in section L1 under Consultation Referrals and Access to Specialists. This provision remains in noncompliance due to the lack of the required IPN documentation. <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. 2. 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. 3. The medical director should ensure that the state database or another database with adequate information has been appropriately implemented. 4. 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 Stanly Cal, MD, Medical Director o Albert Fierro, RN Medical Compliance Nurse o David Ann Knight, RN o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily medical meeting/Medical rounds
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions (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 provision H1 the facility provided data related to several of the assessments completed. For H2, data related to the audits of diagnoses were provided. For the remainder of the provisions, data were not current because monitoring was, for the most part, suspended after October 2013. 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 made significant changes related to this provision. For more than a year, the facility's QA nurse had served as the section H lead. In November 2013, the medical director assumed the role as facility lead

	for this provision. Clearly, section H was one of many responsibilities of the medical director. While he did not have the ability to devote many hours to working on the issues that required attention, he had the resources of two compliance nurses who worked under the supervision of the Settlement Agreement Coordinator. There was very little progress seen and that was not unexpected given the transition that occurred. There was progress in provision H1 as the facility continued to monitor the timeliness of the various assessments. The November 2013 QA report indicated that no data for provisions H3-H7 were presented and audits were not conducted or scheduled. The self-assessment reflected that monitoring was temporarily suspended. The suspension was unfortunate because the facility had made good progress in H1 and previous compliance reviews provided evidence that the fundamental work needed to move forward with this provision was in progress.

#	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 monitored: • 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 data for annual assessments to ensure that the assessments were current and available for review 10 days prior to the ISP. Compliance data are presented in the table below.	Noncompliance

Annual Assessments 2013
Compliance With Timely Submission (%)

	Jun	Jul	Aug	Sep	Oct	Nov
OT/PT	33	93	86	92	100	100
Speech Annual	60	73	71	91	81	83
Audio Annual	80	89	100	82	92	100
Nutrition Evaluation	0	89	94	71	88	73
Nursing Comprehensive	40	42	71	59	83	80
Medical Annual	20	89	71	59	96	93
Psychiatry Comprehensive	100	29	27	23	23	7
Psychology APES	2	35	53	67	58	73
Dental Annual	60	72	53	59	88	60
QDRR	20	0	0	9	9	33

#	Provision	Assessment of Status	Compliance
		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. Therefore, the facility began auditing a sample of medical, dental, and psychiatry assessments to determine if the assessments met this requirement. Compliance for medical and dental was reported as 100% for the reporting period, with 0% compliance for psychiatry. The data presented in the section H self-assessment were not consistent with data found in other sections of this review. Neither the medical nor dental departments had 100% compliance with timely completion of annual assessments Eight interval assessments were 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 Assessments 2013						
	Jun	Jul	Aug	Sep	Oct	Nov
PNMT RN	100	50	100	100	100	100
Provider Post Hospital	100	100	100	100	100	80
RN Post Hospital	0	40	63	80	70	60
Psychiatry (restraint)	100	0	0	20	82	--
Pharmacy (restraint)	0	0	0	20	82	--
Psychiatry-Pharmacy	47	100	100	47	94	--
Psychology ESM	80	60	80	100	40	60
Nursing Serious Injury	50	100	100	100	100	100

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. The post hospital assessment included evaluations completed following return from the emergency department. It was reported that a 100% sample was done and compliance was 97%. The monitoring team found examples in which assessments were not completed following return from the emergency department. This is discussed in section L1.

Some departments had tools to assess the quality of the various assessments. This was not done by all departments. Therefore, no data relative to the quality of the assessments were provided.

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, the facility's average compliance for the three months prior to the review was 85%. The PCPs began completing Quarterly Medical Assessments in October 2013. 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 85%. Dental assessments are discussed in section Q2. • Comprehensive Nursing/Quarterly Nursing assessments for the 12 records reviewed showed improvement in the timely completion of nursing assessments since the previous compliance review. The nursing department recently changed the nursing format and nurses had not been adequately trained. Therefore, there were many blank and incomplete evaluations. Regularly scheduled quarterly and annual nursing assessments were present in all of the 12 records. • The PNMT conducted assessments for individuals referred to the team. These assessments resulted in a series of recommendations for the IDT and the PNMT to address collaboratively. Follow-up was also collaborative, as IDT members attended the PNMT meetings when the individual they supported was scheduled for review. The details of actions or consults by the PNMT were generally documented in the IPNs, though the quality of this was inconsistent. • OT/PT/SLP assessments were completed annually for individuals provided direct and indirect supports and services in the format of a Comprehensive Assessment or Assessment of Current Status. These were also completed when a change in status was identified by the IDT, post-hospitalization or by referral for an identified need. • As described in sections O, P, and R of this report, the timeliness of assessments continued to be problematic, though improvement was ongoing. There continued to be a significant lack of timely communication assessments. There had been improvements noted in the content aspect of the OT/PT and communication assessments. • The facility reported that data were not known regarding the percentage of timely evaluations of the QPMRs that were done within 90 days since the last visit and 66% of the individuals who received psychotropic medication did not have an Appendix B evaluation completed. These were the two avenues to ensure that no individual received psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. • Psychological assessments were completed for 99% of individuals and 100% of individuals had annual psychological assessments.	

#	Provision	Assessment of Status	Compliance
		• Ninety-six percent of individuals with a PBSP had a current functional assessment. • 75% of preference assessments, and 56% of functional skills assessments were completed at least 10 days prior to the ISP <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. SGSSLC 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. The facility's audits indicated continued compliance with this provision item. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Overall, the medical diagnoses were consistent with ICD nomenclature and fit the reported signs and symptoms of disease. • Over the course of the visit, the monitoring team observed that the IDT addressed maladaptive behaviors more so than being knowledgeable about the psychiatric symptoms identified in order to establish the diagnosis. The IDT needed to develop combined case formulations in order to provide cohesive diagnostics consistent with the current version of the DSM and to implement an applicable treatment plan. The revision of diagnostics predominantly occurred during the QPMRs. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance.	Substantial 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	The facility did not do any additional work in this area. Assessment for this area consisted of presentation of data for Round 7 of the Internal Medical Management audits that was conducted in August 2013 and Round 8 of the Internal/External Medical Management audits completed in November 2013. The results of the audits are discussed in section L2 and section L3. The facility determined that the scores indicated a lack of compliance with the clinical pathways for the conditions reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessments and diagnoses.	As noted in the previous compliance review, this provision required that treatment and interventions for conditions other than the six identified in the state protocols be assessed. The monitoring team made the following observations: • With regards to the management of psychiatric diagnoses, treatment may not be applicable if the plan did not address the presenting symptoms. The plan outlined by the psychiatrist through the IDT process must be reflected in the multidisciplinary plans, such as the PBSP, nursing assessment, psychology assessment, and QDRRs. Upon record review, diagnostics were not reliably congruent. If diagnostics were not congruent, treatment would not be designed for management of the specific condition and would impact timely and clinically appropriate based intervention. There remained a need to enhance both the identification and implementation of non-pharmacological interventions. • In the case of direct speech therapy, the quality of documentation was inconsistent and did not meet generally accepted standards. Functional and measurable objectives for direct therapy provided were consistently and clearly identified in the assessments, but were not generally integrated into the ISP or ISPA for OT/PT or speech. • Interventions and treatments following acute care treatment/assessment were not always timely. That is, the medical staff did not consistently conduct assessments in a timely manner. The return from an acute care facility often involved a new diagnosis requiring a change in management. <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 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.	

#	Provision	Assessment of Status	Compliance
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.	Data for the months of June 2013 and September 2013 were presented for diabetes, pneumonia, and osteoporosis. The metrics were labeled " process indicator" and "outcome indicator." The process and outcome indicators used were not identified. Furthermore, the self-assessment stated that monitoring had been suspended. The monitoring team observed that a system for effectiveness monitoring of all aspects of the PNMP was established, but was not yet consistent or timely. Though improved, the annual therapy assessments did not consistently include a review of the monitoring findings to document the effectiveness of interventions throughout the year or particularly, staff compliance with these plans. The development of the six state protocols was a good starting point in monitoring the efficacy of treatments and interventions. 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. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance.	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 charts 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 the IDTs remained in the early stages of addressing risk and documenting the evaluation of risk in the assessment. There were no data presented for the months of October 2013 and November 2013. The self-assessment indicated that monitoring for this provision was suspended. The monitoring team made the following observations with regards to the assessment of risk: • As noted in the previous review, a number of nursing care plans were not implemented, revised, or resolved to meet the individuals' needs and changes in their health/mental health conditions and risks. Protocol cards that guide nursing assessments were not being consistently implemented, and ACPs and associated staff instructions were not being consistently developed to effectively monitor the health status of the individuals. • A system to effectively monitor the psychiatric health status of individuals involved the participation of numerous disciplines in the QPMRs. Nursing staff	Noncompliance

#	Provision	Assessment of Status	Compliance
		presented documented medical information for the psychiatry clinic. The psychiatrist had access to the physician's medical assessment in the record. The behavioral health representative reported data predominantly composed of information, such as aggression to self/others. The IDT did not routinely discuss details of who or what was going to be definitively collected and analyzed in relation to the monitoring of the psychiatric health status of those receiving psychotropic medication. • The Annual Medical Assessments did not address risk. Even when individuals clearly had risk factors for conditions such as pneumonia or metabolic syndrome, the AMAs did not define the risk, outline a clear plan to mitigate the risk, or adequately document the supports that would be implemented. 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 acute changes and chronic long-term disease. 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 • 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. This requires that the activities above function as designed with the appropriate participation of clinical staff. 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. 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:	

#	Provision	Assessment of Status	Compliance
		1. Ensure that medical staff is attending ISPAs, particularly those that occur following hospitalization. 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.	Per the self-assessment, monitoring was not implemented and no tools were developed. The facility must identify clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on clinical guidelines developed. These indicators will help determine when treatment plans must be altered. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. 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.	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.	The self-assessment documented that monitoring was temporarily discontinued. <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. The Integrated Clinical Services Tool may serve as one metric by measuring the utility of the meeting products – recommendations and plans. 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 facility's 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 contractures 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 with metabolic syndrome o List of individuals who were missing and/or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o Data reports regarding the submission of assessments for IDT review prior to annual ISP 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 #354 and Individual #331 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #328, Individual #55, Individual #183, Individual #57, Individual #251, Individual #194, Individual #327, Individual #203, Individual #99, Individual #271, Individual #267, Individual #217, Individual #58, Individual #77, and Individual #338. <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 Vanessa Barrientez, QIDP Coordinator o Roy Smith, Human Rights Officer o Vicky Hinojos, Residential Director o Section I discussion with departmental leads o Dana Robertson, Provision Coordinator o Liz Love, Behavioral Health Specialist o Jalown McCleery, Incident Management Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 2/17/14 and 2/19/14 o ISP preparation meeting for Individual #354 and Individual #331 o Annual IDT Meeting for Individual #55 and Individual #331 o
	Facility Self-Assessment: SGSSLC submitted its self-assessment updated 12/1/13. 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 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. To assess compliance, the facility: • Reviewed facility policies on risk management. • Reviewed training to ensure that all staff were trained on the risk process. • Gathered and analyzed data on the submission of assessments prior to annual ISP meetings. • Reviewed ISPs to determine if risks were identified and supports were developed to address risks. • Reviewed attendance data to determine if all relevant team members were present at meetings to contribute to the risk discussion. • Completed monitoring of ISP meetings using the ISP Monitoring Tool to determine if the risk

	discussion: o Used risk guidelines. o Included a rationale based on clinical data. o Resulted in plans to address all risk areas. o Resulted in the development of measureable objectives o Included integrated discussion regarding how risk areas impacted each other. o Considered supports in place when choosing risk ratings. • Reviewed risk documentation to ensure IRRF and ICHP documentation was complete and submitted within policy timeframes. • Reviewed a sample of IHCPs monthly using the Section I Audit Tool. • Reviewed documentation and conducted staff interviews to determine if staff were trained on plans. • Reviewed a sample of risk plans to determine if staff were reviewing plans for effectiveness. • Reviewed ISPAs for individuals admitted to the hospital or had an identified change of status to determine if the IDT met to discuss and reassess risk ratings in a timely manner. Findings from that review were similar to findings by the monitoring team. 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 parties agreed the monitoring team would conduct reduced monitoring for all provisions in section I because the facility had made limited progress due to the decision to focus on the completion and quality of assessments. The monitoring team observed the risk identification process at two ISP meetings and noted some progress made. IDTs were engaging in better discussion regarding risk levels. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. The monitoring team agrees that this needs to be a primary area of focus. Supports were not being monitored and revised as needed to address risks identified. Teams were not consistently documenting the completion of assessments and implementation of 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. As noted throughout this report, the monitoring team has concerns related to the accurate identification of risk factors for individuals and the processes that the facility had in place to address those risks.

	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. • 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. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

#	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 parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection because the facility had made limited progress due to the decision to focus on the completion and quality of assessments. The noncompliance finding from the last review stands. While the facility continued to provide training to IDTs on the risk process and developing plans to address risks, they acknowledged that having an effective assessment process in place was necessary to accurately identify risks and develop adequate supports. There had been a strong focus placed on developing an adequate risk assessment process in the months prior to the monitoring visit. It was positive to see that, not only was the facility looking for evidence that assessments were completed, but they were also assessing the quality of those assessments. The facility focus included: • Gathering data on assessment submission and attendance by relevant IDT members at the annual ISP meeting related to the ISP development process. Addressing those areas will be key to ensuring that an adequate risk discussion occurs annually at the IDT meeting and that IDTs have the information needed to assess risk and develop supports based on recommendations from those assessments. • Ensuring that the facility took an interdisciplinary approach to identifying and addressing risks. The section I lead had met with each discipline department head to review the risk assessment process. While this was in the beginning stages, the monitoring team saw evidence that the section I lead was encouraging input from other department leads during a meeting held with the monitoring team to discuss the risk process. All department leads were present at the meeting and engaged in good discussion regarding how the departments could work together to identify when individual's experienced a change of status. • QIDPs and nursing staff had received additional training on developing	Noncompliance

#	Provision	Assessment of Status	Compliance
		measurable action steps in the IHCPs. The facility continued to train DSPs on identified risks for individuals and how to implement supports to address those risks. Priority had been placed on ensuring that staff received competency based training on mealtime supports and PNMPs. The monitoring team observed two IDT meetings. Progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). At the IDT meetings observed, each discipline presented relevant information during the risk determination process. In most cases, the IDTs agreed to continue supports that were already in place to address risks, even when data indicated that the supports had not been effective. The IDT for Individual #331 engaged in a fairly comprehensive discussion regarding her medical risks, even noting when one risk might impact another. For example, the IDT discussed how her risk for polypharmacy might impact her risk for constipation. This was good to see, however, the team did not relate supports developed to address risks to her preferences and to assisting her to meaningfully participate in programming. For example, the team identified her behavioral risk and acknowledged that those risks impacted her ability to participate in programming based on her preferences (i.e., live in the community). The team then agreed that behavioral supports were adequate and made little revision to supports. Similarly, Individual #354's IDT acknowledged that his health risks prevented him from meaningfully participating in programming. The IDT continued most of his health supports that were in place without considering what supports might increase his participation in activities based on his preferences, such as attending church or participating in community activities. 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. The facility was tracking submission of assessments by discipline. The submission of assessments was a barrier to accurately identifying risks and support needs for individuals. Data submitted by the facility indicated that all disciplines were not routinely completing IRRF assessments prior to annual ISP meetings. The table below shows the overall percentage of assessments submitted 10 days prior to the risk discussion July 2013 through November 2013. Discipline specific data can be found in section F of this report. July: 68%; August: 66%; September: 69%; October: 69%; November: 67%	

#	Provision	Assessment of Status	Compliance
		A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample included Individual #194, Individual #55, Individual #183, Individual #271, Individual #338, Individual #57, Individual #267, Individual #99, Individual #77, Individual #251, Individual #328, Individual #58, and Individual #217. Zero (0%) of three individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess 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. Based on a review of 12 records, of which 11 had completed nursing assessments, IRRFs and, IHCPs, eight of 11 (73%) included sufficient Annual/Quarterly Comprehensive Nursing assessments to assist the team in developing appropriate plans sufficient to meet the individual's health care needs. In order to mitigate risk prior to a significant event or change in status, IDTs should carefully consider all risk indicators and conservatively assign risk ratings with the intent of implementing supports to minimize risks before an adverse outcome or change in status occurs.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., updates only) for this subsection because the facility had made limited progress due to the decision to prioritize other subsections. The noncompliance finding from the last review stands. 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. As noted in section F, data were often not consistently reviewed. This raised the question of whether or not IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. The facility did not yet have an adequate system in place to identify when an individual experienced a change in status unless the change resulted in a serious incident (i.e., hospitalization). It will be important for the facility to develop thresholds that will alert the IDT to consider a change in status prior to a critical incident occurring.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility was tracking when the IDT met following hospitalizations and ER visits. IDTs were still not consistently meeting within five days to review supports following hospitalizations. Unit directors had recently been assigned responsibility for tracking change of status meetings through the morning unit meetings. Information was shared daily at both the unit morning meetings and the clinical services meeting that might trigger discussion regarding whether or not a change of status has occurred for an individual. The facility should establish a protocol for capturing this information and alerting the IDT that a change of status may have occurred.</td><td></td></tr>
<tr><td>I3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands.

According to data provided to the monitoring team, plans were in place to address risks for all individuals designated as high or medium risk in specific areas, however, the team was struggling with the timely implementation of plans following development. The following table shows findings from the facility's self-assessment regarding timely completion of IRRFs and IHCPs following the team meeting to discuss risk from 7/1/13 through 11/31/13.

<table>
<tr><td>2013</td><td>July</td><td>August</td><td>September</td><td>October</td><td>November</td></tr>
<tr><td>IRRF</td><td>73%</td><td>75%</td><td>80%</td><td>71%</td><td>11%</td></tr>
<tr><td>IHCP</td><td>7%</td><td>50%</td><td>62%</td><td>63%</td><td>55%</td></tr>
</table>

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., monitor weights weekly, 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:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		1. Develop action plans with measurable criteria for assessing outcomes. 2. Document the implementation of action plans. 3. Document that clinical data is gathered and reviewed at least monthly. 4. 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 was 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 For the past six months, minutes from the committee that addressed polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 <u>newly prescribed</u> 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 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 Any psychiatry peer review o List of all individuals with a completed CPE o Data regarding Clozaril prescriptions for the previous six months: date of CBC, date medication dispensed, submission to the Clozaril registry. o All data presented, doctor's notes and documentation for Dr. Crowley's clinic 2/18/14 regarding Individual #329 and Individual #70. o Minutes of the Medical Review Committee for the previous six months. o All data presented, doctor's notes and documentation fro Dr. Manshardt's clinic on 2/17/14 regarding Individual #367 and Individual #263. On 2/19/14 regarding Individual #37. On 2/20/14 regarding Individual #279 and Individual #376. o Chemical restraint spreadsheet for the monitoring period. o Assessment for medical/dental pretreatment sedation spreadsheet. o Cumulative Data Comparison Summary for February 2014 o Psychiatry time allowance o These following documents for these individuals: Individual #76, Individual #196, Individual #329, Individual #346, Individual #354, Individual 201, Individual #35, and Individual #100 • 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) • Pharmacy section (for the last six months) • Consent section for pretreatment sedation (for the last six months) <u>Observations Conducted</u>: o Psychiatry clinic conducted by Dr. Crowley o Psychiatry clinics conducted by Dr. Manshardt o Polypharmacy Committee meeting o Pharmacy and Therapeutics Committee meeting o Daily Provider meeting o Medication Review Committee meeting o DNR review meeting o QA/QI meeting o Risk Discussion o Positive Behavior Support Plan Committee meeting

	Interviews and Meetings Held: o Trina Cormack, M.D., Psychiatry Department Head o Jennifer Quisenberry, psychiatry assistant o NiNi Swe, M.D., facility psychiatrist o John Crowley, M.D., facility psychiatrist o Stanley X. Cal, M.D., Medical Director o Roy Guevara, R.N., facility psychiatry nurse o Dana Robertson, MS. POI Coordinator with John Church, MA, M.Ed., Assistant Director of Behavioral Health Services o Todd Walker, DDS, Dental Director with Belinda Lendermon, RDH, Sierra McCutchen, DA, and Lisa Willingham RDH o Janis A. Rizzo, R.Ph., pharmacy director with Sara Dempsey, Pharm. D. and Isaac Pan, Pharm. D. o Misty Mendez, SAC o Angela Garner, RN, BSN, Chief Nurse Executive o Lynn Zaruba, BCBA, LPA, behavioral health clinical supervisor
	Facility Self-Assessment: SGSSLC submitted documentation regarding section J for the self-assessment dated 12/1/13 that yielded the results of statewide self- monitoring tools. As outlined in the ensuing report, there were areas where the data collected failed to capture the relevant information required for an accurate self-assessment. In addition, there were areas where data provided via the facility self-assessment did not agree with than provided via other data sources (e.g., the Cumulative Data Comparison Summary). 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. 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 provided the majority of the update for section J to the monitoring team because the previous facility lead psychiatrist had left the facility in December 2013. 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., new lead psychiatrist, facility psychiatrists, psychiatry assistant, and psychiatric nursing staff), the need for improved integration with other disciplines 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 for continuing to proceed in the right direction in the absence of a lead psychiatrist.
	Summary of Monitor's Assessment: SGSSLC was found to be in substantial compliance with one of the items in this section of the Settlement Agreement. Since the last monitoring visit, there had been challenges due to a turnover in psychiatric clinic staff. The facility lead psychiatrist had left the facility and current services were being provided via locum tenens physicians. The facility had recruited two new full time psychiatrists, one designated as the lead. Both of these providers were in orientation at the time of this monitoring visit. In addition, the facility had retained the services of a child and adolescent psychiatrist 12 hours per month. At the time of this monitoring visit, 81% of the facility population, or 177 individuals were receiving services via psychiatry clinic. The monitoring team observed four psychiatric clinics. Per interviews with psychiatrists and behavioral health staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was some participation in the discussion and collaboration between the disciplines (psychiatry, behavioral health services, nursing, QIDP, direct care staff, and the individual). There were, however, areas in need of improvement. Psychiatric clinicians must utilize data available to them in order to make medication decisions, and if data provided were not applicable to the review, they must work with the IDT to ensure that appropriate target symptoms are identified and defined for monitoring. A review of psychiatric documentation revealed ongoing deficiencies with regard to timeliness of quarterly psychiatric medication reviews. 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 behavioral health 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. In discussions with the director of behavioral health, dental director, and medical staff, the need for improved integration was identified. Most provision items in this section rely on collaboration with other disciplines. The different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT. Behavioral health could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The physician was not reliably provided appropriate data in order to make decisions regarding pharmacology and, per a review of records, made medication additions or adjustments in the absence of data regarding specific clinical indicators associated with the individual's psychiatric disorder. In order for psychiatry to meet the requirements of the Settlement Agreement, the department will need the ongoing support of facility administration and the leadership of related disciplines. During some of the clinical encounters observed, there were reports that some individuals were experiencing increased behavioral challenges. These were opportunities for psychiatry and behavioral health to work together to develop non-pharmacological interventions for specific individuals, but the IDT did not concentrate on this during the clinics observed or in the documentation reviewed. It was time to expand this vital area of clinical intervention to include identification and implementation of non-pharmacological regimens that would be beneficial to the individual instead of a generic plan. The monitoring team similarly identified paucity of combined assessment and case formulation as evidenced by the fact that only 34% of comprehensive psychiatric evaluations per Appendix B had been completed. Due to the inadequate number of psychiatric assessments completed, the quality of diagnostics and justification for treatment with medication evidenced deficiencies. This task was likely hindered by a lack of consistent 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 via interpretation of the presenting symptoms, and intervention to take place by the IDT. In regard to J4, the facility must ensure that following the pretreatment sedation review, a consensus is obtained with regard to the administration of a particular medication, 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 facility had authored policy regarding administration and referral following a positive Reiss screen.

	This policy was pending final approval for implementation. Data provided regarding the completion of the Reiss screens were confusing and should be reviewed by the facility to ensure the consistency of information provided via various sources (e.g., self-assessment, cumulative data review, and the document request). 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 behavioral health could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, and collaboration regarding case formulation). SGSSLC had instituted a monthly polypharmacy meeting, however, this meeting was chaired by psychiatry clinic. This was not appropriate, as it was not appropriate for psychiatry chair a meeting regarding a review of their prescribing practices. The responsibility for the organization of this meeting should be housed in the pharmacy. In addition, the psychiatric providers had not begun authoring clinical polypharmacy justifications for review. 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 facility made progress in the area of informed consent, but remained in noncompliance with J14 due to the lack of completed informed consent documents. The psychiatry department was now responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. There were issues identified with the review of CBC results, dispensing of Clozaril, and reports to the Clozaril registry by the facility. Although data were requested in an effort to determine the accuracy of this process, data provided were not adequate to make the assessment. It was concerning that the facility staff reported that the psychiatric nurse was responsible for making reports to the Clozaril registry regarding CBC results. This should be a function of pharmacy, such that these results are reviewed by them prior to the dispensing of further medication.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> 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. The facility had retained the services of a new lead psychiatrist who began work during the week of this monitoring review. In addition, the facility had retained the services of a board certified child and adolescent psychiatrist 12 hours per month to provide care for youth, particularly under the age of 14 and/or prescribed polypharmacy with complex psychiatric	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		conditions. As such, the professionals were qualified. Experience The facility had experienced turnover in the psychiatry department, and for approximately three months of this monitoring period, had relied on locum tenens providers to perform clinical duties. One full time provider had 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, the previous lead psychiatrist, who left the facility in December 2013, had 20 years of experience providing care for individuals with developmental disabilities in the MHMR programs in the state of Texas. Information regarding the experience of two recently hired full time providers was submitted and showed that both had experience providing mental health services to individuals with developmental disabilities. 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 in agreement with the facility self-assessment. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5.	
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, 177 of the census of 217 individuals received psychopharmacologic intervention at the time of this onsite review. The facility continued to struggle with the completion of the evaluations completed in Appendix B format. Per the Cumulative Data Comparison Summary for February 2014, a total of 61 individuals had a current CPA completed. Of these, 29 were completed in the intervening period since 12/31/13. Interviews indicated that the delays in completing CPAs was due primarily to the lack of psychiatric staffing and frequent turnover in the psychiatry department (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 and diagnostic concordance, 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 annual medical review, ISP, PBSP). Per an "Active Record Diagnosis Audit" where in the months of November 2013 and December 2013 audits of 63 health records were performed: • In 30% of the records, diagnostic concordance was present between documents	Noncompliance

#	Provision	Assessment of Status	Compliance
		(i.e., History & Physical (H & P), Active Problem List, (APL) and Psychiatry) • In 59% of the records, psychiatric diagnoses differed from those documented in the H & P and the APL. There were additional concerns noted in some clinic observations. For example, during the psychiatry clinic for Individual #37, the team met for approximately one hour, discussing this individual's history, diagnosis, and treatment from an anecdotal perspective. It was concerning that a CPA had been completed the week prior, but this information was not reviewed by the psychiatrists participating in the clinic. Furthermore, the psychiatrists began discussing plans to revise this individual's medication regimen without reviewing the CPA, reviewing data provided by the behavioral health staff, and without interviewing the individual. They were prompted by the monitoring team to review the CPA, however, they only reviewed it in cursorily. They were prompted by the monitoring team to meet with the individual prior to making adjustments to the medication regimen, and they did so. In other clinics observed, 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 generally available, but rarely discussed in the clinic setting until inquiry by the monitoring team about all data available to the psychiatrist. The psychiatry team had not guided the behavioral health staff 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 behavioral health 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 13 records revealed varying content in their completeness. Given the paucity of completed CPA documents, it was difficult to determine diagnostic accuracy. If diagnostics are not appropriately addressed in a clinically justifiable manner, the other provisions, such as polypharmacy regimens, will not be successfully addressed. <u>Tracking Diagnoses and Updates</u> The psychiatry department implemented a database to track diagnoses and capture diagnostic updates. For example, a numbered spreadsheet of individuals prescribed psychotropic medication listing Axis I, II, and III diagnoses was provided with dates of clinical contact.	

#	Provision	Assessment of Status	Compliance
		The psychiatry department indicated that they were behind with regard to the completion of quarterly psychiatric medication reviews (QPMR). Staff indicated this was due to the recent push to complete some CPA documents. Given the data provided, it was noted that there were a number of individuals who were last seen in psychiatry clinic for a quarterly review in May 2013. A graph of monthly data showed the number of required reviews and the number that were completed. The data showed what the staff reported. 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. <u>Monitoring Team's Compliance Rating</u> 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 in agreement with the facility 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. 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 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). 2. The facility could schedule CPA reviews in lieu of a quarterly psychiatric clinic. 3. Focus on the completion of CPA documents and utilize this information in clinical decision making.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as	<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. Per the Cumulative Data Comparison Summary for February 2014, of the 176 individuals receiving psychiatric treatment at the time this	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	document was authored, six did not require a PBSP. For another three individuals, the PBSP was in the process of development. One individual's PBSP was out of date and required an update. It was reported that psychiatry was not involved in the development of the PBSP for individual's participating in psychiatry clinic. For additional information regarding the quality of the PBSP documents, see section K. Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. Per the review of 13 records, all had diagnoses noted in the record. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. Given the team approach to psychiatry clinic that was utilized throughout the facility, behavioral health representatives and other staff disciplines were present at clinic. It will be important for collaboration to improve between behavioral health and psychiatry in regard to case formulation, in the joint determination of target symptoms and descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. It will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary, inclusive of behavioral data and, in the process, generate a hypothesis regarding behavioral-pharmacological interventions for each individual. In addition, it can serve as a forum to discuss strategies to reduce the use of emergency medications. It is also imperative that this information is documented in the individual's record in a timely manner. <u>Emergency use of psychotropic medications</u> Data provided via the document request indicated that from 6/1/13 through 11/30/13 (six months) there were a total of 75 episodes of chemical restraints. This was a decrease of 29 restraints compared to the previous monitoring period when there were 105 chemical restraints. Additional data provided via the Cumulative Data Comparison Summary for February 2014 revealed that in the period between 6/1/13 and 1/31/14 (eight months) there were a total of 98 episodes of chemical restraints administered to a total of 29 individuals. Of these, all were noted to have an active PBSP. As per policy, an IDT meeting should occur for any individual that accrues more than three of any type of restraint within any rolling 30-day period (see section C7). • Of the 29 individuals, there were IDT meetings held for seven individuals (24%). Documentation did not indicate if additional individuals should have had an IDT meeting.	

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		• It was documented that no members of the psychiatry clinic attended any of these post chemical restraint IDT meetings. 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. Documentation regarding post chemical restraint clinical review was requested. Three examples were provided. Of these, the review regarding Individual #185 was blank. The review regarding Individual #329 indicated that three medications (Haldol, Ativan, and Benadryl) were ordered, however, only Haldol and Ativan were available, so these medications were administered. There was question whether Benadryl, administered 30 minutes later, was necessary because documentation indicated that the individual was calm. Furthermore, the use of multiple agents as a chemical restraint is risky. Individual #38 received IM injections of both Haldol and Zyprexa (two antipsychotic medications) on four occasions. Use of these two medications may increase the blood levels or add to the side effects associated with either medication. This can result in increased sedation, agitation, or an increased risk of movement disorders. Of the 98 chemical restraint episodes outlined via the document request, 16 incidents involved the use of two medications and 10 incidents involved the use of three medications. This use of multiple medications in the course of a chemical restraint is concerning because these emergency medications, in addition to the individual's prescribed medication regimen, can result in drug-drug interactions and severe sedation. <u>Monitoring Team's Compliance Rating</u> Given the deficiencies outlined above, this provision will remain in noncompliance in agreement with the facility 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. 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. 2. The different departments (i.e., nursing, pharmacy, medical, behavioral health, psychiatry) must communicate with one another for addressing the utilization of restrictive measures (i.e., emergency chemical restraints) to allow for appropriate	

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		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. o Reconsider the utilization of multiple agents in the chemical restraint process.	
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 revised 11/26/13 included Attachments, such as the "Pretreatment Sedation Notification Form" and the Systematic 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 behavioral health specialist 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. While this information was useful, there was no documentation of the consensus decision regarding the utilization of a particular medication for a particular individual. This should be done via the IDT and documented on the form. • Per the facility self-assessment, between the months of June 2013 and November 2013, there were 33 pretreatment sedations scheduled. There were, however, only six (18%) "Pretreatment Sedation Notification Forms" completed. • Per the Cumulative Data Comparison Summary for February 2014, 67 medical or dental sedations occurred over the previous seven months, a 46% increase from the previous monitoring visit. 53 of these individuals received only pretreatment sedation. Eleven of these individuals received TIVA. For those individuals who received pretreatment sedation, it was noted that the pre-sedation consultation was only completed in seven instances. <u>Extent of Pretreatment Sedation</u> The facility data regarding the extent of pretreatment sedation were confusing. For example, via the document request, a listing of all individuals receiving pretreatment sedation, including TIVA, was provided. Per this list, between 6/12/13 and 11/25/13 there were a total of 45 sedation episodes, nine of these were noted as TIVA. For the remaining 36 instances, 33 were documented as medical pretreatment sedation and three were noted as dental pretreatment sedation. The document noted that 39 (86%) of the individuals	Noncompliance

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		receiving pretreatment sedation or TIVA were participating in psychiatry clinic. These data were in conflict with the Cumulative Data Comparison Summary for February 2014, which noted a total of 67 pretreatment sedation episodes, with none of these utilized for medical procedures. In order to correctly evaluate the extent of pretreatment sedation utilized at SGSSLC, the data must be consistent and accurate. It will be necessary to compile an accurate listing 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 information should then inform the Cumulative Data Comparison Summary and the facility self-assessment. <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. • Between the months of June 2013 and November 2013 there were a total of 33 pretreatment sedations scheduled. There were however, reportedly only six (18%) "Pretreatment Sedation Notification Forms" completed. This must be addressed because most of the individuals who received pretreatment sedation were also prescribed psychotropic medication. • In addition, as discussed above, the current review process performed prior to the administration of pretreatment sedation did not include a consensus review where the IDT reviewed the information and made a determination with regard to the use of additional medication. 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 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>Monitoring After Pretreatment Sedation</u> A review of documentation for 10 individuals regarding the nursing follow-up and monitoring following administration of pretreatment sedation revealed that, per protocols,	

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		nursing did document review of the vital signs and assessment following TIVA and other pretreatment sedation administration, however, nurses followed the post-sedation protocols rather than the anesthesia protocols (see section Q1). Other Strategies (i.e., Behavioral Rehearsal Plan, Desensitization Plan) 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. Per the Cumulative Data Comparison Summary for February 2014, between June 2013 and January 2013, there were a total of eight individuals referred for an assessment for dental or medical desensitization plans/strategies. Conflicting data were provided in the facility self-assessment, where it was noted that between June 2013 and November 2013, 23 individuals were assessed for dental or medical desensitization plans/strategies. Per the document request, there was one individual with a dental desensitization plan, implemented 8/5/13. The facility self-assessment indicated that of the 23 individuals referred for an assessment regarding the need for a desensitization plan/strategies, eight individuals required a plan/strategies, and eight were implemented. Again, these data were confusing and did not allow for an accurate review. In the documents received, there were one desensitization plan and nine behavioral rehearsal plans currently implemented. Review of these plans revealed that while the desensitization plan was implemented in August 2013, eight of the behavioral rehearsal plans provided were authored in 2012 and revised in February 2013, approximately one year prior to this review. Monitoring Team's Compliance Rating Given the challenges noted above, this provision will remain in noncompliance in agreement with the facility 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. Improve the accuracy of the data collection process for this provision. 2. Ensure that the pretreatment sedation review by the IDT is performed for all individuals requiring pretreatment sedation. 3. Ensure that a consensus opinion regarding the use of pretreatment sedation is both obtained and documented. 4. Ensure that individuals requiring pretreatment sedation are assessed to determine the need for desensitization plans and/or other types of strategies to reduce the need for pretreatment sedation.	

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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 81.5% of the census received psychopharmacological intervention at SGSSLC as of 2/17/14, which was a four percent increase since last review. Of these, eight individuals were younger than 18 years of age (one individual was 12 years old). This was an increase over the previous monitoring period where there were only two individuals younger than 18 years of age. The facility indicated, via the cumulative data comparison summary for February 2014, that there was a 3% increase in the number of individuals receiving psychopharmacological intervention over the course of the period between August 2013 and February 2014. Over the course of the prior seven months, there were a total of 24 admissions to the facility, and all were admitted with psychotropic medications included in their medication regimens. The psychiatry department had a full time lead board certified general psychiatrist who began work at the facility during the week of this monitoring visit. A second full time board eligible general psychiatrist had been hired and was in the process of facility orientation. During the period of facility orientation by the above two providers and one general psychiatric on extended leave, the facility had relied upon locum tenens providers (one board eligible general psychiatrist full time, one board eligible general psychiatrist 10-20 hours per week). In addition, the facility had retained the services of a board certified child and adolescent psychiatrist, who provided services 12 hours per month. 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. Three FTE psychiatrists would include enough time for the completion of the Appendix B comprehensive assessments, quarterly reviews, attendance 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 an asset to the psychiatry department and provided information for section J during this visit because the previously designated lead psychiatrist had left the facility and the new lead psychiatrist had assumed work	Noncompliance

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		during this monitoring visit. She worked very well with the psychiatrists, medical staff, and other disciplines. <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. <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of noncompliance in the self-assessment for this item 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 with the new lead psychiatrist, the anticipated return of a full time psychiatrist, the recruitment of a third full time psychiatrist, and contracting with a board certified child and adolescent psychiatrist.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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	<u>Reiss Screen Upon Admission</u> 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 facility had developed policy and procedure entitled, "Reiss Screen for Maladaptive Behavior and Reiss Scales for Children's Dual Diagnosis Protocol," revised 1/30/14. Per the documentation, this policy had no date of approval. The psychology department had taken over the responsibility of administration of Reiss screens as of 1/1/14. The psychiatry and psychology departments must share this vital	Noncompliance

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	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.	information as part of the functional assessment process 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., in the comprehensive functional assessment and/or in the ISP document). The monitoring team was informed there were 20 new facility admissions from June 2013 through November 2013. Of these, it was noted that all were administered the Reiss Screen. Other data indicated that during the monitoring period (dates not provided) there were a total of 19 new admissions to the facility. It was noted that 17 of these individuals received a Reiss screen. In the case of Individual #162, the Reiss screen was not performed because "she was readmitted only three months after community placement." In the case of Individual #227 the Reiss screen was not yet due at the time the data were compiled. For both data sets, it was not possible to determine if a CPE was performed following a positive screen. In order to calculate the percentage in regard to the timeliness of the completion of the Reiss screens, the data requested via the document request outlined the name of the individual, date of admission, and date of the completed Reiss. As data were not presented in this manner, it was not possible to determine if the Reiss screen was performed in timely manner following admission. The cumulative data summary from February 2014 indicated that in 91% of admissions, the Reiss screen was performed within 30 days of admission. It also noted that in 33% of cases, the CPA was performed. This was, however in conflict with data provided via the facility self-assessment where it was noted that for individuals with positive Reiss screens between June 2013 and November 2013, there were a total of 14 positive Reiss screens, but no CPA completed. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The cumulative data summary from February 2014 indicated "current residents requiring Reiss screens" totaled 25 and that 24 had been completed. The facility self-assessment indicated that for the months of June 2013 through November 2013, there were an average of 42.8 individuals at the facility who were not receiving psychiatric services and would be required to have a baseline Reiss screen administered. The data revealed that, of these, a	

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		total of 12 Reiss screens had been completed. As evidenced above, data provided regarding Reiss screen completion and referral/completion of the CPA following the Reiss screening were confusing, with different data accessed via the facility self-assessment, the cumulative data summary from February 2014, and the document request. <u>Reiss Screen for Change in Status</u> There must be a rescreen if there is a change in status. If the screen so indicated, a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) was to then be attained and completed in a clinically justifiable manner. Nine individuals required a Reiss screen for change in status and the facility completed these screens. There was, however, no specific process for determining when a change in status should result in a Reiss screen being implemented. There were no completed psychiatric assessments for these nine individuals because there were "none needed." The facility self-assessment indicated that between June 2013 and November 2013 a total of 27 individuals were referred for a CPA. Of these, only two were completed. Consideration should be given to reasonable timelines for referral and completion of a CPA following a positive Reiss screen (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> Given the deficiencies outlined above, this provision will remain in noncompliance in agreement with the facility 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. The facility must improve data collection to ensure that all individuals requiring a baseline Reiss screen receive one. 2. The facility should review and finalize policy and procedure regarding administration of and response to Reiss screen data.	
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	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

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	other interventions through combined assessment and case formulation.		
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Per the facility self-assessment, this provision was not in substantial compliance because "improvement is needed in regards to completing comprehensive assessments, including multidisciplinary information pertaining to alternative non-pharmacological treatment interventions, or supports and implementing information to the IDT and documented in the ISP." The monitoring team identified deficiencies 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. The dual description of the behavior as being 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. For example, in the case of Individual #196, target behaviors were delineated as physical aggression, verbal aggression, unauthorized departure, and unfounded allegations of abuse/neglect. This individual was prescribed psychotropic medications including Valproic Acid (a mood stabilizer), Clonazepam (an anxiolytic), and Invega Sustenna (an atypical antipsychotic). Diagnoses included Oppositional Defiant Disorder, and rule out Bipolar Mood Disorder. This was confusing because the medications in the regimen are not indicated for the treatment of Oppositional Defiant Disorder, but rather for Bipolar Mood Disorder. The target symptoms outlined in the medication consent forms for these medications included anxiety, psychosis, and mood stabilization. These target symptoms/behaviors were not being tracked via data collection processes, therefore, it would be impossible to make data driven decisions regarding the efficacy of these agents. The review of the sample of records for 13 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 maintained by environment/operant factors. The differentiation of the maladaptive behaviors with which the individual presented were	Noncompliance

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		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 were (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 decreased (if not eliminated) the risk of psychotropic medication being inappropriately utilized to suppress learned behavior. In a corollary manner, it also assisted in ensuring the least intrusive and most positive interventions were used to address the individual's challenging behaviors. <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 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 data regarding psychiatric participation in the ISP meetings were confusing. For example, it was reported, "psychiatry has attended three ISPAs…since June 2013…it is unknown how many the department may have been requested to attend." The facility data indicated that over the previous eight months, psychiatry attended 34% of ISP meetings. A review of ISP attendance tracking for the months of June 2013 through January 2014 revealed that of a total of 149 ISP meetings, psychiatry attended 15 (10%). Again, data were confusing, as in some designated ISP meetings, no attendance data were included. In addition, there were ISP meetings where psychiatry attendance was noted as NA even though the individual was participating in psychiatry clinic (i.e., indicating that psychiatry should have been a participating member of the ISP). The lack of psychiatric participation in the PBSP and ISP process negatively affected the decision-making process in regard to recommendations of other less intrusive measures, diagnostics, and indications for utilization of psychotropic medication. <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	

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		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 (see the example regarding Individual #196 above). The monitoring team provided information in previous reports encouraging the psychiatrist to meet with the IDT <u>before</u> a proposed PBSP for individuals receiving psychiatric care is implemented. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> During the psychiatric clinics observed, the psychiatric staff and IDT engaged in some discussion of non-pharmacological interventions provided to the individuals (e.g., activities, outings, personal preferences). This process needs to improve and become integrated into both documentation and practice. <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item therefore remained in noncompliance, in agreement with the facility self-assessment.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Policy and Procedure</u> The SSLC statewide policy and procedure for psychiatric services, updated 5/1/13 and implemented 7/1/13, included the exact language from the Settlement Agreement J10. 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 was in noncompliance because "improvement is needed in regards to completing multidisciplinary information reviews pertaining to risk-benefit of an individual's mental illness vs. medication and nonpharmacological treatment or interventions with the IDT. In addition, there are also elements that have not yet been implemented." Furthermore, the facility self-assessment indicated that for this monitoring period, record review regarding the quality of the	Noncompliance

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		risk/benefit analysis documentation was not performed. <u>Quality of Risk-Benefit Analysis</u> 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 (see J14). This transition was completed on 3/10/13 for all of the new psychotropic medications prescribed. The informed consent explanation for the use of psychoactive medication form had a section to outline the expected risks of medication versus 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 specific psychotropic medications that the individual received (e.g., Divalproex, Zyprexa, Seroquel), which had the potential to cause, contribute to, 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 an evidence-based approach that was in line with the psychiatric condition, or if simplification (e.g., one dose reduction) of at least one medication was necessary. Example of risk-benefit analysis: • The consent for Individual #227 for Valproic Acid in order to address mood instability indicated the risk/benefit analysis for this medication as "the risk of illness is thought to be greater than the risk of medication. She has a history of mood instability manifested by hostility, refusing to take prescribed psychiatric medications, bizarre behavior and unusual thought content." Per this individual's medical record, she had a history of medical conditions, including obesity, diabetes mellitus, and Hepatitis C. This document did not include side effect information regarding hepatotoxic side effects associated with Valproic Acid. This would be concerning given this individual's history of Hepatitis C. It was also noted that this individual was prescribed Metformin (a medication to address diabetes). This medication has known hepatic side effects. The risk/benefit analysis should discuss if the risk of taking this particular medication would be outweighed by the benefit. 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	

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		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. 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, and psychopharmacology for all individuals prescribed psychotropic medication were appropriate. • Utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with behavioral intervention. • 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, behavioral health specialist, 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. <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 side effects for a medication. For example, if an individual had problems with being	

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		overweight, was diabetic, hypertensive, s/p cerebrovascular accident, was elderly, and had hyperlipidemia, the psychiatrist would have to factor in these 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, considers potential interactions with other prescribed medications, considers other health conditions the individual may have, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the IDT, but did not thoroughly outline findings in the documentation in the records reviewed in the form of a risk-benefit analysis. The QPMRs listed a number of pertinent findings from various disciplines, but the psychiatrist will need to process the information and then decide risk-benefit and treatment decisions based on the data provided. This should be an ongoing process and not accomplished in only one clinic setting. <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 individual 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	<u>Facility-Level Review System</u> Staff interviews and documentation indicated that the facility had been conducting a polypharmacy meeting on a monthly basis. Data provided via the facility self-assessment indicated that, from June 2013 through November 2013, there was no documentation of justification for specific medication regimens that met the criteria for polypharmacy.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The monitoring team attended the polypharmacy meeting that was conducted during the monitoring visit. Currently, this meeting was the responsibility of the psychiatry department. It was discussed with staff that this facility level review should be the responsibility of pharmacy because it was inappropriate for psychiatry to review themselves. While the psychiatry assistant's attempt to maintain the integrity of the committee in the absence of a lead psychiatrist was laudable, the meeting was more of a clinical review of the individual's case, not a review of the justification for a particular regimen. The meeting was attended by numerous staff (i.e., pharmacy staff, lead psychiatrist, psychiatric assistant, medical director, 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 polypharmacy over time. This process resulted in the facility (and the monitoring team) being unable to review trends of the percentage of individuals prescribed this type of regimen. In addition, the manner in which data were provided did not allow for a determination of what medication classes an individual was prescribed that met criteria for polypharmacy (e.g., was the individual prescribed two or more medications from the same class, were medications utilized for both seizures and mental health disorders included). Data, however, nicely outlined the names of individuals who received three medications, four medications, five medications, and so on. Per a review of the data provided, during the onsite visit that 97 out of 177 individuals (54%) who were enrolled in psychiatry clinic received psychotropic polypharmacy. This compared with 88 out of 166 individuals in August 2013 (49%), 167 individuals prescribed polypharmacy in August 2012 (this number, however, was due to incorrect implementation of the polypharmacy definition by the facility), and 56 individuals prescribed in May 2012. It was imperative for the facility to have detailed data regarding facility-level review of the prescription of intraclass and interclass polypharmacy. 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. The pharmacy department should be knowledgeable about the	

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		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 #148), 19 received five, 33 received four, and 38 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 frequent staff changes in psychiatry and supporting individuals with complex psychiatric profiles. <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. The practice pattern of unjustified polypharmacy regimens will continue without establishing an evidence-based practice by the psychiatric team. 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. At the time of this monitoring review, comprehensive justifications of medication regimens that met the criteria for polypharmacy were not being authored by prescribers. <u>Monitoring Team's Compliance Rating</u> The facility continued to struggle in addressing this provision item therefore remained in noncompliance in agreement with the facility self-assessment. To move in the direction of	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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 of polypharmacy regimens chaired by pharmacy staff to monitor at least monthly, the polypharmacy trends, aggregate data, prescribing practices, and justification for the psychotropic medication regimens prescribed.</td><td></td></tr>
<tr><td>J12</td><td>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.</td><td><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>
Per the DISCUS tracking for June 2013 through January 2014, it was noted that generally, these assessments were performed during the month they were due:
<table>
<tr><th>Month</th><th>Number Due</th><th>Number Completed</th></tr>
<tr><td>July 2013</td><td>42</td><td>42</td></tr>
<tr><td>August 2013</td><td>45</td><td>44</td></tr>
<tr><td>September 2013</td><td>69</td><td>63</td></tr>
<tr><td>October 2013</td><td>47</td><td>47</td></tr>
<tr><td>November 2013</td><td>62</td><td>61</td></tr>
<tr><td>December 2013</td><td>62</td><td>62</td></tr>
<tr><td>January 2014</td><td>50</td><td>50</td></tr>
</table>
MOSES tracking data were presented differently, it was difficult to determine the timeliness of completion for these assessments. In addition, 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 is discovered.

The facility provided a completion ratio of individuals who had been evaluated with the MOSES and DISCUS in graph format from June 2013-November 2013:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Month	Percentage of MOSES Completed	Percentage of DISCUS Completed
June 2013	100%	100%
July 2013	100%	100%
August 2013	97%	98%
September 2013	100%	100%
October 2013	100%	100%
November 2013	87%	92%

There were discrepancies noted in these data. For example, the previous table indicated that for the month of November 2013, 61 of a total of 62 DISCUS examinations were performed (98%). The table above indicated that 92% of DISCUS examinations were performed.

Additional data provided by the facility self-assessment indicated that for the months of October 2013 and November 2013, there were deficits in the number of MOSES and DISCUS assessments reviewed by psychiatry and signed in a timely manner:

Month	Number of MOSES/DISCUS due	Number reviewed and signed by psychiatrist	Percentage signed in a timely manner by psychiatry
October 2013	87	52	7.5%
November 2013	80	13	6.4%

Psychiatry must review the above data sets and develop processes to ensure that MOSES and DISCUS assessments are performed in a timely manner and that the treating psychiatrist reviews them in a timely manner.

Since the last monitoring report, the facility implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS results, can be stored. In order to complete the clinical correlation section of the MOSES and DISCUS and electronically sign the document, the physicians must log onto Avatar. Then, once completed electronically, the document will print with all the necessary sections. It was reported that the facility had revised the policy and procedure regarding MOSES and DISCUS assessments to include the process for the completion of the assessment in the Avatar system. Policy and procedure documents provided included "DISCUS-Monitoring of Medication Side Effects and Tardive Dyskinesia" was updated 9/22/11 and did not include Avatar requirements. A second policy, "MOSES-Monitoring of Side Effects" was updated 4/26/11 and did not include Avatar requirements.

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		Three individuals were prescribed Reglan (Metoclopramide). Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. These three individuals did not have a diagnosis of TD. During June 2013 to January 2014: • Individual #287 received Reglan, but had no administration of the DISCUS documented. • Individual #85 received Reglan, but had only one DISCUS administered on 6/17/13. • Individual #217 received Reglan, but had only one DISCUS administered on 9/4/13. <u>Training</u> Documentation provided by nursing 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 15 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." It was noted that all of these individuals had monitoring via the DISCUS within the previous four months. Data provided did not include scoring history for the assessment scales, therefore, it was not possible to determine if the identified individuals had experienced increased symptoms over time. The facility did not provide adequate history about prior neuroleptic history in the completion of the rating scales or in the records of most of the individuals. 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	

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		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 in agreement with the facility 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. The timely administration of the standard assessment tools, timely psychiatric review of the 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 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	<u>Policy and Procedure</u> SGSSLC facility-specific policy and procedure "Psychiatric Services" 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 for 13 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 facility reported that 100% of individuals enrolled in psychiatry clinic had a treatment plan. The monitoring team reviewed the records for 13 individuals and reviewed data	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	provided by the facility with regard to the most recent quarterly psychiatry clinic held for each individual participating in psychiatry clinic and discovered there had not been timely psychiatric consultations (J2). Four of the records reviewed had their last quarterly review prior to 9/1/13. Review of the data provided by the facility showed numerous instances in which the last psychiatric clinic for an individual exceeded three months, indicating that individuals were not seen in clinic on at least a quarterly basis. 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. For example, Individual #63 was prescribed two antipsychotic medications, one of which was a long acting depot medication. This individual was last seen for a quarterly psychiatry clinic in May 2013. Individual #244 was prescribed Depakote ER, Clonidine, and Zyprexa. This individual was last seen for a quarterly psychiatric clinic in July 2013. Based on the psychiatry database, these and other individuals did not receive timely psychiatric monitoring. 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. Polypharmacy 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. 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. <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	

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		that every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, must ensure that the treatment plan for the psychotropic medication addressed the cited requirements of this provision based on the individual's current status and/or changing needs, no less often than quarterly. Psychiatry Clinic The monitoring team attended four clinics. The records for the individuals participating in psychiatry clinic were available to the psychiatrist and IDT. 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. Medication Management and Changes The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be 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). As such, the majority of medication adjustments made during the clinic observations during this monitoring visit were made based on anecdotal evidence rather than data driven decisions. Monitoring Team's Compliance Rating The facility continued to struggle in addressing this provision item therefore remained in noncompliance in agreement with the facility 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. 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 regimen.	

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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 5/01/13, 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)." There was a facility specific policy "Informed Consent: Explanation, Education, and Due Process" dated 5/10/02 revised 8/17/07. This policy was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian or party consenting to treatment) the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the record. There are plans for DADS to promulgate a statewide policy and procedure regarding informed consent. Once this is finalized, it will be necessary for SGSSLC to review this document and ensure that facility specific policy is consistent with statewide requirements. Staff interviews indicated that the transition process for the responsibility of informed consent to the psychiatry department was completed in March 2013. Since that time, psychiatry was responsible for obtaining consent for psychotropic medications, both for medications that were newly prescribed and for annual medication renewals. The monitoring team previously recommended that the prescribing practitioner for the medication regimen was the party responsible for establishing the content of the consent and to ensure the designated representative for the individual (i.e., LAR/Guardian) understood the risk versus benefit analysis. Current Practices Per the facility "Cumulative Data Comparison Summary" for February 2014, "the psychiatrist prescribed 383 medications requiring informed consent, at this time 127 (33%) are outdated…the psychiatry RN is working on updating all consents by completing the forms and obtaining verbal consent with the psychiatrist from LAR/Guardians on 40 needed consents today (2/18/14) and projects to complete the other 87 this month."	Noncompliance

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		In addition to the above, the facility self-assessment indicated that for the months of July 2013-October 2013, the consents were not reviewed. A review of new psychotropic medication prescriptions in the month of November 2013 revealed that for the two medications prescribed, the list of pertinent medication side effects, the rationale for the use of the medication, and the target symptoms associated with the psychiatric diagnoses were not included in the documentation. The monitoring team requested 10 examples of consent for those who were prescribed new psychotropic medications. The consent documents included the name and discipline of the person giving explanation of the content of the consent. While overall, the consent format was improved, the listing of medication side effects should be comprehensive. The psychiatry department should consult with the pharmacy department with regard to medication information documentation for each medication prescribed. For example, Individual #141 was prescribed Lithium as a mood stabilizer, an appropriate target symptom for this medication. In review of the medication side effects listed, it was concerning that thyroid abnormalities and nephrotoxic effects were not noted. 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 dispensed. 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 should reflect a revised risk-benefit analysis in regard 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, in agreement with the facility self-assessment. This was due to the lack of completed informed consent documents, incomplete side effect listings, and the need to	

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		revise the consent form and practices with regard to resuming treatment with a medication without completion of a revised consent form indicating the indication and risk benefit analysis for a that particular medication.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plans (PBSPs) for: • Individual #202 (7/10/13), Individual #22 (3/15/13), Individual #77 (8/21/13), Individual #266 (7/17/13), Individual #63 (8/21/13), Individual #186 (10/16/13), Individual #129 (10/2/13), Individual #170 (9/27/13), Individual #223 (11/20/13), Individual #183 (10/2/13), Individual #246 (1/15/14), Individual #329 (10/29/13), Individual #243 (2/13/14), Individual #58 (10/18/13), Individual #209 (11/28/13), Individual #370 (9/12/13) o Functional Assessments for: • Individual #202 (7/10/13), Individual #22 (10/30/13), Individual #77 (8/21/13), Individual #266 (7/17/13), Individual #63 (8/14/13), Individual #186 (10/20/13), Individual #129 (9/18/13), Individual #170 (8/14/13), Individual #223 (11/13/13), Individual #183 (9/18/13), Individual #127 (11/20/13), Individual #190 (11/20/13), Individual #339 (11/27/13) o Six months of progress notes for: • Individual # 202, Individual #22, Individual #77, Individual #266, Individual #63, Individual #186, Individual #129, Individual #170, Individual #223, Individual #183 o Annual Psychological updates for: • Individual #223 (6/27/13), Individual #129 (11/29/13), Individual #263 (6/30/13), Individual #77 (6/27/13), Individual #266 (8/6/13), Individual #202 (7/11/13), Individual #22 (10/3/13), Individual #170 (11/2/13), Individual #183 (9/6/13), Individual #186 (6/12/13) o Initial Psychological Assessments for: • Individual #110, Individual #93, Individual #343 o Individual Support Plans (ISPs) for: ▪ Individual #142, Individual #120, Individual #250, Individual #380, Individual #251, Individual #328, Individual #217, Individual #316, Individual #140, Individual #245, Individual #317, Individual #246, Individual #35, Individual #203, Individual #58 o Section K Plan of Improvement, August 2013-January 2014 o Section K Presentation Book, undated o Behavioral Support Monitoring Tool, undated o Summary of all treatment integrity/behavior drills and IOA checks, June 2013-November 2013 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 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 Minutes of behavioral health services department meetings during the last six months o SGSSLC Self-Assessment, dated 12/1/13 o SGSSLC Action Plan, dated 1/28/14 o Replacement behaviors implemented by program resources, 10/8/13 o Flesch-Kincaid Readability scores for August 2013-January 2014 o PBSP Competency Assessment, undated <u>Interviews and Meetings Held</u>: o John Church, Assistant Director of Behavioral Health Services o John Church, Assistant Director of Behavioral Health Services; Lynn Zaruba, BCBA, Clinical Supervisor o John Church, Assistant Director of Behavioral Health Services, Lynn Zaruba, BCBA, Clinical Supervisor; Daryl Barnes, Behavioral Health Specialist; Sim Nyakunika, BCBA, Applied Behavior Analyst; Neal Perlman, Counselor o Monique Prince, Behavioral Health Specialist o Dena Johnston, Director of Rehabilitation Therapy o Dana Robertson, Section C Lead o Lynn Zaruba, BCBA, Clinical Supervisor o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors <u>Observations Conducted</u>: o PBSP training • Instructor: Ermelinda Samaripa, Behavioral Health Assistant • PBSP trained: Individual #246 o Psychiatry Clinic Rounds • Psychiatrist: Dr. Crowley • Individual Presented: Individual #329 o Psychiatry Clinic Rounds • Psychiatrist: Dr. Manshardt • Individual presented: Individual #37 o Psychiatry Clinic Rounds • Psychiatrist: Dr. Manshardt • Individuals presented: Individual #279, Individual #376 o Functional Assessment review 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: The monitoring team believes that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. SGSSLC's self-assessment included some relevant activities in the "activities engaged in" sections, however, some provision items in this self-assessment did not include activities that were identical to those found in monitoring teams report. For example, K4's self-assessment included an audit of the completion of progress notes, evidence of action to address the absence of progress, and a review of data collection timeliness and interobserver agreement (IOA). These are topics that are included in the monitoring team's review of K4. K4's self-assessment, however, did not include several additional items (i.e., graphing of target and replacement behaviors, evidence that data are used to make treatment decisions, demonstration that goal frequencies and levels of data collection timeliness and IOA are achieved) that are identified in this report as necessary to achieve substantial compliance with K4. The self-assessment for other items included the review of data that were not included in the monitoring team's report. For example, the self-assessment for item K10 included a review of treatment integrity, however, the monitoring team's report discusses treatment integrity in K11. The rating of substantial compliance or noncompliance found in the self-assessment was not always consistent with the criterion in the monitoring team's report. For example, K3 indicated that both internal and external peer review occurred at the intervals prescribed in the monitoring team's report, but concluded that the item was not in compliance. The self-assessment for item K7, on the other hand, indicated only 72% of the annual assessments contained the essential elements (the monitoring team's report indicated that at least 85% of the annual assessments needed to be complete to achieve substantial compliance), but concluded that this item was in substantial compliance. The monitoring team suggests that the behavioral health services department review, for each provision item, the activities engaged in by the monitoring team (based on the report), the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made in the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Finally, it is suggested that the department review the criterion for compliance in the monitoring team's report, and ensure that the self-assessments use the same criterion. SGSSLC's self-assessment indicated compliance for items K2, K5, K7, K8, and K11. The monitoring team's review of this provision, as detailed in this report, found K2, K3, K5, K7, K8, K9, 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: There were several improvements since the last review, resulting in one additional item rated in substantial compliance (K9). Additionally, the facility maintained substantial compliance on the six items (K2, K3, K5, K7, K8, and K11) that were in substantial compliance prior to this review. A summary of these improvements are listed below and described in detail in the report: • Continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written (K4, K10) • Documentation that PBSPs were consistently implemented within 14 days of receiving the last required consent (K9) • Improvements in the quality of the PBSPs (K9) The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that all behavior specialists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors (K4) • Review the procedures for collecting IOA, treatment integrity, and data collection timeliness data (K4, K10) • Ensure that replacement/alternative behaviors are collected and graphed for all individuals with PBSPs (K4) • Establish minimal frequencies of data collection timeliness, IOA, and treatment integrity based on individuals rather than behavioral specialists schedules (K4, K10) • Demonstrate that established minimal frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved (K4, K10) • Ensure that current data are consistently available and graphed at interdisciplinary meetings to foster data based decisions (K4) • Ensure that in those instances when an individual is not making expected progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4) • 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 restraint.	The parties agreed the monitoring team would not monitor this provision because the facility did not make compliance on this item. The noncompliance finding from the last review stands.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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 monitoring team noted some improvements in this area, however, more work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. At the time of the onsite review, the SGSSLC used a PBSP data collection system that included the use of scan cards. Scan cards were preprinted individual cards, containing categories of target behaviors. The data system required direct support professionals	Noncompliance

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	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.	(DSPs) to record a predetermined code in each recording interval (15 minutes) if target or replacement behaviors occurred, and another predetermined code if no target or replacement behaviors occurred. The cards could then be scanned and used to produce graphs of the data. The ease of implementation and the simple process from data collection to graphing were clear advantages of this scan card system of data collection. One disadvantage of this system at SGSSLC, however, was that technical problems often occurred resulting in the loss of data (see comments below), and the inability to graph the data directly from the cards. Another disadvantage of the system was that replacement behaviors were not preprinted on the cards, resulting in confusion in some of the DSPs interviewed, and missing replacement data. A third disadvantage of the scan cards was their inflexibility. A data system should be flexible to individual needs. For some behaviors, a partial interval sampling of every 15 minutes represents an accurate measure. Some behaviors, however, may require a different measure to most accurately capture the behavior. For example, in some cases, it may be important to capture the frequency of the behavior within the intervals (e.g., severe self-injurious behavior), or the duration (e.g., tantrum) rather than simply indicating if a behavior occurred in five-minute intervals. Additionally, the recording of the occurrence or nonoccurrence of a behavior every five minutes for a behavior that typically only occurred weekly or less often (e.g., elopement), appeared to be an unnecessary requirement, and could contribute to DSPs not recording data accurately or in a timely manner. In addition to the scan cards, SGSSLC also collected antecedent and consequent behavior (ABC data) on a separate data sheet. Although ABC sheets represent an alternative, or complimentary, measure to the scan cards for target behaviors that occur at low rates, at the time of the onsite review, the ABC data were collected for <u>all</u> individuals with a positive behavior support plan (PBSP). It is recommended that the facility review their current data system and ensure that it is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors, and that it is efficient so that it encourages the timely and accurate recording of data. The monitoring team assessed data collection timeliness 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 eight of 18 scan cards reviewed (44%) were completed within the previous 60 minutes. This was similar to the last two reviews when 44% and 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 their own data collection timeliness. Their data, however, were substantially higher than that found by the monitoring team. Their November 2013 data collection on timeliness, for example,	

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		indicated that 82% 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 behavioral health specialists and the methodology they reported appeared to be the same as that used by the monitoring team. It is recommended that the facility review their procedures for collecting data collection timeliness data to ensure they are adequately sampling all treatment sites and staff. As reported in the last review, not all individuals' replacement behaviors were being collected at the time of the onsite review. None of the 18 data cards reviewed by the monitoring team during the onsite review had replacement data. Additionally, although all 10 of the progress notes reviewed contained replacement behavior graphs, four were missing some replacement data. As discussed above, the absence of pre-printed specific replacement behaviors on the scan cards may contribute to this problem. The facility needs to ensure that the replacement/alternative behaviors are consistently collected for all individuals with PBSPs. While data collection timeliness 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. SGSSLC had established that each behavioral health specialist would conduct two data collection reliability and IOA sessions per month. The goal level for data collection reliability and IOA was established as 80%. Although the self-assessment indicated that data collection reliability and IOA across the facility was above the established levels, there was not documentation that all individuals with a PBSP were represented. It is recommended that minimal frequencies of data collection timeliness and IOA data be based on individuals rather than behavioral health specialist's schedules. Additionally, SGSSLC should develop a tracking system so that it can document that data collection timeliness and IOA occur at the established frequencies. All the graphs of target and replacement behaviors 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. As indicated above, however, several graphs had incomplete replacement behavior data. The routine use of data to make treatment decisions was mixed. In a psychiatric clinic for Individual #376 and Individual #279, observed by the monitoring team, the behavioral health specialist presented graphs that were current, clearly indicated when important environmental events occurred, and were simple to understand. The clear and current graphs contributed to a very productive discussion by these individuals' teams, and to data based decisions concerning their future course of treatment. In	

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		another psychiatric clinic observed (for Individual #329) graphed monthly data were presented up to the previous month. The behavioral health specialist, however, indicated that some of those data were inaccurate because of a malfunction of the scan card system. The most recent data (to the previous day) were verbally presented. This individual, however, had 35 restraints in the last two weeks and a medication change in the last week. It would have been beneficial (i.e., fostered a data based decision) for the team to have seen graphed daily data over the last two weeks to better assess the effects of the new medication. In a third psychiatric clinic observed, Individual #37 had data graphed up to the previous month, however, in the two weeks since the last monthly datum point, Individual #37 had a move to another home and a medication change. Given these potentially important changes, data based treatment decisions would have been more likely if the most recent data were available for the team to review. It is recommended that SGSSLC ensure that all treatment decisions are data based. Specifically, the facility needs to demonstrate the value of data by ensuring it is current and reliable, and consistently graphed in increments that encourage data based treatment decisions. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for nine individuals (individual #223 did not have any severe target behaviors), three (Individual #129, Individual #183, and Individual #266), or 33%, indicated no obvious improvement in severe behavior. This represented an improvement from the last review when 50% of the individual's reviewed showed no obvious improvement in severe behavior. As discussed in the last review, the monitoring team found examples of action taken to address the lack of progress (e.g., Individual #129), however, other progress notes reviewed (e.g., Individual #183) with a lack of treatment progress, documented no action to address the undesired outcome (e.g., retraining of staff, modification of PBSP, etc.). It is recommended that in those instances when an individual is not making expected progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. Over the next six months it is recommended that the facility expand the flexibility of the data collection system, and ensure that replacement/alternative behaviors are consistently collected and graphed for all individuals with PBSPs. Additionally, SGSSLC should establish minimal frequencies of the data collection timeliness and IOA collection based on individuals rather than behavioral specialists schedules, and ensure that established goal frequencies and levels are achieved. Finally, it is recommended that SGSSLC ensure that when an individual is not making expecting progress, the progress	

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		note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred, and ensure that current data are consistently available and graphed at interdisciplinary meetings to foster data based decisions.	
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.	The facility continued to be in substantial compliance with this item. <u>Psychological Assessments</u> A spreadsheet of full psychological assessments indicated that 215 of the 217 (99%) individuals at SGSSLC had a full psychological assessment. This is identical to the last review when 99% of individuals had a full psychological assessment. The spreadsheet indicated that no full psychological assessments were completed in the last six months. One hundred percent of full psychological assessments reviewed in the last two reviews 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 190 of the 190 individuals with PBSPs (100%) had a functional assessment. One hundred and eighty three of those 190 functional assessments (96%) were current (i.e., revised/reviewed within one year). This represents a slight decrease from the last review when 100% of the functional assessments were current. The spreadsheet indicated that 112 functional assessments were completed in the last six months. Thirteen of these (12%) were reviewed to assess compliance with this provision item. Ideally, 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 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. Additionally, all 13 of the functional assessments reviewed (100%) were judged to contain adequate direct assessment procedures. This represented an improvement from the last review when 92% of direct observation procedures were judged to be acceptable. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This represented another improvement over the last report when 92% of all functional assessments included potential antecedents	Substantial Compliance

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		and consequences. One functional assessment (i.e., Individual #129), however, included both antecedent and precursor behaviors (i.e., behaviors that the individual engaged in that often predicted the target behavior). Precursor behaviors (e.g., raising her voice, cursing, pacing, etc.) can be useful to include in a functional assessment, however, it is suggested that they appear in a separate category of the report so as not to confuse the reader. All 13 of the functional assessments reviewed (100%) were judged to have a clear summary statement. This is consistent with the last review when 100% of the functional assessments reviewed were found to have a clear summary statement. Overall, 13 of the 13 functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This represents an improvement from the last review when 85% of the functional assessments reviewed were evaluated as acceptable. 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 are complete. Additionally, the facility needs to ensure that 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 are judged to be complete.	
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 parties agreed that the monitoring team would not monitor this provision, because the facility did not make progress. The noncompliance finding from the last review stands.	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 item continued to be rated in substantial compliance. In addition to the full psychological assessment, SGSSLC completed annual psychological updates. A spreadsheet provided to 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 is consistent with the last review when 100% of individuals had current annual psychological updates. A spreadsheet indicated that 119 annual psychological updates were completed in the last six months, and 10 (8%) of these were reviewed by monitoring team to assess their comprehensiveness. All 10 annual psychological updates reviewed (100%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history,	Substantial Compliance

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		a review of behavioral/psychiatric status, and a review of medical status. This represented an improvement from the last review when 91% of the annual assessments reviewed were rated as comprehensive. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that 19 of the 22 individuals admitted to the facility in the last six months (86%) had psychological updates completed 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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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	SGSSLC's self-assessment indicated that only 70% of the PBSPs were implemented within 14 days of receiving the last required consent. During the onsite review, however, the monitoring team was provided with an updated list that documented that 89% of PBSPs had been implemented within 14 days of receiving consent. Additionally, the overall quality of the PBSPs had improved since the last review. Therefore, this provision item is now judged to be in substantial compliance. A list of individuals with PBSPs indicated that 190 individuals at SGSSLC had PBSPs and all of these (100%) were current (i.e., reviewed/revised at least every 12 months). This was identical to the last review when 100% of PBSPs were current. All PBSPs had the necessary consent and approvals (i.e., individual, LAR, BSC, HRC, RPO, and/or facility director). Since the last review, SGSSLC began tracking the time from receiving consent to the implementation of the PBSP. At the time of the onsite review the tracking documented that 169 of 190 PBSPs (89%) were implemented within 14 days of receiving the last required consent.	Substantial Compliance

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	Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	One hundred and twenty eight PBSPs were completed since the last review, and 16 (12%) of these were reviewed to evaluate compliance with this provision item. The 16 PBSPs were sampled from each of the 10 behavioral services staff who wrote PBSPs across all units at the facility. All 16 of the PBSPs reviewed (100%) were implemented within 14 days of receiving consent. As found in the last review, all PBSPs reviewed (100%) included operational definitions of target and replacement behaviors. All 16 of the PBSPs reviewed (100%) 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 represented an improvement from the last review when 86% of the PBSPs reviewed were judged to be consistent with the stated function. Replacement behaviors were included in all (100%) 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 14 of the 16 (88%) replacement behaviors that could be functional were functional (Individual #170 and Individual #183 were the exceptions). This was similar to the last review when 86% of all replacement behaviors that could be functional were functional. An example of a replacement behavior that was not functional was: • Individual #170's PBSP hypothesized that her physical aggression and self-injurious behavior was maintained by gaining attention from staff. Her replacement behavior was practicing deep breathing exercises. These activities appear to be incompatible with her severe target behaviors, however, they did not appear to be functional. Examples of a functional replacement behavior could be teaching her alternative ways to gain staff attention (e.g., requesting a to speak to staff, etc.). 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 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 16 PBSPs reviewed (100%) included the reinforcement of replacement/alternative behaviors.	

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		The monitoring team noted that several replacement behaviors were written as SAPs when the replacement behavior appeared to be in the individual's behavioral repertoire (e.g., Individual #129's replacement behavior of requesting a break). This required DSPs to record the replacement behavior on both the SAP data sheet (see S1) and the scan card, and could contribute to the inconsistencies in the recording of replacement behaviors noted in K4. It is suggested that the facility review the utility of SAPs for replacement behaviors that are part of an individual's behavioral repertoire. Overall, 14 of the 16 PBSPs reviewed (88%) represented examples of complete plans that contained all of the following. This represented an improvement from the last review when 79% of the PBSPs reviewed were judged to be acceptable. • rationale/purpose of the plan • description of potential function(s) of behavior • history of prior intervention strategies and outcomes • consideration of medical, psychiatric, and healthcare issues • operational definitions of target behaviors • operational definitions of functional replacement behavior • behavioral objectives for one or more target behaviors • behavioral objectives for one or more replacement behaviors • strategies/SAPs to promote the acquisition or occurrence of replacement or alternative behavior (or stated why not) • baseline data for one or more target behavior • antecedent-based or preventative strategies • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures • signed and dated The two plans that were not rated as being complete were rated as such only because the replacement behaviors were not directly related to the function of the target behavior or behaviors (Individual #170 and Individual #183). The behavioral health services department should be commended for their improvements in the timeliness and quality of PBSPs. In order to maintain substantial compliance with this provision item, the facility needs to document that at least 85% of PBSPs are consistently implemented within 14 days of receiving consent, and ensure that at least 85% of the PBSPs reviewed are complete.	

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K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There were improvements in this provision item, however, more work (discussed below) is required before it could be rated as substantial compliance. At the time of the onsite review, the goal level IOA for the facility was established as 80%. Although the self-assessment indicated that IOA across the facility averaged 96% over the last six months, there was not documentation that all individuals with a PBSP were represented. As discussed in K4, it is recommended that minimal acceptable frequencies of IOA data be established ensuring that all individuals with a PBSP have IOA . 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. Since the last review, SGSSLC expanded the collection of treatment integrity of the PBSPs to all behavioral health specialists. The facility had established that each behavioral health specialist would conduct two treatment integrity sessions per month. The goal level for treatment integrity was established as 80%. Although the self-assessment indicated that treatment integrity across the facility averaged 92% over the last six months, there was not documentation that all individuals with a PBSP were represented. It is recommended that minimal frequencies of treatment integrity be based on individuals rather than behavioral health specialist's schedules. Additionally, SGSSLC should develop a tracking system so that it can document that treatment integrity occurs at the established frequencies. Target and replacement behaviors were consistently graphed. All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines/indicators, data points, and a data path.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	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 continued to be rated as being in substantial compliance. SGSSLC utilized a brief behavior support plan that was located in the individual books, and was written so that DSPs could understand them. The monitoring team reviewed 16 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 were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 3.1 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 all PBSPs. Ninety-three percent of the PBSPs completed in January 2014 averaged an 8th grade level or lower.	Substantial Compliance

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		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.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	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 behavioral health services department maintained logs documenting staff members who had been trained on each individual's PBSP. Behavioral health specialists and behavioral health assistants conducted the trainings prior to PBSP implementation and whenever plans changed. The monitoring team observed the training of DSPs on Individual #246's PBSP. The training included a review of the PBSP by a behavioral health assistant, an opportunity for DSPs to ask questions, and written questions pertinent to Individual #246'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.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	The parties agreed the monitoring team would not monitor this provision because the facility did not make progress on this item. The noncompliance finding from the last review stands.	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 SGSSLC Medical Care Policy, 9/1/13 o Medical Policies and Procedures, Document submission IX.6 o Pneumonia Review Committee Meeting Minutes, 9/18/13, 10/16/13, 1/15/14, 2/20/14 o Shannon Hospital Partners Meeting Minutes, January 2014 o Clinical Daily Provider Meeting Minutes o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Mortality Review Documents o Clinic Tracking Logs o Listing, Neurology Clinics o Internal and External Medical Reviews o Listing, Individuals with seizure disorder o Listing, Individuals with history of status epilepticus since last compliance review o Listing, Individuals with diagnosis of refractory seizure disorder o Listing, Individuals with VNS o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 21 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 AED Polypharmacy Data 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 #188, Individual #215, Individual #331, Individual #199, Individual #134, Individual #59, Individual #182, Individual #180, Individual 37, Individual #238 o Annual Medical Assessments the following individuals: • Individual #345, Individual #279, Individual #14, Individual #129, Individual #170, Individual #386, Individual #148, Individual #208, Individual #227, Individual #339, Individual #202, Individual #389, Individual #10, Individual #352, Individual #185 o Neurology Notes for the following individuals: • Individual #95, Individual #381, Individual #379, Individual #215, Individual #385, Individual #52, Individual #277, Individual #50, Individual #46, Individual #108 <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 Angela Gardner, RN, Chief Nurse Executive o David Ann Knight, RN, <u>Observations Conducted</u>: o Daily Medical Provider Meetings o Pneumonia Review Meeting o Administrative IDT Meeting o Medication Variance Committee Meeting o Polypharmacy Review Meeting
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. The medical director served as the lead for this provision, but the self-assessment was completed by the medical compliance nurse. The self-assessment listed a number of activities that were completed to assist in determining a self-rating. For L1 the assessment included items related to preventive care, documentation, physician participation in the ISP process, and documentation of post hospital follow-up. This was an improvement from previous assessments and should be expanded to include even more areas reviewed by the monitoring team. A similar process was completed for the other provision items. The activities were listed, long with the results and self-ratings. The monitoring team recommends that moving forward the medical director becomes more involved in the self-assessment process and develop additional metrics for review based on the comments and recommendations of this report.

	The facility rated itself in noncompliance with all four provision items. The monitoring team concurred with the facility's self-ratings of noncompliance.
	Summary of Monitor's Assessment: There was minimal progress seen in the medical department. One area with improvement was staffing. The facility had two full time primary care providers in addition to the medical director. The part time primary provider continued to work at the facility as well. The medical department had the support of two registered nurses who functioned as compliance nurses under the supervision of the Settlement Agreement Coordinator. Physicians continued to have very little participation in the ISP process, attending only two meetings over an eight-month period. Attendance at ISPAs was not tracked. Even though attendance was poor, there were anecdotal accounts that the primary care providers were very accessible to the IDTs and staff and, overall, worked well with other disciplines. The quality of IPN documentation was very provider specific. Some IPN entries included the required information while others did not. The AMAs reviewed were completed in the old format. The plans for the active problems were considerably improved. The facility had recently implemented the new AMA format and Quarterly Medical Summaries re-implemented in October 2013. Generally, individuals received basic medical care. There was documentation that annual assessments were completed along with routine annual labs and screenings. Cancer screenings showed some slight improvements, but the facility did not provide adequate documentation for many individuals who did not have screenings. In many instances, the only information submitted was discontinued, "See IPN," or risk greater than benefit. There were many issues related to the medical care provided to individuals with more complicated medical issues. Individuals with numerous chronic medical conditions were treated with standing orders without physician notification. The condition of the individuals sometimes warranted physician evaluation and sometimes the use of standing orders was not appropriate. Based on the record sample, individuals were not being assessed as required following hospitalization and emergency department evaluations. In some cases, the medical staff was conducting phone consults with SGSSLC nursing in lieu of actual evaluations following return from the hospital. Pneumonia management needed additional work. It was not clear that the current process captured all cases of pneumonia. The Pneumonia Review Committee was not meeting on a regular basis. Documents submitted did not reflect that the meetings produced organized reviews or resulted in any definitive action plans. The facility tracked individuals with diabetes mellitus. At some point, a decision was made to no longer track individuals with metabolic syndrome even though it is a risk factor in subsequent development of type 2 diabetes and/or cardiovascular disease. It appeared that there were some individuals with metabolic syndrome who were undiagnosed.

	There continued to be no effective means of integrating neurology and psychiatry and the need for joint evaluation was observed in the sample of neurological records reviewed. The problems with providing neurology services appeared to be expanding to providing general follow-up. Nearly all of the records reviewed involved delinquent follow-up. Some were several months delayed and one was delayed nearly three years. The external and internal medical reviews were completed as required. There continued to be problems with implementation of the corrective action plans. Mortality reviews were conducted, but significant delays were seen in the completion of two of the reviews. The medical department did not develop a medical quality program and was not tracking any data related to hospitalizations or disease management. The medical department did not develop any new policies or procedures, but did update the facility's lab matrix. A number of policies and procedures were submitted for review. Some had not been revised in 18 years. It was clear that the medical department needed to do a considerable amount of work in evaluating its current policies and procedures.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff at SGSSLC consisted of a full time medical director and two full time primary care physicians. The two full time PCPs had an average caseload of 107, which was higher than the upper limits of a recommended maximum caseload of 100. The medical director did not carry a caseload. The long-term locum tenens physician continued to work every other week providing support in a variety of roles. The facility also utilized the services of a local physician to provide on-call coverage for several months. It appeared that the current staffing may not be adequate and the facility will need to determine how to decrease caseloads while providing continuity of care. Several of the issues identified throughout the conduct of this review may have been reflective of the relatively high caseloads. **Physician Participation In Team Process** Daily Clinical Services Meeting The facility continued to conduct the daily provider meeting each day at 4:30 pm.	Noncompliance

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		Attendees included the medical staff, medical compliance nurse, nursing representatives, pharmacy director, hospital liaison nurse, psychology, dental director, dietary representative, and residential services. The meetings were facilitated by the medical director or one of the PCPs. The monitoring team attended several of these meetings and observed discussions related to hospitalizations, consultations, medication refusals, and specific clinical cases. The monitoring team also reviewed the minutes submitted for this meeting. Minutes were not completed for each meeting and some did not appear to be finalized. One concern was that many issues were discussed, but there was not documentation of closure. For example, it was reported that Individual #50 was hospitalized with pneumonia. There was some discussion of a possible relationship to dental work that had been recently completed. There was no documentation of the follow-up to the questions/concerns that were discussed in the meeting. It is unclear why the facility continued to conduct the meeting at the end of the day. Such meetings typically occur at the start of the day with the report of the events that occurred over the past 24 hours. Conducting daily meetings in the morning decreases the opportunity for staff with on-call responsibilities to fail to relay valuable information regarding important events. Morning meetings are typically seen at the other SSLCs. <u>ISP Meetings</u> The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data for the months of June 2013 through January 2014 were submitted and are summarized in the table below. Medical Staff ISP Attendance 2013 - 2014 | | Meetings Attended | Meetings Attended (%) | | Jun | 0 | 0 | | Jul | 0 | 0 | | Aug | 0 | 0 | | Sep | 0 | 0 | | Oct | 1 (4) | 25 | | Nov | 0 | 0 | | Dec | 1 (3) | 33 | | Jan | 0 | 0 | The percentage of meetings attended was based on the number of meetings the medical staff was invited to attend. The total number of ISPs was not submitted for the reporting period. Overall, the medical staff attended <u>two</u> annual ISPs during the six-month reporting period. The medical director reported that attendance was improving.	

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		However, the data indicated no improvement. The total number of ISPs conducted from December 2013 through January 2014 was 42. The medical staff attended 2 of 42 (<5%) meetings. There were no data for ISPA attendance. The monitoring team is aware that primary providers are not core members of the IDT, however, a lack of attendance by primary medical providers at annual planning meetings affects the integration of clinical services. The primary medical providers play an integral role in the planning process in terms of determining how the individual's health will impact goals, barriers, transitioning, etc. The PCPs will not be able to attend every meeting with the current caseloads. However, the primary providers should attend the meetings when requested to attend. Attendance at two meetings during an eight-month period does not promote integration and should be considered unacceptable. **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 medical director reported no changes in services. The facility conducted onsite ophthalmology clinic once a month. Podiatry clinic was held twice a month. Clinic schedules indicated that there were months when services were not provided. 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. Meetings were held in October 2013 and January 2014. Participants in the January 2014 meeting included the medical center staff, the SGSSLC medical director, CNE, medical compliance nurse, and hospital liaison. 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, there was evidence that some good care was provided and most individuals received the basic medical services such as screenings, immunizations, and some elements of preventive care. The medical management of conditions became more problematic for those individuals with more complicated problems who required	

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		additional follow-up and those who required outside assessments and evaluations. Individuals often did not receive the appropriate follow-up care. For a significant percentage of individuals reviewed through the record sample, there were examples in which the individuals were not seen appropriately upon return from the hospital. Similarly, for a facility selected sample of neurological records, there was evidence that many individuals did not have the appropriate follow-up. As noted in previous reviews, there was an overuse of standing orders. In several instances, the orders were inappropriate as in the case of an individual with erosive and refractory esophagitis who received Pepto-Bismol for nausea and vomiting. In other cases the appropriate physician notification did not occur. Many individuals in the record samples had frequent chemical restraints for behavioral episodes, but some also received medication to complete lab draws, undergo physical assessments, and receive IV fluids at the facility. In some instances, multiple chemical restraints occurred within a short period of time (Individual #238). The monitoring team was unclear on the HRC approval process that was required for use of these particular restraints. The list of chemical restraints did not include any used for the purpose of drawing labs, inserting IVs, etc. The specific incidents identified were not included in the listing. **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%) records included an AMA • 10 of 10 (100%) AMAs were current • 9 of 10 (90%) AMAs included comments on family history • 9 of 10 (90%) AMAs included information about smoking and/or substance abuse history • 8 of 10 (80%) AMAs included information regarding the potential to transition	

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		The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 14 of 15 (93%) AMAs were completed in a timely manner. • 13 of 15 (86%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 14 of 15 (93%) AMAs included information regarding the potential to transition The facility reported that for the months of October 2013, November 2013, and December 2013, compliance rates for timely completion were 82%, 87%, and 87% respectively. The AMA was considered timely if it was completed within 365 days of the previous summary. The medical director reported that the facility implemented the new state AMA template. The sample of 15 AMAs submitted was all completed in November 2013 in the old format as were all AMAs found in the active records. This format differed significantly from the newly required format. The monitoring team observed that several of the AMAs documented that, moving forward, the PCPs would review the MOSES and DISCUS evaluations on a quarterly basis with psychiatry. The plans included in the AMAs reviewed were improved. There was still a need to ensure that a plan was included for all active diagnoses. For example, Individual #170 did not have a plan for the diagnosis of metabolic syndrome. The implementation of the new state template will be reviewed during the next compliance review. <u>Quarterly Medical Summaries</u> The primary care providers began completing Quarterly Medical Summaries in October 2013. For the records contained in the record sample: • 5 of 10 (50%) records included current QMSs The primary providers began completing QMSs in October 2013. The state template was used for some summaries, but not all. The medical director was aware that only one provider was using the template. This will be further assessed during the next review. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL	

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		It appeared that most providers were updating the active problem list. Orders were frequently written to add or remove diagnoses from the list as problems arose or resolved. There were still diagnoses that were not included in the APL so continued work is needed in this area. <u>Integrated Progress Notes</u> The medical staff generally documented in SOAP format, but the quality of the documentation was very provider specific. Legibility of the IPN entries was very problematic for one provider. Some IPN entries included adequate information while others consistently lacked the required documentation. For those that lacked the required documentation, vital signs, pertinent positive and negative findings were consistently not documented. For example, in the case of Individual #215 who had a foot injury the following was documented: 1/27/14, 15:45 S - TV fell R foot, x-ray pending O - NT forefoot A - foot pain S/P trauma, x-ray pending The physician's exam did not document bruising, swelling, deformity, or the neurovascular status. There was no plan to address pain even though the assessment was foot pain. The nursing IPN entry indicated there was bruising, redness, and swelling. The presence of a pedal pulse was also documented. An appropriate assessment should have documented the ability to bear weight, the presence, or absence of deformity, bruising, swelling, and neurovascular status. In addition to the lack of information in this particular entry, there was no follow-up documentation to indicate the results of the x-ray or a follow-up assessment of the injury. Unfortunately, this type of IPN documentation, lack of documentation of x-ray findings and failure to document follow-up of acute issues was not an isolated occurrence, but was seen in a number of records reviewed. <u>Physician Orders</u> Generally, physician orders were dated, timed, and signed. There were several concerns related to medication orders at SGSSLC, including incomplete orders, orders lacking indications, and illegible orders. The facility revised a set of standing orders in December 2013. These orders were used for a variety of conditions including pain, fever, sore throat, nausea, and vomiting. Many could be implemented without physician notification. The monitoring team encountered several instances in which the use of these orders was not appropriate.	

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		NSAIDs could and were given to individuals with relative contraindications, such as chronic kidney disease, GI disease, and lithium use. There were also examples in which physician notification should have occurred, but there was no documentation of notification. Specific examples of problems related to indications and standing orders are provided in the case examples. Medication orders are discussed further in section N1. <u>Consultation Referrals</u> The facility did not utilize the state developed consultation tracking database. It was reported that nursing services maintained a spreadsheet to track appointments. The facility had encountered problems with receipt of neurology consultations, but reported that this was resolved at the time of the review. The primary providers were required to provide adequate information to the consultants. The physicians continued to utilize the consultation form to document agreement or disagreement with the recommendations of the providers. The medical director did not appear to be aware of the specific IPN documentation requirements. Records indicated that the medical staff was also unaware of the specific documentation requirements. The following is an example of recent IPN consult documentation: 1/23/14 (untimed) S - neuro -noted O - not examined A - seizure disorder P - next app? In another instance, the PCP documented on the consult form for Individual #238, 1/9/14 that the recommendations were accepted. The individual did not go to the clinic appointment due to a lack of staff. The monitoring team was confounded by the consistency of this type of documentation because the medical compliance nurse had developed, but not implemented, an audit tool that targeted the exact IPN requirements that were discussed at length during the September 2013 compliance review and carefully listed in the monitoring team's report. The misunderstanding may be due in part to guidance given to the medical auditors conducting the external audit for Question #45. However, it appears that guidance was incorrect because IPN documentation is not about "why consultation recommendations were not addressed within five business days." While the requirements for this area were not complex, SGSSLC continued to be challenged by this task. The metrics of internal audits and external audits presented in the QA report were not valid ones and clearly indicated that the facility lacked clarity in this area. The audit tool capable of measuring compliance was not used and, therefore,	

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		the medical director was unaware of the fact that facility physicians were not documenting the required elements in the IPN. The failure to adequately address consultations resulted in untimely follow-up for some individuals. Further discussion is found in the case examples and section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals at the facility. Hearing screenings were provided with high rates of compliance. Most individuals had documentation of appropriate vision screening. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Documentation of varicella immunity was also very good. Compliance with prostate cancer screening remained high. State policy continued to recommend yearly PSA testing. Screening for breast, cervical, and colorectal cancer required improvement. The facility reported data for screenings that were discontinued, but for many individuals, there was no reason provided for discontinuing the screening. The medical director reported that whenever a screening was discontinued, the decision was referred to the IDT. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 2 of 10 (20%) forms included the signature of the provider The Preventive Care Flowsheets were found in 100% of the records reviewed. Most had recent data, but many did not appear to be updated with the annual assessment. There was no way to determine who made the entries because the forms were usually not signed or initialed. <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza vaccinations • 10 of 10 (100%) individuals had documentation of hepatitis B status • 8 of 10 (80%) individuals received the pneumococcal vaccination • 10 of 10 (100%) individuals received the Td vaccination • 8 of 10 (80%) individuals had documentation of varicella status Several documents indicated that individuals did not meet requirements for the	

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		pneumococcal vaccination. The CDC guidelines for adults residing in long term care facilities should be reviewed by the medical staff. <u>Screenings</u> • 8 of 10 (80%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 1 of 7 males met criteria for PSA testing (based on state guidelines) • 1 of 1 (100%) men 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 40 males: • 36 of 40 (90%) males had current PSA screening <u>Breast Cancer Screening</u> • 1 of 3 females met criteria for breast cancer screening • 0 of 1 (0%) female had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 32 females, the date of the last mammogram, and explanations for any lack of testing: • 18 of 32 (56%) females had current screenings • 2 of 32 (6%) females had no reason for lack of current screening • 6 of 32 (7%) females had no screening due to age • 3 of 32 (3%) females had no screening due to sedation risk • 3 of 32 (8%) females had no screening due to refusal, inability to cooperate, or other reasons <u>Cervical Cancer Screening</u> • 3 of 3 females met criteria for cervical cancer screening • 3 of 3 (100%) females completed cervical cancer screening within three years A list of females age 21 and older was provided. The list included the names of 75 females, the date of the last pap smear, and explanations for any lack of testing: • 37 of 75 (40%) females had current screenings • 13 of 75 (11%) females were excluded due to age > 65 • 5 of 75 (9%) females were not due or refused • 5 of 75 (6%) females had screening discontinued with no documented explanation • 5 of 75 (6%) females had no screening with no explanation	

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		• 6 of 75 (8%) females had pending evaluations • 4 of 75 (5%) females had no screening due to virginal status, risk, or refusal <u>Colorectal Cancer Screening</u> • 3 of 10 individuals met criteria for colorectal cancer screening • 3 of 3 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list included 84 individuals divided into those with colonoscopies and those with discontinued screening. The total for both lists was 84 individuals: • 40 of 84 (47%) individuals completed colonoscopies • 5 of 84 (59%) individuals did not complete colonoscopies due to problems with bowel preps • 2 of 84 (1%) individuals were unable to complete/not appropriate • 2 of 84 (2%) individuals refused screening • 2 of 84 (2%) individuals had screening cancelled due to weather • 2 of 84 (2%) individuals had pending screenings • 9 of 84 (10%) individuals had screening discontinued due to sedation risk • 4 of 84 (4%) individuals had screening discontinued due to refusal • 10 of 84 (12%) individuals had screening discontinued with no explanation submitted other than "see IPN" • 5 of 84 (6%) individuals had screening discontinued due to age, hospice care, etc. • 3 of 84 (35%) appeared to have completed colonoscopies, but were reported as discontinued **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. The management of chronic diseases is discussed below. <u>Pneumonia</u> The facility submitted a list of individuals who were diagnosed with pneumonia from June 2013 through November 2013. Data for that period are shown in the table below. Pneumonia 2013 | | Jun | Jul | Aug | Sep | Oct | Nov | | Total | 1 | 1 | 1 | 1 | 2 | 5 |	

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		The total number of cases of pneumonia for the reporting period is presented in the table above. The facility did not provide any specific data on the types of pneumonia. The information provided in the AVATAR report forms did not match the data for the total number of cases of pneumonia presented. AVATAR reports were found for seven individuals diagnosed with pneumonia during the reporting period. Individual #134, who was diagnosed with aspiration pneumonia in June 2013, was not included in the list and is not reflected in the data reported by the facility in the table above. The Pneumonia Review Committee met to review individuals diagnosed with pneumonia. This may have been helpful to some degree, but based on documents reviewed and observations, this was not an effective review process. There was one meeting conducted since the last compliance review. The committee convened on 1/15/14, however, it deferred clinical reviews documenting that cases would be discussed "when the monitors were present." The purpose of the process is to review the episode of pneumonia to best categorize it, but more importantly to determine what further actions (diagnostics and treatments) are required to minimize a recurrence. This review should not be delayed. For the meeting that occurred on 10/16/13, the documentation presented a mix of comments from meeting participants in a disorganized manner. The comments were relevant to the care of the individual, but it was difficult to determine the outcome of the discussion and if there was a plan. There was no systematic review of each case during the meeting. Meetings did not occur in November 2013 and December of 2013. The monitoring team attended the Pneumonia Review Committee meeting held during the week of the compliance review. The meeting was well attended with much greater participation than seen documented for the previous two meetings. The state issued tool was utilized for the first time during this meeting, however, the effectiveness was limited because the tools were not completed prior to the meeting. The monitoring team pointed out during this meeting that staff needed to explore all possibilities when discussing pneumonia. For example, consideration must be given to the fact that a single negative MBSS does not rule out aspiration when classic symptoms are present in an individual with risk factors, such as dementia and the use of psychotropic medications. SGSSLC will need to devote some time to address the management of aspiration and aspiration pneumonia: • The accuracy of the pneumonia data must be examined. There was evidence that the data were not accurate. • The Pneumonia Review Committee should continue to use the checklist. It	

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		should be completed prior to the meeting to improve efficiency. Data should be discussed during the meeting. • A process to ensure that every episode of pneumonia is captured should be developed. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department. • A comprehensive set of guidelines is needed to provide guidance to the medical staff on the management of recurrent aspiration. The facility reported that Infection Control Committee meetings occurred during the first three quarters of 2013. The medical and nursing requests for infection control minutes were responded to with "no data." Thus, there was no documentary evidence of an active infection control committee and discussion of pneumonia by the committee. The facility also reported attendance for pneumonia committee meetings conducted in October 2012 and November 2012. The monitoring team attended the meeting during the December 2012 compliance review, which was reported to be the first Pneumonia Review Committee meeting. The Infection Control and Pneumonia Review Committees provide important contributions to the clinical care provided at the facility. Facility management must ensure that these committees meet as required and provide appropriate documentation of attendance and records of the meetings. Diabetes Mellitus Two records were reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy (3) annual dilated eye examinations, and (4) administration of yearly influenza vaccination: • 2 of 2 (100%) individuals had adequate glycemic control • 1 of 2 (50%) individuals had urine microalbumin documented • 2 of 2 (100%) individuals had documentation of eye examination • 2 of 2 (100%) individuals had documentation of influenza administration The facility identified 24 individuals with diabetes mellitus. Three of 15 individuals included in the AMA sample were diagnosed with metabolic syndrome. The sample of QDRRs submitted also included individuals not diagnosed, but who potentially had the diagnosis of metabolic syndrome. Previous compliance reviews indicated that many individuals had the diagnosis of metabolic syndrome and some of this appeared to be associated with the use of new generation antipsychotic medications. There was no evidence that the facility continued	

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		to maintain a list of individuals with the diagnosis or conducted any analysis related to the use of psychotropic medications and metabolic syndrome/diabetes mellitus. However, the clinical pharmacist was identifying individuals who had criteria for metabolic syndrome and was requesting that the PCPs conduct an evaluation. This has been a recommendation in previous reports and it was good to see the clinical pharmacist addressing this in the QDRRs. Given the importance of metabolic syndrome as a risk factor in subsequent development of type 2 diabetes and/or cardiovascular disease, it is imperative that these individuals be identified for the purpose of appropriate risk mitigation. **Case Examples** Individual #134 • This individual was given Pepto-Bismol and promethazine for nausea and vomiting per standing order in early September 2013. This occurred over a period of several days. On 9/16/13, the individual was transferred to the emergency department for evaluation of persistent diarrhea and fever. Upon return to the facility on 9/20/13, the PCP documented at 2:30 pm that the individual had "reportedly been afebrile" for 48 hours. The assessment did not include any vital signs or temperature. At 8:00 pm, nursing documented that the individual was returning to the emergency department for evaluation of fever of undetermined etiology. The individual was discharged back to the facility on 9/21/13, but was not seen by a physician. There were two IPN entries by a primary provider, presumably the on-call physician. Both notes indicated that the contacts were phone consultations and no actual contact was made with the individual. The entries were dated 9/21/13 (8:30 am) and 9/22/13 (1:00 pm). • On 9/23/13 at 9:00 am, the PCP documented a hospital return note indicating new findings of a skin rash, presumably due to the newly prescribed Bactrim, and bilateral pedal edema. A venous ultrasound and d-dimer were obtained to rule out a deep venous thrombosis. Nursing IPN entries also noted the pedal edema after return from the emergency department. Prior exams did not document this finding. Deep vein thrombosis was ruled out. • This individual experienced a downward course, was diagnosed with CHF in January 2014, and returned to the hospital on 2/23/14. The monitoring team is concerned about the events surrounding the return to the facility on 9/20/13: o It is not clear why the term "reportedly been afebrile" was used in the IPN entry dated 9/20/13. The PCP should have had access to the hospital discharge information, hospital liaison data that included vital signs, or had the ability to contact the hospital. It was reported that hospital reports were returned with individuals or faxed in a timely manner.	

#	Provision	Assessment of Status	Compliance
		o The current vital signs should have been documented. o The individual should have been evaluated by a physician upon return from the emergency department on 9/21/13. This was even more important because the individual experienced problems significant enough to warrant return to the hospital within 24 hours of discharge. The facility is required to provide medical coverage on a 24-hour basis. The requirement to have follow-up following return from an acute care facility within 24 hours is not suspended on weekends. o Bactrim was discontinued due to suspicion as the etiology of the skin rash. Subsequent physician order forms did not list Bactrim as a medication allergy. The 180 day physician order form generated by pharmacy listed Bactrim as an allergy. The monitoring team did not find an ADR report related to this event. Individual #331 • On 11/27/13, an order was written for Augmentin 875 mg BID for treatment of a sinus infection. This individual was allergic to penicillin. There was no IPN documentation of an assessment. The order was not cosigned. • The individual received Kaopectate over a period of time for diarrhea through the implementation of standing orders. Eventually, a gastroenterology consult for evaluation of diarrhea was obtained. On 1/22/14, the gastroenterologist documented " if you agree we will go ahead and put on the schedule for a screening exam (colonoscopy) in the near future." This consult and the recommendations were never addressed in the IPN. The consult was received on 1/30/14. Individual #37 • On 9/10/13, the individual had an EGD and the gastroenterologist recommended high dose PPIs for treatment of erosive esophagitis. On 9/11/13, the PCP documented that the individual was on high dose PPIs for months, remained symptomatic, and GI would be notified. The PCP indicated that it might be necessary to proceed to pre-op studies. There was no referral to the IDT and no documentation of further discussion with GI. On 12/5/13, the PCP documented that vomiting was persistent and follow-up with GI would be scheduled. • This individual was noted to receive Pepto-Bismol through standing orders for complaints of stomach pain. On 10/13/13, Pepto-Bismol was administered following two episodes of vomiting with the individual reporting stomach problems. The package insert for this medication advises against use when there is a history of ulcers or bleeding problems. Erosive esophagitis, being characterized by erosions (ulcerations) and bleeding, would prohibit the use of	

#	Provision	Assessment of Status	Compliance
		this OTC med. Individual #199 • On 1/21/14, this individual received Tamiflu for an indication of "sore throat." The influenza screen was negative. • On 1/22/14 at 11:30 am, SOP #10 was administered and the vomiting protocol implemented. The physician was not notified that the individual vomited. The vomiting protocol required notification of the physician for all episodes of vomiting. Individual #215 • There were multiple chemical restraints in October 2013 with no documentation in the IPN by the PCP. This individual had a complicated medical history including atrial fibrillation requiring anticoagulation with Xarelto. • On 10/21/13, the individual was transferred to the emergency department for evaluation due to head trauma. The individual was back at the facility by 8:00 am on 10/22/13, but was not seen by a physician until 11:00 pm. There was no additional follow-up documentation for this individual in whom bleeding secondary to anticoagulation was a serious concern. The next IPN documentation was on 11/18 /13. It was related to rhinitis. There was also no follow-up for this condition. Individual #59 • This individual had a history of a VP shunt and hydrocephalus. On 2/20/14 at approximately 6 pm, the individual was transferred to the hospital for evaluation due to a change in mental status and left sided weakness. The individual returned to the facility on 2/23/13 shortly after midnight. The individual was not seen by a physician the following day. On 2/23/14 around 5:40 pm, nursing documented the individual was found on the floor and required assistance getting up. The on-call physician requested transfer to the hospital for evaluation of mental status changes, and an unwitnessed fall. A locum tenens provider made an IPN entry on 2/24/13 at 4:00 pm summarizing the ED reported from 2/20/14. The individual was hospitalized at the time. • It is not clear why this individual was not evaluated by a physician following return from the emergency department. The lack of documentation of appropriate post acute care follow-up at the facility appeared to be a significant problem that will need to be addressed by the facility director.	

#	Provision	Assessment of Status	Compliance
		Seizure Management A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 81 individuals. Those data are summarized below: • 18 of 81 (22%) individuals received 0 AED • 43 of 81 (53%) individuals received 1 AED • 17 of 81 (21%) individuals received 2 AEDs • 3 of 81(4%) individuals received 3 AEDs The facility continued to conduct an onsite neurology clinic.	

Neurology Clinic Appointments 2013	
Jun	7
Jul	1
Aug	21
Sep	10
Oct	11
Nov	19

A total of 69 appointments were completed for the reporting period of June 2013 – November 2013. The average number of individuals seen each month was 11.5, which was a slight increase from the last reporting period.

The facility reported that 3 of 81 (3.7%) individuals had refractory seizure disorder. Two individuals had undergone VNS implantation. Fourteen individuals required transport to the emergency department for evaluation due to prolonged or new onset seizures and three individuals had refractory seizure disorder. One individual was reported to have experienced status epilepticus since the last compliance review.

The medical director reported that there were problems with the provision of neurological services. There was only one neurologist in the community and the facility still had not managed to arrange for a neuro-psychiatry clinic. There were delays in receipt of consults. It was reported, however, that this appeared to have been resolved. A 60% compliance score was achieved in the area of seizure management for the November 2013 external medical audit. The auditor specifically highlighted the need for the PCPs to document the risks versus benefits of continued AED use without dose reduction when seizures were well controlled.

The monitoring team requested neurology consultation notes for 10 individuals. Records for 10 individuals seen in neurology clinic were submitted. Consultation noted

#	Provision	Assessment of Status	Compliance
		for nine individuals were submitted. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the records: • 8 of 9 (88%) individuals were seen at least twice over the past 12 months • 9 of 9 (100%) individuals had documentation of the seizure description • 8 of 9 (88%) individuals had documentation of current medications for seizures and dosages • 2 of 9 (22%) individuals had documentation of recent blood levels of antiepileptic medications • 4 of 9 (44%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 8 of 9 (%) individuals had documentation of recommendations for medications • 0 of 9 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The monitoring team was concerned about many issues related to the provision of care to individuals with seizure disorder: • The facility did not have an adequate means of integrating neurology and psychiatry. • There were several examples in which individuals did not receive the appropriate follow-up. • There appeared to be delays in receipt of written consults, which resulted in the delay of implementation of recommendations. • There was no indication that the MOSES and DISCUS evaluations were reviewed by, or even provided to, the neurologist. • The written consults appeared to include less information than seen during previous reviews. Specifically, the consults reviewed did not include data related to laboratory studies. The following are examples of concerns identified with regards to neurological care provided to the individuals supported by the facility: • Individual #95 was evaluated in clinic on 11/1/13 and it was reported to the neurologist that since starting Keppra, seizure frequency had decreased. However, the individual reported increasing anger issues and the neurologist noted evidence of self-mutilation. This appeared to be corroborated by staff and an advocate that attended clinic with the individual. None of this information related to behavioral issues was provided to the neurologist in the request for consultation. • Individual #385 had refractory seizure disorder and received multiple medications. Lethargy was documented after receipt of morning medications. The individual was seen in May 2013 and was instructed to return in August	

#	Provision	Assessment of Status	Compliance
		2013. Follow-up did not occur until November 2013. The recommendation was made to decrease the dose of AEDs due to the history of lethargy, nausea, and vomiting. • Individual #52 was seen in clinic on 11/1/13 for management of a seizure disorder. Management was complicated by hyponatremia. This individual was seen in March 2013 and needed follow-up in three months because of the medication changes that were needed. Follow-up occurred eight months later. The neurologist was concerned about medication changes that had occurred. There was a need for greater integration of neurology in the case due to the use of multiple psychotropics and AEDs. • Individual #46 was seen 1/18/13 and follow-up was recommended in 6 months. Follow-up actually occurred on 8/16/13. The consult was received 9/5/13 and documented in the IPN on 9/6/13. • Individual #277 was seen by the neurologist on 11/1/13. An EEG and MRI were requested. The consult was not received until 11/14/13, which delayed ordering the studies. • Individual #108 was seen in clinic on 6/21/13. The PCP documented in the IPN on 7/11/13 that no consultation report was received. • Individual #134 was seen in clinic on 10/1/10 for evaluation of seizures. Follow-up was recommended in six months. In 2013, the individual had an increase in the frequency of seizures at which time the PCP requesting consultation noted, "we missed your request for a six month follow-up." The assessment in November 2013 was recurrent seizure and neuroleptic induced movement disorder. Recommendations were made to increase the AED dose, check labs, and return in six months. Follow-up occurred three years after the initial appointment. **Access To Specialists** The medical department did not monitor the timeliness of clinic appointments. There was no ability to determine if appointments were occurring in a timely manner. The spreadsheet submitted included the date of the appointment, but did not provide the date that the request was made or needed. It also did not separate campus clinics from off-campus appointments. The facility will need to address the requirement to provide access to specialists as part of the provision of healthcare services. Monitoring of clinic appointments must track the timely completion of appointments based on the determined need and prioritization of the appointment. Moreover, the facility must have a procedure in place to ensure that follow-up of failed appointments occurs in a timely manner. The facility must be able to accurately track the needs of the individuals and the response of the facility to those	

#	Provision	Assessment of Status	Compliance
		needs in terms of providing access to health care services. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included 14 individuals. Following the onsite review, the monitoring team was provided several additional documents. Another document listed 19 individuals who had DNR orders. The involvement of the guardians and review by the ethics committee was documented for each individual. Eleven of 19 individuals had guardian involvement. For the eight individuals with no guardian involvement, the ethics committee reviewed three cases. Several of the diagnoses documented, however, appeared vague and included debilitation, failure to thrive, and osteoporosis. One case (Individual #238) did not follow proper procedure and was reviewed by the monitoring team in detail at a meeting with the facility's medical and administrative staff. The monitoring team recommends that in those instances when out of hospital DNRs are considered for individuals with <u>no clear medical justification</u>, there should be a review by the Ethics Committee with input from state office to ensure compliance with state guidelines. <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. Medical staffing will need to be addressed in order to decrease he caseloads of the two primary care physicians to 100 or less. 2. The current process for requesting physician attendance at ISPs should be reviewed to ensure that requests are being made for individuals whose health status has a significant impact on the planning process. Physicians should be held accountable for attending a reasonable segment of the meeting to discuss the health related issues. 3. The facility director should ensure that appropriate medical coverage is provided on weekends. Individuals who return from the hospital and emergency department require evaluation within 24 hours. This can be accomplished by having the on-call physician conduct weekend rounds to address any urgent issues and required follow-ups. 4. The medical director should address the documentation requirements with the medical staff as outlined in the healthcare guidelines. 5. The medical director should re-evaluate the current use of standing physician orders. 6. The medical director should review the requirements for consultation referrals and documentation as discussed in section G2 and ensure that the medical staff	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>are aware of the requirements.
7. The medical director should review specific recommendations relate to pneumonia, diabetes, and neurological care discussed in the report.
8. Recommendations and comments discussed in the various sub-sections should be addressed.</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 - External</u>
An external medical reviewer conducted Round 8 of the medical audits November 14 -15, 2013. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were 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, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. A total of 12 records were reviewed for the general medical audit. The facility submitted data for the external audits. Those data are summarized in the table below:
<table><tr><th colspan="2">Round 8 General Medical Audits
% Compliance</th></tr><tr><td>Essential</td><td>Non-Essential</td></tr><tr><td>97.5</td><td>92</td></tr></table>
Compliance scores were less than 80% for the following questions:
• Q5 – Does the summary include significant medical events of current and past years?
• Q44 – When an initial referral was requested, was pertinent current and past medical history included in communication with consultant?
• Q33 – Are responses to significant lab values documented in the IPN?
• Q29 – Did the provider document a rationale for not following the recommendations made by the pharmacist if the provider chose not to abide by the recommendations

In addition to the general medical audits, medical management audits were also completed. Six charts, three for each selected condition, were reviewed. The results are presented in the table below.
<table><tr><th colspan="3">Round 8 Medical Management Audits
% Compliance</th></tr><tr><td>Constipation</td><td>Seizure</td><td>UTI</td></tr><tr><td>75</td><td>60</td><td>64</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A total of 24 action plans were developed for the general medical audits. Thirteen action plans were developed for the medical management audits. At the time of the compliance review, all of the corrective action plans for the medical management audits were completed. The plans for the general medical audits were not completed. The facility's management of corrective actions was discussed with the medical director during the compliance review. The monitoring team was specifically interested in what corrective action were taken to address the low compliance scores received for the medical management audits. It appeared that each physician addressed specific care or documentation issues, but there had been no additional review to determine if systemic issues contributed to such low scores. The facility completed the external review within the required timeframe and implemented corrective actions for identified deficiencies for the medical management audits. The corrective actions for the general medical audits remained outstanding at the time of the review. In addition to the outstanding corrective action plans the monitoring team had several other concerns: • The findings of the monitoring team were significantly different from that of the external reviewer. While the record sample was not the same, the monitoring team was surprised that none of the problems related to legibility of IPN entries, lack of follow-up, and lack of assessment following acute care evaluations/treatment was documented by the external reviewer. • The quality of the IPN documentation was also not addressed in the external audit. It was very provider specific, but the lack of pertinent positive and negative findings was a significant concern that was not commented on in the exit. Examples were provided in section L1. • While the PCPs may have signed the QDRRs in a timely manner, the majority of the records did not include current QDRRs at the time of the audits. The poor status of the QDRRs at that time was well documented. A problem of this magnitude should have been detected by an external medical review and reported, but it was not. • The compliance scores for the medical management audits indicated that further analysis was needed and that did not occur. • There were problems with the content and comment of the audit tool. Guidance was provided to the auditor for each question. There were several questions in which the guidance provided conflicted with state preventive care guidelines,	

	Total Action Plans	Completed
General Medical	24	0
Medical Management	13	13

#	Provision	Assessment of Status	Compliance
		particularly with regards to the recommendations for mammography and osteoporosis screening. The summary for state policy states "attempt annual screening mammography for women age 40 -70 years." The guidance in the tool is not consistent with this statement. The monitoring team found that the guidance provided for other questions, such as Question #45 related to consultation recommendations, was also misleading. It is recommended that the validity of this tool and the guidance for the questions be re-evaluated. Round 8 was a one day review. The exit for the review occurred at 10 am on the 11/15/13. A through review of medical care that is conducted every six months will likely take more than one day to complete. This review used only <u>one source</u> of information to assess medical care: the active record. The sample size will need to sufficient to make a reasonable determination with regards to the quality of care provided. Twenty-one records were reviewed with nine of the records having a focus on only one specific medical issue. General medical care was assessed for 12 individuals. The sample size for review of general medical care may not be sufficient and should be increased to reflect the requirement for 10% sample. <u>Mortality Management at SGSSLC</u> Seven deaths occurred in 2013 and two had occurred in 2014 at the time of the compliance review. There were three deaths since the last compliance review. The average age of all deaths for 2013 was 65.2 years. The mortality documents for the four deaths that occurred from June 2013 through November 2013 were reviewed. Information for those deaths is summarized below: • The average age of death was 60 years with an age range of 32 to 82 years. • The causes of death were: o Cardiac failure of unknown origin o Chronic respiratory failure, recurrent pneumonia o Cardiac arrest, cardiovascular heart disease, epilepsy o Acute lobar pneumonia, atherosclerotic cardiovascular heart disease • Two autopsies were performed. During the September 2013 compliance review, the facility had not completed all death reviews. The dates for completion of reviews are summarized in the table below.	

Mortality Reviews		
Date of Death	Clinical Death Review	Administrative Death Review
6/24/13	9/11/13	11/4/13
7/16/13	8/14/13	9/9/13

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7/26/13	9/25/13	11/4/13
11/19/13	12/2/13	1/29/14

There were substantial delays in completion of the clinical and administrative mortality reviews. Additional time is allowed for receipt of autopsy reports. A preliminary clinical death review should occur to ensure that major issues are addressed with a follow-up meeting conducted when the autopsy report is available. Once the clinical death review is completed, the administrative review should not be delayed. The lapse between clinical and administrative reviews was not consistent with state policy.

In addition to documented delays, there continued to be a lack of an objective physician review. The medical director reported that he did not review the records of all individuals following a death. An external physician participated in some clinical death reviews, but it was noted that this physician actually provided services at the facility as an on-call physician and, therefore, could not be considered an external reviewer. Recommendations from the administrative death reviews were followed up in the Administrative IDT meetings.

The monitoring team met with the facility director, medical director, CNE, QA director, medical compliance nurse, and QA nurse, to discuss mortality management at the facility. The monitoring team was specifically concerned about the discrepancies in the cause of death noted for one individual. The autopsy report reviewed documented the cause of death as acute combined drug intoxication. The death certificate cited cardiopulmonary failure of unknown origin. It was not clear how the autopsy findings impacted the cause of death cited on the death certificate. This important issue deserved attention and a finite resolution.

The monitoring team encourages the facility staff to improve the mortality review process by taking a number of actions:

- Ensure that adequate information is reviewed (no less than one year of the records, and two if possible).
- Ensure that all hospital information is obtained for review.
- A physician, preferably one not associated with the facility, should conduct a comprehensive and objective review of the medical care. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review.

<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:

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>1. Corrective actions should be tracked in a timely manner and appropriate documentation maintained of the tracking.
2. Low compliance scores require additional evaluation.
3. There should be evidence that data are utilized by the medical department for the purpose of performance improvement.
4. Mortality management should be addressed as noted above.</td><td></td></tr>
<tr><td>L3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.</td><td><u>Internal Medical Reviews</u>
Round 8 of the internal medical audits were completed in August 2013. The results are presented in the table below.
<table><tr><th colspan="2">Round 8 General Medical Audits % Compliance</th></tr><tr><td>Essential</td><td>Non-Essential</td></tr><tr><td>97</td><td>92.5</td></tr></table>
The external and internal audits for Round 8 were completed at the same time to allow for assessment of inter-rater reliability. There were no significant differences in scoring.

Medical management audits were also completed in August 2013. The findings for the six charts reviewed are listed below.
<table><tr><th colspan="3">Round 8 Medical Management Audits</th></tr><tr><td>Constipation</td><td>Seizures</td><td>UTI</td></tr><tr><td>58</td><td>75</td><td>90</td></tr></table>
Corrective action plans to address the general and medical management audits were developed by the QA department. The number of plans is documented in the table.
<table><tr><th></th><th>Total Action Plans</th><th>Completed</th></tr><tr><td>General Medical</td><td>13</td><td>0</td></tr><tr><td>Medical Management</td><td>10</td><td>10</td></tr></table>
The corrective actions for the medical management audits were completed, however, those for the general medical audits were outstanding at the time of the review.

<u>Medical Quality Program</u>
At the time of the compliance review, the facility had not defined any systems, apart from the medical audits, to measure the quality of care provided. SGSSLC maintained databases that included a number of data elements related to preventive care,</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		hospitalizations, seizure management, and pneumonia. There was no evidence that the medical department had a process to review, analyze, and trend this data for the purpose of identifying areas of strengths as well as opportunities for performance improvement. There were no data presented for the diabetes tools that was presented during the last compliance review. The facility must develop a comprehensive set of indicators that includes a mix of well-defined and measurable process and outcome indicators. 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 recommends the consideration of the following. 1. The medical management audits should be expanded to include additional conditions that require monitoring related to the quality of care. 2. The facility must develop and implement a medical quality program. As recommended in the previous reports, the facility will need to develop a comprehensive set of indicators that includes a mix of process and outcome indicators. Clinical outcomes must be assessed as part of this process. The facility will need to demonstrate that indicator data are collected, analyzed, and trended. Such analysis will define the strengths of the department as well as those areas that require improvement and need to be addressed through systems changes.	
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	The monitoring team requested a copy of the complete medical policy and procedure manual including any other facility policies that were related to medical care. The facility submitted a number of policies and procedures. The medical department updated the lab matrix. No other medical policies or procedures were revised or updated. The lab matrix also included guidelines for general preventive care, some of which, such as those for breast cancer and osteoporosis screening, were not consistent with state policy. Several other policies and operational procedures generated by the medical, pharmacy, nursing, and habilitation department were submitted and reviewed. Many of these policies and procedures were key to the delivery of health care services and were not	Noncompliance

#	Provision	Assessment of Status	Compliance
	be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	revised in many years. The following are just a few of the important, but outdated polices submitted: • Admission From Hospital to Infirmary, 2001 • Life Sustaining Treatment and Resuscitative Status, 8/17/07 • Death of a Person Served, 2/28/96 • Administration of Sedation Intramuscular Intravenous, Inhalation Medication, 2001. Each of these policies required review and revision because they were not consistent with requirements of the current standards of the facility. Many other policies and procedures were also noted to be inconsistent with requirements of the Settlement Agreement and, therefore, should be re-evaluated. The medical care policy was adopted in June 2011, but it did not include a description of the basic medical staff requirements and job duties such as caseload responsibilities, completion of clinical rounds, on-call coverage responsibility, and weekend coverage. The serious on ongoing problem related to physician assessment following acute care evaluations and treatment should be defined in policy. The policy should delineate how follow-up will be managed on weekends and holidays. The medical department needs a comprehensive medical manual that includes the relevant information related to operations of the department and provision of health care services. This would include, but not be limited to information on staffing and caseloads, the role of the PCP in the IDT process, requirements for participation in ISPs and ISPAs, and participation of primary providers in various meetings. Procedures related to delivery systems should be provided, such as how consults are ordered, the process for obtaining labs, ordering x-rays, and the various tracking systems. The requirements for the actual provision of care should also be included and cover acute care, preventive care requirements, and the expectations for the use of the various clinical guidelines and protocols. Another component of the manual would be the policies and procedures that describe the oversight processes, such as the internal and external medical reviews, the medical quality program, the mortality review process, and the facility's QA system. Other relevant policies, procedures, and guidelines, such as those related to the use of psychotropics, pharmacy services, and other integrated services should also be included. These official documents must include the issue/implementation date and be signed and dated by the appointing authority. The facility must also have a procedure in place to ensure that all policies and procedures undergo an annual review and are updated and revised as deemed appropriate.	

#	Provision	Assessment of Status	Compliance
		The facility provided documentation that the medical staff received information on the various policies, procedures, and guidelines. It was acknowledged that not all current staff were trained on the relevant policies, procedures, and guidelines. SGSSLC had yet to develop local policies based on state issued clinical guidelines. <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. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions, such as hypertension, hyperlipidemia, and other identified conditions. 2. Local policies should be developed based on state issued guidelines. 3. Each member of the medical staff should have a medical department policy and procedure manual that includes all relevant policies and procedures and guidelines. 4. The medical department should maintain written documentation of all training and in-services that are provided 5. The department should establish a system for annual review of all medical policies and procedures. 6. The recommendations above should be addressed.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SGSSLC Section M Self-Assessment, updated: 12/1/14 o SGSSLC Section M Action Plan, updated: 01/28/14 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 Last six months Nursing staffing reports o SGSSLC Number of Budgeted Positions by RN and LVN o SGSSLC Last six months Nursing Administration Meeting Minutes with Assistant Director of Operations (ADOP) o SGSSLC Shannon Partners Meeting Minutes, dated: 7/31/13 and 1/22/14 o SGSSLC 24 Hour Report Sheets, 2/5/14 through 2/19/14 o SSLC Guidelines: Comprehensive Nursing Review, Quarterly Nursing Record Review, o Quarterly Physical Assessment, dated: January 2014 o SGSSLC Standing Orders, dated: 12/3/13 o SGSSLC RN Case Management Meeting Agenda, 2/1/14 o SGSSLC Last six months RN Case Management Meeting Minutes o SGSSLC RN Case Managers instructions for implementing the, IRRF, IHCP and DSP instructions o SGSSLC Listing of RN Case Managers Tracking Logs, Nursing Assessments, IHCPs, MOSES, and DISCUS o SGSSLC Last six months LVN Meeting Agendas o SGSSLC RN Nurse Managers/LVN Meeting Agenda, 2/19/14 o SGSSLC Emergency Room Visits, Hospitalizations, and Infirmary Admissions for the last year o SGSSLC Admission from Hospital to Infirmary Policy and Procedure, revised: 01/13/06 o SGSSLC Acute Care Nursing Assessment Form o SGSSLC Emergency Response, revised: 12/16/13 o SGSSLC Emergency Equipment Walk Through Checklist, revised: 12/16/13 o SGSSLC Listing of Emergency Bags/Automatic External Defibrillator (AEDs) Locations o SGSSLC AED, Emergency Oxygen Tank, Suction Machine, and Emergency Crash Bag Checklists by units, dated 1/1/14 through 1/31/14 o SGSSLC Last six months Emergency Drill Checklists, raw data o SGSSLC Skin Integrity (SIT) last six months meeting minutes, July 2013 through November 2013 o SGSSLC SIT 2/18/14 Meeting Agenda, and associated documents o SGSSLC Infection Control Policies, revised: 1/30/14 • Statement of Policies in Relation to the Infection Control Program

	• Prevention of Transmission of Infection • Personal Protective Equipment • Care, Cleaning and Monitoring of Refrigerators • Reporting Follow-up for all individuals with infections • Cleaning Up Blood Spills • Environmental Cleanliness • Reporting/Follow-up for all individuals with infections • Laundry and Linen Procedures • Bathing Procedure • Oral Hygiene Procedure • Incontinence Care • Hand Hygiene o SGSSLC Line Listing of Individuals with Known Infectious Conditions/Diagnosis Update, dated: 1/30/14 o SGSSLC Definition of Infection for Surveillance in long-term Care Facilities, revised: 3/20/03 o SGSSLC Quarterly Infection Control Meeting Minutes and associated documents, dated: 1/21/14 o SGSSLC Antibiogram, not dated o SGSSLC Line Listing of Blood Borne Exposures, not dated o SGSSLC Immunization Tracking Report, not dated o SGSSLC 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) 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 Difficile (C-Diff) and/or sexually transmitted disease (STD's) including name, unit and date of diagnosis o SGSSLC Protocol Related to Choking Incidents with Heimlich Maneuver, Self-Clear Choking Incidents, and Coughing Episodes, revised: 10/28/13 o SSLC Nursing Protocol: Skin Management and Wound Prevention, dated: 5/11 o SGSSLC Nursing Protocol: Eternal Nutrition, revised: May 2013 o SGSSLC Nursing Procedure: Gastrostomy Tube: Insertion by a Nurse, dated: June 2013 o SGSSLC Last six months Blood Glucose Control Test Monitoring o SGSSLC Medication Room Audit Inspections raw data, dated: 1/23/14, 1/24/14 and 1/25/14 o SGSSLC Medication Observation Form, dated: 10/31/12 o SSLC Medication Observation Guidelines, dated: October 2012 o SGSSLC Last six months Hospitalizations and ER visits o SSLC Medication Variance Policy #053, effective: 9/23/11 o SGSSLC Medication Variance Report Form, dated: 11/3/11 o SGSSLC Medication Over/Short Form, dated: 11/3/11 o SGSSLC Listing of Medication Administration Times o SGSSLC Hours Commonly Used for Scheduled Medications and Treatments, dated: 9/1/01 o SGSSLC Last ten Medication Variances and Corrective Action Plans (CAP)

	o SGSSLC Medication Variance Committee Meeting Agenda and associated documents dated: 2/19/14 o SGSSLC Medication Review Committee Polypharmacy Agenda and associated documents, dated: 2/17/14 o SGSSLC Pharmacy and Therapeutics Committee Meeting Agenda and associated documents, dated 2/17/14 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 and injury, urgent care/emergency room and hospitalizations, medication administration, 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 Clinical Review Committee Meetings, Clinical Mortality Summaries, and Recommendations for the last six months o A List of Individuals At Risk for: 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 Records reviewed: • Individual #20, Individual #73, Individual #78, Individual #94, Individual #175, Individual #388, Individual #24, Individual #40, Individual #46 Individual #76, Individual #101, Individual #110, Individual #203, Individual #127, Individual #140, Individual #146, Individual #153, Individual #218, Individual #236, Individual #246, Individual #294, Individual #375, Individual #47, Individual #66, Individual #77, Individual #104, Individual #127, Individual #140, Individual #201, Individual #202, Individual #277, Individual #329, Individual #379, and Individual #380 <u>Interviews and Meetings Held</u>: o Angela Garner, RN, BSN, Chief Executive Officer (CNE) o Anna Pittman, RN, BSN, Interim Case Manager Supervisor/Nurse Operations Officer (NOO) o April Watson RN, Program Compliance Nurse o Courtney Daniels RN, Infection Control Preventionist (ICP) o Karen Breast RN, Assistant Infection Control Preventionist (ICP) o Rachael Wittich, RN, Nurse Educator o Leslie Nixon, RN, Hospital Nurse Liaison o Virginia Dooley, RN, Clinic Nurse o Lisa Owen, RN, BSN, Quality Assurance Nurse o Informal interviews with Nurse Managers, Staff RNs and LVNs o At-Risk Meeting 2/18/14 <u>Observations Conducted</u>: o Residential areas at various times of the morning and evening o Medication Observations in units 508A, 508B, 509A, 509B, 510A, 510B, and 516 E during various

	times of the morning and evening o Medication Administration Observations Passes: Individual #40, Individual #46 Individual #76, Individual #101, Individual #110, Individual #203, Individual #127, Individual #140, Individual #146, Individual #153, Individual #218, Individual #236, Individual #246, Individual #294, and Individual #375 o Medication Room Observations of various units, with focused inspection of external, internal stock drugs, and refrigerators o Inspection of Emergency Equipment in units 504, 505, 508A, 509, 511, 512, and 516 E o Individual Support Meeting for Individual #66 held on 2/18/14 o Pharmacy and Therapeutics Committee Meeting 2/18/14 o Skin Integrity Meeting (SIT) 2/18/14 o Polypharmacy Committee Meeting 2/18/14 o Daily Clinical Provider Meetings, 2/17/14, 2/18/14 and 2/19/14 o Nursing Meetings 2/17/14, 2/18/14, and 2/19/14 o Nursing Administration/Medical Meeting 2/19/14 o Medication Variance Committee Meeting 2/19/14 o Pneumonia Committee Meeting 2/20/14
	Facility Self-Assessment: SGSSLC submitted its self-assessment for section M. For each sub-section, SGSSLC had identified activities engaged in to conduct the self-assessment, results of the self-assessments, and a self-rating of substantial compliance or noncompliance with a rationale. The self-assessment documented the type and number of audits. However, there was no supporting documentation in the self-assessment that addressed validation of the audits through inter-rater reliability processes. The facility should evaluate its actions steps, to ensure that the action step contains doable, measurable outcomes that will move the facility forward toward compliance for the identified provision. The action steps on the self-assessment, gave the appearance of tasks. The facility rated itself as being in substantial compliance with section M2, and in noncompliance with the other five provisions. The monitoring team agreed with the facility's self-ratings except for M2, which the monitoring team found to be in noncompliance.
	Summary of Monitor's Assessment: The Nursing Department leadership team had remained stable for the past 12 months. The RN Case Manager was promoted in January 2014 to the Nursing Operations Officer, and an assistant was added to the Nurse Educator position. The vacant RN Nurse Manager had been filled, bringing the Nurse Managers to full capacity. The Nursing department continued to have challenges in filling vacancies and required the

	use of agency staff. The RN Case Manager, prior to taking the NOO position, had implemented processes to ensure: • 100% monitoring and tracking of all nursing assessments for both timeliness and quality • 100% monitoring and tracking of MOSES and DISCUS for timelines and quality The Nursing Department established standing meetings with the Medical Director and worked collaboratively to ensure standardized care and services were individualized (i.e., ensuring P.R. N. orders were individualized). The Infection Control Preventionist reviewed and revised 50% of the facility's infection control policies. The Nursing Department increased oversight through audits to ensure blanks (omissions) on the MAR or unexplained returns were reconciled. The Nurse Educator implemented training for implementation of SGSSLC's newly developed Protocol cards for Coughing Episodes and Choking events. The Nursing Department made improvements to its practice of 24-hour chart review process to now include all units. Based on a review of 45 medication pass observation for 15 individuals, conducted during monitoring team visit, there was negligible progress in following accepted standards when administering medications.

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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 monitoring team conducted its own independent review of the facility's self-assessment, action plans, and information presented in section M. The monitoring team held interviews and meetings with the CNE, NOO/RN Case Manager Supervisor, Compliance Officer, Hospital Liaison Nurse, Infection Control Preventionist, Nurse Educator, Clinic Nurse, Nurse Managers, QA Enhancement RN, direct care RNs, LVNs, and direct support professionals. The monitoring team also reviewed individuals' records, conducted nursing interviews, made observation on the units, and attended a variety of meetings. The monitoring team reviewed the presentation book and other documents submitted by the facility, but found no data for elements of infection control. The CNE quickly fashioned a plan to obtain the document omissions. During the review, the monitoring team observed 25 individuals during various times of the day and evening across eight homes in all three units. Fifteen individuals were	Noncompliance

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		observed receiving their medications on six of those homes. The monitoring team observed 13 nurses on the units, LVNs, Nurse Managers, and RN Case Managers who were observed administering medications or performing an assessment. <u>Staffing, Structure, and Supervision</u> SGSSLC census at the time of the monitoring visit was 217. The nursing department was currently budgeted for 83 nursing positions. This had decreased by three positions since the last monitoring review. The facility's data submission explained the decrease was due to recruitment efforts that resulted in more RN applications than LVNs. Thus, the facility converted six direct care LVN positions to four direct RN positions. This resulted in 47 RN and 36 LVN positions. As of 2/1/14, there were 13 vacancies; five were RN and eight were LVN. The facility continued to require the use of agency nurses in order to meet staffing requirements. Since the last review, the facility filled the vacant RN Nurse Manager position, promoted the RN Case Manager to the position of Nursing Operations Officer, and assigned a nursing position to the RN Nurse Educator. The Infection Control Preventionist Assistant was re-assigned in August 2013 to fill a vacant RN Case Manager Supervisor position until the RN Case Manager vacancy was filled in November 2013. The facility's Risk Data identified that 178 (78%) of the individuals residing at SGSSLC were determined to be High Risk in one or more areas and/or to have health/mental health conditions requiring an Integrated Health Care Plan (IHCP) for performing interventions, and for monitoring their diagnosed health/mental health conditions. The CNE should ensure staffing is managed and assessed, not only by the methods/models of scheduling and staffing ratios, but should also include an acuity factor. One of the ways nursing direction was applied by the RN Nurse Managers was through biweekly meetings with the LVN/RN staff. The monitoring team attended one of the LVN/RN meetings of which only one RN attended. The monitoring team reviewed the document submission of LVN and RN meeting agendas. There was no additional data as to documentation of attendees, actions taken, or if feedback/reminders/directives resulted in change. An example from the facility's agenda was the directive regarding the appropriate use of approved abbreviations. All Nurse Managers were housed in one main building, away from the units where the nurses they supervised provided the day to day nursing procedures (e.g., assessments, sick call, administration of medication). A standard was not in place by the Nursing Department, where RN Nurse Managers were empowered to adjust their Monday through Friday schedule for conducting random unannounced supervisory visits on different shifts, including weekends.	

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		The monitoring team attended one of the facility's Nursing Administration Meetings held with the ADOP. The CNE, nursing leadership, Quality Assurance Nurses, and the ADOP attended the meeting. The meeting was productive as the Nurse Managers were involved in problem solving and data collection related to the process of how narcotics were requested, the number requested, and accountability of narcotics in collaboration with the pharmacy. The group concluded, for next steps, to meet and share their findings with Pharmacy. The monitoring team reviewed the last six months of Nursing Administrative Meetings. The minutes contained verbatim statements rather than a summarized state of the problem/issue and action steps that could be tracked to resolution. Nonetheless, it was positive to find that the ADOP, throughout the minutes, provided guidance and empowered the nursing leadership to set standards and hold nursing staff accountable through appropriate progressive disciplinary actions when remedial training was not successful. <u>Availability of Pertinent Medical Records</u> During the onsite visit, records were accessible, including the individual notebook. The monitoring team reviewed onsite records and found: • Record for individual #218: 24-hour weekly chart checks were documented. Associated documents for an acute illness, IPN note, ACP, staff instructions, and applicable physician orders were accessible in the chart. • Record for individual #24: The record contained an incident report with a corresponding IPN Nursing SOAP note, and an implemented Neurological check sheet. A review of the sample of the 12 records selected for a comprehensive review found: • Nursing IPNs were consistently documented using the SOAP format • Nursing signature and titles were frequently illegible • Temperatures did not include the method of which they were obtained • Inappropriate abbreviations with documentation that could be deciphered • Oxygen saturations did not consistently indicate if room air or on oxygen • Medication/Treatment Records contained omissions (blanks) • Acute Care Plans, staff instructions for the associated problem were not found in the records <u>Hospitalization and Hospital Liaison Activities</u> During the monitoring team's attendance at various meetings (e.g., Daily Provider Clinical Meeting), the Hospital Liaison was observed providing current information regarding individuals who were hospitalized. It was impressive to find that the Hospital Liaison Nurse, when asked or when information was pertinent to discussion of individuals, was able to readily access and provide the information during the meeting.	

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		The monitoring team interviewed the Hospital Liaison Nurse, who had prepared for the meeting in advance. She brought examples of documentation of Hospital Liaison activities she performed as follows: • Hospital Liaison Visits Reports • Documentation of applicable communication emails to IDT, Residential, Nursing, and Medical team members regarding changes that occurred before or after the Hospital Liaison report was initiated, or at any time if they had questions or concerns • Hospital/ER Admissions spreadsheet • Audit examples of completed Urgent Care/ER/Hospitalizations Monitor Tool for • Audit examples of completed Documentation/Hospital Transfer • Shannon Hospital Partners Meeting Minutes, dated: 7/13 and 1/22/14 In addition to the above activities, the Hospital Liaison: • Attended Daily Provider Meetings and reported on the status of hospitalized individuals • Made daily hospital rounds (Monday through Friday). The facility had an assigned nurse for weekends and holidays for follow-up on individuals who were or became hospitalized. • Conducted Quality Assurance Audits as assigned • Entered data into Avatar for hospitalizations • Requested, received, and distributed hospital information • Completed Hospital Liaison Reports and submitted to units • Coordinated consults or follow-up medical appointments for post hospitalizations The monitoring team reviewed nine of the Hospital Liaison Hospitalizations Reports for Individual #140's and Individual #66's recent hospitalizations and found: • Nine of nine (100%) had a daily visit/or telephonic communication • Nine of nine (100%) of the reports contained pertinent information to keep the team informed of the health status of the individuals It was evident that the Hospital Liaison continued to make improvements with the Hospital Liaison activities, which included being proactive in the Partners Meeting held between the hospital and facility. Exampled below are actions taken by the hospital and actions taken by SGSSLC related to their discussion, as evidenced in the meeting minutes: • Hospital Actions: Ensure Emergency Transfer form, ER Summary, services provided, prescriptions and discharge instructions accompany the individual upon discharge. • SGSSLC Actions: Ensure Individual's requiring special equipment, were made	

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		available to the hospital. • Hospital/SGSSLC Actions: Investigate care issues related to hospital acquired skin breakdown/decubitus. The monitoring team also reviewed three of the most recent hospitalization Post-Hospital/ER/LTAC Nursing Assessment, and IPN notes for Individual #140 and Individual #66 and found: • One of two (50%) Post Hospitalization/ER/LTAC Nursing assessments contained sufficient information about the discharge and current health status of the individual. • None of the two (0%) records contained an Acute Care Plan or staff instructions for the individual's acute care problems. In November 2013, the Hospital Liaison began the audit process for Urgent Care/ER/Hospitalizations. The findings showed an overall score of 36% for November 2013. The monitoring team's findings were comparable with those from the audit. <u>Infirmary</u> The facility continued to have a functioning Infirmary. Individuals, returning from more than a 23 hours hospital admission, were admitted directly to the infirmary. As noted in the last two monitoring reports, the facility had neither reviewed nor made revisions to its current policies (e.g., Admission From Hospital to Infirmary). The facility's document submission, for the period of 6/12/13 through 12/20/13, showed that there were 14 admissions, of which four (29%) of the individuals had one or more admissions. The length of stay in the Infirmary varied from one day to 67 days. The monitoring team reviewed the record of Individual #277, who had a recent infirmary admission related to seizure activity and found: • IPN Physician note on 11/1/13 at 6:00 pm contained an order for transferring from the unit to the Infirmary for "better supervision." • Physician orders on 11/1/13 at 7:15 pm contained an order to admit to the Infirmary. • A corresponding IPN Nursing note for the 11/1/13 admission to the Infirmary was not found in the record. The next available IPN Nursing note was recorded on 11/2/13 at 4:25 am and 8:50 am, both referred to the completion of an "acute care assessment" which was not located in the document submission. The IPN Nursing notes did not include historical information regarding her last seizure, current medication she was receiving for seizures, or a review of the record for an assessment for constipation. The IHCP, dated 4/17/13, had an objective that the individual would continue to take her medicine, with a goal of not having any	

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		seizure activity over the next 12 months, which was not a realistic goal. The record had an omission for any staff instructions or the implementation of an Acute Care Plan for seizures. • For Seizure records, dated 11/1/13, corresponding IPN Nursing notes were not found in the record. <u>Wound and Skin Integrity</u> The RN Nurse Manager continued to chair the Skin Integrity Committee (SIT). The monitoring team attended the SIT meeting, which was also well attended by Nursing, QA, PNMT, Medical Director, Pharmacy Director, and Infection Control Preventionist. The meeting included agenda items and handouts for discussion. The meeting was well organized, and there was active participation by the team members. The RN Nurse Manager provided data on the number of pressure ulcers per individual and whether or not each was facility or hospital acquired. The data submitted by the facility identified the number of pressure ulcers by home. From June 2013 through January 2014, the reports showed a total of 16 pressure ulcers. December 2013 and January 2014 reported six pressure ulcers, five were Stage II and one was Stage III. Four of the Pressure Ulcers were reported as hospital acquired. The SIT committee was active in discussing underlying rationale for the occurrence decubitus that had occurred both in the facility and in the hospital, and omission of practices, such as implementing an Acute Care Plan to ensure sufficient staff training. The following issues were also raised by the committee during the meeting for continued planning and intervening to improve upon the facility's practices and procedures related to skin integrity. • Clarify and instruct on what is and what is not a decubitus • Update and revise the Skin Integrity Policy • Update shared systems to ensure tools and assessment documents are the most current The above initiatives were pending for further review and implementation by the committee. The monitoring team will follow-up at the next visit. <u>Infection Control</u> The monitoring team met and interviewed the Infection Control Preventionist and Assistant Infection Control Preventionist, with the CNE in attendance. Since the last monitoring visit, the Infection Control Preventionist had obtained membership in a nationally recognized Infection Control Organization. The membership provided access to current acceptable standards of infection control practices, surveillance, and literature resources. The nurses reported that the access was an asset in performing infection control activities. In addition, it was positive to find the Infection Control Preventionist	

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		had developed an ongoing relationship with their state and local public health departments, and frequently made contact to seek advice on outbreaks (e.g., flu). Advice from the health department resulted in recommended treatments with anti-viral medications, based on their 34 cases of flu, of which the recommendations were implemented by the facility. The ICP, as recommended by the monitoring team at the time of the previous review to review and revise their policies, had revised the following Infection Control Policies and Procedures: • Statement of Policies in Relation to the Infection Control Program 1/30/14 • Prevention of Transmission of Infection1/30/14 • Personal Protective Equipment 1/30/14 • Care, Cleaning, and Monitoring of Refrigerators 1/30/14 • Reporting Follow-up for all individuals with infections 1/30/14 • Cleaning Up Blood Spills 1/30/14 • Environmental Cleanliness 1/30/14 • Reporting/Follow-up for all individuals with infections 1/30/14 • Laundry and Linen Procedures 1/30/14 • Bathing Procedure 1/30/14 • Oral Hygiene Procedure 1/30/14 • Incontinence Care 1/30/14 • Hand Hygiene 1/30/14 Additional Activities by the Infection Control Preventionist included: • Tracking of Immunizations • Tracking of Individual and Staff PPDs and Convertors • Participation in Community Emergency Mock Drills • NEO orientation • Training specific to identified infections, outbreaks (e.g., Quarantine of Flu) • Real Time monitoring of infections • Monitoring refrigerator temperature logs <u>Infection Control Meetings</u> The Infection Control Committee had met once since the last review, even though the facility policy indicated meetings were to occur quarterly or more frequently based on infections. The monitoring team reviewed the 1/21/14 Quarterly Infection Control Minutes, associated data, and the requested infection data to date for January 2014 and February 2014. The minutes specified for the Antibiogram, attachment #1, which was not included in the requested document submission. The minutes contained discussion as to underlying issues for associated increases and decreases and spikes in the reported infections, outbreaks, and sexually transmitted diseases, and actions taken to minimize the spread of those infections. Even so, the monitoring team was perplexed as to the	

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		explanation of or lack of explanation for the increase in the number UTIs on home 516. The monitoring team recommends that, in order to have a robust infection control program, all infections should be assessed and evaluated for the underlying reasons for trends, increases, and spikes in the data or conducted surveillance. In addition to the minutes, the monitoring team reviewed the line listing provided in the document submission for blood borne pathogen, type of exposure, exposure risk and treatment log for the last six months for employees. The log showed for dates of 9/1/13 through 1/28/14 for a total of 22 occurrences. • 17 of 22 (77%) occurrences were documented as bite (human bite). Of the remaining occurrences, three were classified as exposure to bodily fluids and two were puncture. • 17 of 17 (100%) of the employees bite exposure received "low education" regarding the risk • 15 of 17 (88%) of the employees bite exposure "refused testing" • Three of three (100%) of the exposures to bodily fluids received education and completed or ongoing follow-up testing • Two of two (100%) refused testing for their puncture wound The facility should ensure the obtained data from all exposures are routinely reviewed as part of the Infection Control Agenda to ensure required practices for pre- and post-exposures have been effectively assessed, evaluated, and followed-up. <u>Immunization/Vaccine Data/PPD Testing</u> The facility reported the status of vaccinations for individuals residing at SGSSLC by percentages. | MMR	TDaP	Varicella	Hep A	Hep B	Meningococcal	Pneumococcal
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85%	94%	84%	78%	91%	73%	89%	 There was not additional explanation provided for the percentages falling below 100%. In addition, the document did not contain information on the number of individuals who were eligible to receive the Shingles vaccine or had been vaccinated against the Shingles virus. The Infection Control Preventionist is credited with audit trend findings for omission of immunization data or titers for new admissions. The facility, as a result of the findings took steps to coordinate with the transition RN to obtain the immunization history prior to an admission. • 99% of the individuals at SGSSLC received their flu vaccination. One individual was noted to have "refused" her vaccination, however, no information was available if the individual had capacity to refuse. The facility had documentation	

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		where several different attempts were made to explain the importance on receiving the vaccine. Even with these efforts the individual continued to "refuse" her flu vaccination. • 57% of the staff were vaccinated against the flu, 148 had declinations and their reason for the declining the vaccine, of which the larger number was reported as "doesn't want." • 100% of SGSSLC individuals and staff were current with their PPD testing. The document request included the number of individuals who had converted and their follow-up status, of which the facility provided a line listing. However, the monitoring team could not discern, from the data, the number of individuals who were actual converters, the status of their annual assessments, or who conducted those assessments. <u>Emergency Response</u> Since the last monitoring visit the facility had made the following improvements: • Revised the Emergency Response Policy and associated check sheets • Stocked and re-distributed Emergency Crash Bags in accordance with changes made in the revised Emergency Response Policy. The monitoring team, attended by a member of the nursing leadership team, conducted unannounced checks of emergency equipment on various homes and units. The monitoring team found all of the equipment was available in the designated areas, and operational. Nurses proficiently demonstrated how to use the oxygen and responded correctly to questions when ask specifically about the application of oxygen. AEDs were located in each of the units, with the expiration dates of the pads easily viewed. For the homes and units visited, only one unit had a sign identifying the location of the AED. A review of the requested Emergency Equipment Checklists for all units by the monitoring team for January 2014 found: • Nine of nine (100%) were compliant for documenting a daily check for the AED, Oxygen Tank, Suction Machine, and Emergency Crash Bag occurred • Unit 512's Check Off sheet showed a noncompliance for failing to document a daily check for 12 consecutive days The facility CPR Delinquent Course data showed that five staff were delinquent. The document indicated four of the five were pending orientation. No explanation was provided for the fifth delinquency. The monitoring team was provided with six months of the facility's raw data for their code blue drills. None of the information had been summarized or analyzed. Thus, the	

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		monitoring team was unable to evaluate the successfulness/unsuccessfulness or problems associated with the drills. The facility should have a system in place to process, review, analyze, and report findings from its own data. The monitoring team noted that the Environmental Safety Meeting minutes, dated 11/19/13, stated that, "if we see someone "chocking" (choking) we must respond." The minutes further stated that the custodians were not trained to perform CPR. The rationale of why custodians on the units were expected to respond, but were not trained how to respond in emergency response, administering CPR or associated procedure for choking that could be lifesaving was perplexing to the monitoring team. During a Mortality meeting review of the facility's recent deaths, held by the monitoring team, the facility alluded to the associated actual emergency response. Further information provided during the meeting, regarding the implementation of the emergency response, concluded that the facility did not have a system in place for debriefing/reviewing after the occurrence of actual emergencies. The monitoring team previously addressed this concern in the last report. For more information related to Mortality please see section L. <u>Quality Enhancement Efforts</u> The monitoring team interviewed Compliance Nurse with the CNE in attendance. The Compliance nurse reported that, since the last monitoring visit, audits for the Protocol cards were assigned to the Nurse Managers. The audits were retrospective, chosen at random, and selected from facility's medium or high risk list. The Compliance Nurse explained that, in October 2013, monitoring of four protocol cards (Seizure, Pain, UTI, and Temperature) were discontinued in order to refocus on other areas. The refocus resulted on concentration of Neurological, Respiratory, Constipation, and Vomiting Protocols Audits. • The facility initiated the following new audits: o Infection Control Real Time Audits 6/13 o Infection Control Antibiotic Audits 7/13 o Skin Integrity Audits 11/13 o Urgent Care Audits 11/13 Other Nursing Department Compliance Activities included: • Enlisted facility administration to conduct unannounced non-clinical medication observations during Executive of the Day (EOD) rounds • Revised/discontinued facility PRN blanket orders • Discontinued orders in conflict with Nursing Policies and procedures/standard of practices, for example, pre-mixing of medications hours prior to administration	

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		The monitoring team also interviewed the Quality Assurance Nurse who continued to complete mortality summaries and tracked mortality recommendations. All of the Nursing recommendations from death reviews for the past six months had been completed within the targeted dates. The last death, occurring in January 2014, had a target date for completion of a Nursing recommendation targeted for 2/28/14. The monitoring team will follow-up at the next visit. There was documentation of collaboration between Nursing and QA, through observed attendance at Nursing Meetings and Nursing Minutes. The QA Nurse had recently been assigned to work with the Nursing Department to evaluate their practices, or lack of practices, in medication safety. During the monitoring team's visit, the QA Nurse observed, with the monitoring team, medication observations in several units. The monitoring team will follow-up at the next visit, to see if were actions taken by the Nursing Department as recommended or assessed, for improvement in medication safety practices, as a result of the facility's own observations and audits. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The facility held Daily Clinical Provider Meetings that included staff members from Nursing, Medical, PNMT, Psychiatry, Dental, Psychology, and Quality Assurance Nurses. The monitoring team attended three of the meetings during the week of the visit and consistently found: Meetings were facilitated by the Medical Director or physician designee, who reviewed individuals with acute changes in status. The facilitator reviewed, and held discussions as necessary, to address or follow-up on individuals with changes of status. The following items were addressed during the meetings. • Emergency Room/Transfers/Discharges • Hospital Admissions/Discharges • Infirmary Transfers/Admissions/Discharges • Hospital Liaison Reports for individuals currently hospitalized • Review of application of Restraints and/or Administration of Emergency Psychotropic Medications • Individuals not in receipt of their medications • Review of individuals with ongoing or newly diagnosed Acute illness/Injuries/Infections/Choking/PICA • 24-hour nursing unit reports • Physician's on-call reports • Ordered Consults, Labs, Specialty Testing	

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		It was positive to observe much participation by the team members who provided additional information upon request or made clinical team decisions about an individual's care. As a result of follow-up by the Medical Director with an external provider, he led discussion with the team that the consult did not contain information regarding the individual's current status regarding his advance directives. Thus, the Medical Director, during this meeting, included reminders that, when ordering a consult, to include sufficient information that provides an accurate picture of the individual's current health/mental health condition/status. The monitoring team reviewed the following individuals who had recent acute care changes and found: • On 2/18/14 at 8:20 am, Individual #206 reported to the nurse that she had fallen. The IPN Nursing note assessed the individual for a raised hematoma and bruising on her right hip. The injury required the application of the following Protocol cards: Fall or Suspected fall, Head Injury, and Pain. The protocol cards were not sufficiently implemented. The IPN Nursing note did not contain notification to the physician. The record had an omission of implementing an Acute Care Plan and staff instructions. The IHCP included an initiated date of 10/25/13, for Medium Risk factor for falls. The nursing goal stated the individual would have no falls. A DSP instruction sheet related to the risk was not located in the record. • On 2/6/14 at 10:30 am, staff reported the individual had vomited. The Vomiting protocol card was not carried through to resolution. An ACP for the vomiting or staff instructions were not located in the record. The IPN note was also problematic for inappropriate abbreviations, for example"LSCT4". The facility's self-assessment indicated the provision was not in substantial compliance because nurses were not appropriately identifying, reporting, monitoring, and documenting individuals' health care needs sufficiently to readily identify change in status, of which the monitoring team findings were similar. The monitoring team was in agreement that the facility was not in compliance with this provision. To move in the direction toward substantial compliance, the monitoring team recommends that the Nursing Department/facility consider the following for focus/priority for the next six months. 1. The CNE/Nursing Department/Facility should advance steps of leadership that lead to: o Nursing schedules/ratios also include a model for nursing acuity, and are used to determine nursing staffing. o Ensure nursing supervision is modeled and nurse supervisors are empowered to implement progressive disciplinary actions when	

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		performance standards have continued omissions or failures to adhere to policy and procedures. 2. The facility should institute a system for reviewing and analyzing their mock and actual drills. 3. The Nursing Department should consider, when selecting samples for audits, also including the low risk population, as it should be recognized that the assignment of low risk does not rule out the eruption of a serious health conditions. 4. The facility should ensure the Infection Control Meeting minutes encompass the status of the surveillance of health care associated infections, quality assurance, and performance (e.g., employee exposures, compliance to TB skin testing, conversions), environmental monitoring, compliance monitoring for clinical practices (e.g., hand hygiene), new rules or regulations, and clinical issues related to infection prevention that impact safety of residents. 5. The facility should ensure there are ongoing training opportunities for all staff to participate in campaigns that promote standard precautions (e.g., hand hygiene), and tools to conduct these trainings are available for conducting the training/monitoring. 6. The Nursing Department should ensure individuals who have acute changes in their mental health/health status are sufficiently assessed, and there is a plan of care in place that includes applicable instructions/training for staff.	
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 RN Case Manager Supervisor continued to ensure that individuals, who resided at SGSSLC, had an assigned RN Case Manager. For any absences or vacancies by an RN Case Manager, the individual was re-assigned with another RN Case Manager. During the interview with the RN Case Manager, with the CNE in attendance, her enthusiasm and commitment were evidenced by the many plans put in place to assure consistency among the RN Case Managers, and their assessments. Since the last monitoring visit the RN Case Manager Supervisor: • Developed, as recommended by the monitoring team, more formalized Nursing Minutes • Developed its own Monitoring Tool for monitoring Annual Nursing/Physical Assessments • Conducted individual reviews with each Case Manager related to findings from audits, and instituted performance counseling as appropriate (e.g., assessments that were late). • Weekly held meetings with RN Case Managers to review an IHCP/Annual Nursing Assessment for an upcoming IDT • Send reminders to RN Case Managers for upcoming Annual/Quarterly Nursing Assessments, MOSES and DISCUS • Developed a comprehensive spread sheet for tracking and monitoring 100% of	Noncompliance

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		Annual/Quarterly Nursing Assessments/Physical Assessments, MOSES and DISCUS • Implemented the SSLC Standardized Format dated 9/30/13 to include the update of 1/23/14. The monitoring team reviewed the most recently completed Admission, Annual, and or Quarterly Assessments of a sample selected from the facility's At Risk List and from one unit each: Individual #47, Individual #66, Individual #77, Individual #104, Individual #127, Individual #140, Individual #201, Individual #202, Individual #277, Individual #329, Individual #379, and Individual #380. • Ten of 12 (83%) of the most recently completed Admission/Annual Nursing Assessments were completed timely as required by facility policy. • The 12 last completed Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed (using a monitoring tool similar to the tool currently used by the facility) and had an overall compliance of 73%. o Items on the tool that fell significantly below 90% compliance were the result of inconsistent nursing summaries, which did not qualify/quantify, for every health/mental health problem/diagnosis, the data, by indicating progress or lack of progress toward the stated goal, or the effectiveness of the heath care plan. • For SGSSLC individuals who were newly admitted to the facility since the last review, one of one (100%) showed Admission Comprehensive Nursing Assessments were completed within 30 days of admission. o The Admission Comprehensive Nursing Assessment analysis was problematic, however, for the evaluation sections. The analysis did not address elevated lab values; rather it stated, "see results." A Tertiary Care Review noted none, with evaluation documented unremarkable. Some notable improvements since the last monitoring visit included: • Current active medical diagnosis were updated • Current Status section was consistent with the medical diagnosis for the Active Problem List • Immunization status included dates or titer results, however not this was consistently applied across all Annual/Quarterly Nursing Assessments Five of the 12 (42%) were completed on the newly standandarized nursing forms, of which it was evident that more continued experience was needed in completing the nursing assessments on the new forms. The facility's overall average for the last six months (August 2013-January 2014) for	

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		nursing assessments timeliness was 86%, and for quality of nursing assessments 80%. The facility's self-assessment stated they had met compliance with M2. The monitoring team's reason for disagreement was based on significant findings related to the quality of the content of the Comprehensive Nursing Assessments. Much continued work is needed to produce quality nursing summaries that sufficiently address the individual's health/mental health status. For the next six months the monitoring team recommends: 1. The facility continues its positive practices that have resulted in improvement in meeting timelines for assessments. 2. The Nursing Department should continue to provide through its process of one-to-one over the shoulder, training/training remediation for making improvements in the identified areas.	
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.	State office issued correspondence, on1/23/14, that the Nursing Discharge Summary Form associated with CDLP was to be discontinued and replaced with the Comprehensive Nursing Review Standardized format that had also recently undergone changes. The SSLC Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment (January 2014) procedure included timelines for admission, annual, and return admissions. Although the Community Living Discharge Planning Process had been added, a timeline for completing was not provided in the policy. The guidelines also included identifying the reason for the use of the Assessment and for leaving Section VII-Community Living Services for the CLDP review blank. The RN Case Managers' weekly meeting minutes indicated staff had acknowledgement of the changes in the SSLC Guidelines for Community Discharges. The monitoring team reviewed five of the most recent discharges and their associated document packets for Individual #20, Individual #73, Individual #94, Individual #175, and Individual #388, which were not subject to the new format because they occurred prior to the policy change. The monitoring team's review found: • Five of five (100%) of the discharges were completed for the individuals prior to discharge/transferring to the community. • None of the five (0%) Nursing Discharge Summaries were sufficiently completed for the sections of Special Instructions, Medication techniques (likes/dislikes, crushed, etc.), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, etc.), and other pertinent information (i.e., how I communicate, signs and symptoms of pain). • Individual #388's Nursing Discharge Summary documented a consult for gynecology on <u>his</u> record. A summary of Consults documented a second report of	Noncompliance

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		an elevated lab level, where the individual had an ordered a 24 hour urine collection. The collection was noted to be unsuccessful due to the fact that the individual had a supra pubic catheter, and self-emptied. The record stated the order for the collection was cancelled. There was no additional information in the record regarding follow-up for the elevated lab value. The record stated the nurse would address with the physician to discontinue the fluid restriction prior to discharge, of which no additional information was documented in the record if this occurred. The special instructions documented on the Nursing Discharge summary did not include information for how staff should care for or assist the individual with his supra-public catheter or what to do in the event the tube should come out. The discharge packet contained information that the individual had a risk for choking, due to poor chewing, and unsafe eating. The Nursing Discharge Summary did not reference any special instructions or refer to a plan for the identified risk. • Individual #175's Nursing Discharge Summary for consults, stated, "see results." Nutrition and Weight Management was absent for a documented BMI, and did not contain sufficient information about her nutritional/weight status, even though her desired weight range was noted between 122-164 pounds, and her current weight was documented at 288.8 pounds. The summary also failed to summarize the individual's referenced latent Tuberculosis treatment status. Nursing Discharge Summaries are important documents that assist in guiding care and services. Thus, the Nursing Discharge Summaries should be peer reviewed to ensure accuracy of the data and the inclusion of pertinent information. The facility reported they were in receipt of correspondence from the State Nursing Coordinator regarding a new process for executing a new Acute Care Plans template that included a bank of interventions. The CNE and NOO noted this process was new and the facility had not begun implementation. The monitoring team will follow-up at the next visit for the status of the implementation and the effectiveness of the implementation of the new process. The monitoring team reviewed Acute Care Plans, associated IPNs, and Neurological Checklist for individuals #77, Individual #202 and Individual #329, and found as exampled below, that Nursing Protocols for Falls or Suspected falls that resulted in Head Injury were not sufficiently implemented, and when implemented were not sufficiently followed to resolution. Acute Care Plans and their associated staff instructions were not found in the chart, if they existed at all. On 11/2/13, 11/30/13, 1/12/14, and 1/14/14, Individual #329's IPNs documented four incidents of head banging.	

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		• None (0%) of the Neurological Exams Checklists were conducted in accordance within the recommended schedule for Head Injury Nursing Protocol. • An Acute Care Plan and associated staff instructions were not found in the record for any of the dates. • Two of four (50%) of the nursing assessments included notification to the physician. On 2/18/14 at 8:20 am, Individual #202's IPN documented that staff reported that she had fallen. • Neurological Exams Checklists were conducted within the recommended schedule for following the Head Injury Protocol. • The IPN nursing assessment did not include notification to the physician. • An Acute Care Plan for Pain and associated staff instructions were not found in the record. On 12/29/13 at 3:40 pm, Individual #77's IPN documented that a peer (another individual) reported: she (the individual) "just fell face first off the cart." • Neurological Exams Check List were conducted within recommended schedule for the Head Injury protocol card • The IPN nursing assessment did not include notification to the physician • An Acute Care Plan and associated staff instructions were not found in the record. The facility's self-assessment findings for this provision stated they were not in compliance because health care plans continued to be incomplete, delinquent, not completed in the appropriate time frame with sufficient staff training, and/or were not sufficient to address the individuals' health care needs. The monitoring team conducted its own review, which was comparable to the facility's and agrees with the self-assessment for the noncompliance for this provision. For the next six months the facility should: 1. The Nursing Department should provide practice opportunities that assist nurses in developing Acute Care Plans and their associated staff instructions. 2. Ensure the new procedure completing CLDP discharges/transitions is fully operationalized, and that the nursing discharge summaries contain accurate data, and that communication within the summaries assures the provision of quality of care. 3. Ensure the procedural change for the implementation for Acute Care Plans Template is operationalized.	

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M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	<u>New/Revised Policies, Procedures, Protocols and Guidelines</u> • Procedure for Choking Incident • Procedure for Coughing Episode • Death of an Individual Protocol • Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, January 2014 • SGSSLC Protocol Related to Choking Incidents with Heimlich Maneuver, Self-Clear Choking Incidents, Coughing Episodes, revised: 10/28/13 <u>Training Activities</u> The Nursing Educator provided documentation of a detailed data base for didactic and skills classroom competency training and the percentage of RNs and LVNs who completed each, as well as a listing for each RN and LVN for the subject matter below. The data reported for January 2014 showed: • 100% Nursing Services Policies • 100% Medication Administration/Medication Variance/SAMs Program • 100% Weight Management • 100% Management of Acute Illness and Injury • 100% Documentation Class • 71% Critical Thinking • 59% Mosby Chapters10, Head and Neck • 67% Mosby Chapters 14, Heart • 67% Mosby Chapters 21, Musculoskeletal • 72% Mosby Chapters 22, Neurological • 100% Dashboard Competencies (includes initial and annual for skills, e.g., injections, tracheostomy) The Nurse Educator sent out reminders to the CNE and the Nursing Supervisor for the staff person for courses that need to be scheduled or rescheduled, and for no shows, evidenced by emails provided to the monitoring team. During an interview with the Nurse Educator, with the presence of the CNE, the monitoring team toured the classroom space for training and skill competencies. It was positive to find classrooms had separate designated areas for didactics and skills competency with applicable set up of stations for the skill type (e.g., a manikin with openings for a tracheostomy tube, Foley, eternal feeding equipment). The Nurse Educator reviewed each area and explained how competency was determined for systems and nursing procedures, all of which were classroom based. The Nurse Educator manikin was an older model, which did not include the mechanism for training on normal and abnormal lung and heart sounds. This was perplexing as to how competency for lung and	Noncompliance

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		heart was accomplished. The Nurse Educator explained the competency for medication administration and eternal feedings was classroom didactic and classroom check off. The monitoring team strongly suggests the facility include more opportunities for nurses to demonstrate competency in addition to the classroom-simulated competencies. The facility should ensure the competencies conducted are one-on-one, over-the-shoulder, and that there is opportunity for feedback from the trainee, prior to assigning the nurse to work independently. The Nurse Educator should keep the CNE informed of nurses that fail to progress with initial or remedial training/competencies. For nurses that fail to meet competency, or regress in maintaining competency, the CNE should take the appropriate progressive disciplinary action. The Nurse Educator was recently afforded an assistant to assist with the training activities. Reportedly, the requirement for conducting annual medication observations competency will be assigned to the Nurse Education Unit. The monitoring team will follow-up at the next visit as to the functions and roles of the assistant, and for any changes made for conducting competencies. The monitoring team randomly selected six records from the sample of 12 individuals chosen for the sample. The monitoring team found the following: Negative examples: • On 1/16/14 at 8:00 pm, staff reported Individual #379 "fell in the bathroom." The IPN nursing note stated "Staff also reported the bathroom floor was wet and slippery." In addition to the fall, staff reported the individual "had been coughing throughout the shift." The Nursing Protocol that guides nursing assessment for falls was not sufficiently applied to include performing a neurological assessment, examination related to fall impact areas, and a head to toe physical examination. The individual was administered cough medication. The IPN/MAR had an omission of documenting the effectiveness of medication. The next IPN Nursing note did not occur until 1/21/14, and referenced a quarterly nursing review. The individual's IRRF, dated 8/13/13, showed he was at high risk for falls. The IHCP did not include realistic goals or nursing interventions in accordance with the protocol card for falls. The monitoring team was also perplexed that Cos Direct Support Professional Instructions for the determined high risk category for falls determined at the 8/13/s13 ISP meeting, per the document (DSP instructions), was not initiated until 10/23/13. • On 1/22/14 at 10:30 am, the IPN Nursing note for Individual #127 documented an abrasion. The record did not include documentation of resolution for this skin integrity issue.	

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- On 11/3/13 at 3:15 am, Individual #77's IPN nursing note documented a complaint of a headache, of which she received a prn medication for her pain. The Nursing Protocol for Pain was not sufficiently applied. There was an omission of the response to the effectiveness of the pain medication.
- On 2/7/14 at 9:00 am, Individual #47's IPN nursing note documented the individual's complaint of "nurse my eye is red." The IPN nursing note did not document if the individual was referred to the physician. However, there was documentation that the individual was evaluated, on 2/7/14 at noon, and prescribed antibiotics for the eye infection. The Protocol Card for Antibiotic Therapy and Pain were not followed through to resolution. The record did not contain an Acute Care Plan or staff instructions.

Positive Examples

- On 1/2/14 at 4:47 pm, Individual #277's IPN nursing note documented the individual's complaint of pain in his right lower jaw. The dentist was called, an order was received for an antibiotic and pain medication, and he was scheduled for a dental exam, which subsequently required an extraction of the tooth abscess. The Antibiotic therapy and Pain protocol were adequately initiated. The record included an adequate Acute Care Plan with documentation of staff instructions, and a date of being resolved corresponding to the IPN nursing note, dated 1/16/14 at 2:00 pm.
- On 12/23/13 at 9:10 am, Individual #380 reported he "threw up." The IPN note included notification to the physician. The Vomiting Protocol Card, initiated on 12/23/13, was followed to resolution. The date of the resolution for the vomiting was 12/25/13 at 10:00 am. The record included an adequate Acute Care Plan, documentation of staff instructions, and had an applicable date for being resolved.

The following are the scores reported by the facility and their overall average for all Protocol Card/Other Audits for the period of August 2013 through January 2014, which was 51%.

Protocol Card/ Audits	August	September	October	November	December	January	Overall Average
Head Injury	57%	57%	47%	63%	57%	49%	55%
Respiratory	75%	52%	46%	28%	52%	62%	53%
Constipation	42%	42%	55%	56%	59%	33%	48%
Vomiting	47%	45%	50%	48%	61%	62%	52%
UTI	41%	39%	46%	Audit D/C			42%
Seizure	54%	52%	41%	Audit D/C			49%
Temperature				54%			54%
Pain	62%	58%	64%	Audit D/C			61%
Antibiotic	47%	75%	67%	33%			56%

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		<table><tr><td>Real Time Inf. Control</td><td>100%</td><td>80%</td><td>80%</td><td>100%</td><td>100%</td><td>64%</td><td>87%</td></tr></table> The facility's self-assessment findings reported this provision was not in substantial compliance because the facility had not established a system of monitoring to ensure training was effective and that the nurses were knowledgeable for process that had been implemented. The monitoring team conducted its own review and also found this provision in noncompliance as evidenced in this section and throughout of the many examples that the training had not sufficiently transferred to practice. The monitoring team recommends that for the next six months: 1. The Nursing Department should re-assess its evaluation process for determining sufficient competencies in the areas of medication administration and enteral feedings, and other applicable areas. 2. The facility should ensure the Nursing Department has sufficient equipment for training, (e.g., appropriate manikins for performing sufficient nursing assessments (heart-lung sounds)). 3. The CNE should ensure for required trainings (Mosby) that for Critical Thinking, nurses become compliant.	
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 monitoring team held an At Risk meeting with the facility to further determine the status of the facility's actions with regard to section I. It was positive that the RN Case Manager Supervisor position continued to co-chair section I. As reported in the meeting, there were ongoing discussions about teams coming prepared to meetings to discuss risk. The facility reported that it had implemented process for assessing risk, discussion of risk, documentation of risk and, monitoring of risk. The monitoring team reviewed examples of the audits for nursing associated with section I effectiveness of IHCP nursing goals, and the frequency of monitoring the IHCP interventions. The data for August 2013 was 50% and September 2013 was 58%. In November 2013, the facility began an audit process to determine if the assessments sufficiently addressed risk. The audit report showed 14% compliance. The monitoring team attended the ISP for individual #66 and found: • All of the relevant IDT members were present during the meeting. Reportedly, the individual was not able to attend any segment of the meeting due to his health status. The individual's family member was also present for the meeting. During her conversation with the team, she shared many of the positive memories she had of her son's favorite things to do, visit, see, touch, and his love of animals. The IDT members continued engagement with the parent, inquiring about his likes	Noncompliance

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		and dislikes regarding animals, of which it was apparent to the monitoring team, the team were not fully aware of this historical information. • Disappointedly, discussion for community placement during the ISP was brief, which hampered opportunities to review options for exploring for community living options. • During the meeting, questions pertaining to the individual's health and the unified record were referred to. The RN Case Manager provided additional applicable information. • The risk ratings appeared appropriate, based on a review of all the documents. The monitoring team selected from the sample of 12 records, five ISPs, IRRFs/Risk Action Plans/IHCPs that identified and/or contained information about the individual's High Risk for aspiration: Individual #66, Individual #104, Individual #127, Individual #202, and Individual #379. The monitoring team findings found were comparable to the facility's self-assessments/audits. • Five of the five (100%) identified significant changes in health status since the last review. • Five of five (100%) had comprehensive interdisciplinary assessments completed. • Two of the five (40%) Risk Actions for health sufficiently were sufficiently correlated. • Three of the five (60%) assessments sufficiently provided data to assist in determining risk. The monitoring team also reviewed the five records for Aspiration Trigger Sheets and found: • For five of five (100%) of the individuals identified as being at Risk for Aspiration, the records contained Aspiration Trigger sheets. Of the five records, there were 16 Aspiration Trigger Data sheets for documenting and monitoring the risk. • None of the sixteen (0%) Aspiration Trigger sheets were individualized. • Six of 16 (38%) Aspiration Triggers Data sheets did not contain omissions (blanks) for documenting the individuals signs and symptoms. • Ten of 16 (62%) of the Aspiration Trigger Data sheets as required, were reviewed by the RN Case Manager. • On 1/17/14 and 1/21/14, the Aspiration Trigger Data sheet for Individual #104 indicated a total of three triggers. Neither the Observation notes nor the Nursing IPN notes contained any corresponding documentation, even though the document included nursing initials for having reviewed the Aspiration Trigger Sheet data. • Five of five (100%) IHCP had an associated Direct Support Professional Instructions with signatures. It was difficult to discern the date of the	

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		training/instruction because there was not an applicable place next to the signature for recording the date. • None of the five IHCP (0%) for the combined risk factors of Choking, Aspiration, Respiratory compromise, and constipation nursing interventions were individualized or contained realistic goals. • One of five (20%) IHCP had dates that indicated the IHCPs were developed and were initiated in accordance with facilities Nursing Policy and Procedure of 14 days. The facility's self-assessment stated that they were not in compliance with this provision because the facility was not yet proficient in process used to identify risks or change in individual's risk status. The monitoring team's independent assessment from the review of records concluded that the facility continued to evaluate/assign risk as to whether or not the individual actually had an event and/or a negative outcome from the event, rather than a continuum of screening for risk that focus on prevention. The facility for the next six months: 1. The facility should focus on incorporating critical thinking that assists in understanding the difference between screening for risk (focus on prevention) and assessments (established diagnosis) in order to arrive at prevention strategies and measurable outcomes that are realistic and individualized. 2. The facility should continue its process for tracking and monitoring the effectiveness of the risk process.	
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	<u>Monitoring Team's Medication Administration Observations</u> The monitoring team made various observations across the units, and selected various units for conducting unplanned medication pass observations during the early morning and evening. Fifteen individuals were observed for a total of 45 medication passes. All of the medication observations were accompanied by a member of the Nursing Leadership team. The monitoring team applied the observations using the facility's own Medication Observation Tool for conducting Medication Passes. Overall, none (0%) of the medication pass observations met compliance with acceptable standards of safe medication practices. Examples of noncompliance included: • A nurse documented medication before administering; the monitoring team called this to the attention of the CNE in attendance. This resulted in over the	Noncompliance

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	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	shoulder performance counseling by the CNE. • At the beginning of a medication pass, the individual was not identified in accordance with the facility's own policy and audit tool. The nurse was prompted by the CNE regarding procedures for identification prior to administration. • Nurses were prompted to retain the open medication package on the cart before disposal to use for the third required check when documenting the administration on the MAR. • Failure to follow basic hand hygiene standards. • Failure to follow infection control practices, prior to, during, and after medication administration. • Failure to follow "essential elements" weighted on the facility's Medication Observation Form (i.e., identification of the individual, and following the individuals PNMP). • Failure to perform the three quality checks. • The monitoring team queried the nurses, of which one was a new nurse and the nurse training the new nurse, during an observation for checking for placement of the gastrostomy tube prior to administering medications. The nurses were not consistent in their responses. Thus, the monitoring team requested the facility's policy. Even after the nursing leadership team reviewed its own policy/procedure for checking placement, there was not a consensus as to the interpretation of the policy/procedure. The facility should, sooner than later, seek clarification with the state office nursing coordinator on the policy/procedure for checking placement of gastrostomy tube prior to administering medications or enteral feedings. • The monitoring team reviewed the Medication Administration Records and associated IPNs for the observations conducted and found: On 2/5/14 at 8:15 am for Individual #76, the MAR documented the administration of a rectal medication for staff reporting "no BM (bowel movement) in 3 days." The IPN nursing note dated 2/5/14 at 2:15 am did not adhere to the nursing protocol for documenting constipation that resulted from the use of the PRN medication for constipation. No information was found that the medication was effective. Thus, the facility's Medication Administration Policy was not adhered to. <u>Monitoring Teams Oversight and Monitoring of Medication Administration Practices</u> • Eight of eight (100%) medication room inspections conducted for homes 508A, 508B, 509A, 509B, 510A, 510B, and 516E carts, and controlled substances drawers located within the carts, were observed as doubly secured, and accounted for in accordance with control logs. • Eight of eight (100%) focused reviews for homes 508A, 508B, 509A, 509B, 510A, 510B, and 516E storage found all medications with current expiration dates,	

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		opened medications were dated, and stored in accordance with accepted standards of practice. • 18 of 20 (90%) Refrigerator/temperature logs, reviewed for January 2014 through 2/9/14, documented the temperature and appropriate action code. • 10 of 10 (100%) of the most recent Medication Room Audit Inspections conducted with a noncompliance finding had appropriate actions taken (e.g., out of date insulin, external/internal medications not separated). • 18 of 20 (90%) Quality Blood Glucose Strip Test findings for a High/Low Quality Blood Glucose Strip contained documentation for conducting the weekly testing. In addition, the review noted inconsistency in documenting the Lot Number; instead a check mark was documented in the box. • None (0%) of the submissions contained documentation of the Range Numbers in which the Control Test result must fall to assure the systems are working properly. The Nursing Department should ensure a sufficient Quality Control Record that captures, and adheres to manufacturer's instrument blood glucose recommendations for problem solving, as the blood glucose quality testing are used to detect errors and variance in operator performance. Individual's routine insulin dosages/sliding scale are reliant upon accurate systems to determine the individual's blood glucose prior to administering routine/sliding scale insulin, and/or when individuals are symptomatic with signs and symptoms of hypo or hyperglycemia. The monitoring team followed-up with the CNE regarding the conflict between physician orders and the facility's Medication Administration Guidelines regarding the practice of pre-mixing of crushed medications hours ahead of the scheduled time for administration, which precluded the medications from being identifiable up to the point of administration. The CNE reported physician orders for this inappropriate practice had been discontinued. The monitoring team, through a review of records and medication observations and querying of nurses, found evidence that this practice had been discontinued. <u>Medication Variance Administration and Pharmacy and Therapeutics Committee Meetings</u> The monitoring team attended both the Medication Administration and Pharmacy and Therapeutics Committee meetings. It was positive to find there was linkage of the data from both committees being shared and presented at the committees meetings. The committee reviewed and discussed the data and analysis of the data. During the Medication Variance Committee meeting, the CNE was pulled away. Another member of the nursing team, the Compliance Nurse was able to immediately stand in and continue the meeting. The Compliance Nurse was well versed in the data and was able to respond to questions and explain the data. More positively, the data presented for blanks in the	

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		MAR was presented in a graph, longitudinally, over a 12-month period, which included insertions when the facility implemented a strategy. It was also positive to find, in the analysis of data, that the facility took necessary steps to evaluate their own audits, such as for lack of double signature for order transcription verification. Nonetheless, the monitoring team was concerned with the lack of a framework for disciplines (nursing, medical, and pharmacy) to meet, review, and assign the severity of the medication variances, tracking and reporting all levels of severity, and non-supporting documentation/analysis regarding the difference in the number of unreconciled medications and omissions (blanks) versus the actual number of variances reported. For more information regarding Pharmacy and Therapeutics Committee please refer to N8. The monitoring team reviewed the SGSSLC submission of the 10 most recently completed Medication Variance Reports for Individual #16, Individual #22, Individual #24, Individual #25, Individual #40, Individual #42, Individual #100, Individual #127, Individual #208, and Individual #254. The monitoring team found: • One of 10 (10%) of the Medication Variance Report was completed for all applicable items on the report form. • Two of 10 (20%) Medication Variance Reports included notification to the physician. • Three of 10 (30%) Medication Variances were discovered within 24 hours, two (20%) over 30 days, and the remaining five ranged from five to 23 days. The facility self-rating indicated this provision was not in substantial compliance because the nurses were not administering medications in accordance with current, general accepted professional standards of care. The monitoring team was in agreement. For the next six months the facility should consider the following: 1. The Nursing Department should augment its existing medication administration competency training/check offs, and oversight for medication administration to ensure compliance with accepted standards of practice for safe medication practices. 2. The Medication Variance Committee and Pharmacy and Therapeutics Committee should complete a more in depth analysis of factors contributing to the variances, or lack of variances (under-reporting), and re-assess /strengthen measures used for corrective action, specifically those variances that continue to be repeated (such as omissions (blanks) on the MAR). 3. The facility should ensure the Medication Variance Policy has been fully operationalized.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 5/15/13 o SGSSLC Self-Assessment for Section N o SGSSLC Action Plan Provision N o SGSSLC Provision Action Information o SGSSLC Organizational Charts o SGSSLC Pharmacists Prospective Review Of Medication Orders, 11/17/11 o SGSSLC "PRN" Medication Pharmacy Review, 11/17/11 o SGSSLC Quarterly Drug Regimen Review, 11/17/11 o DISCUS - Monitoring of Medication Side Effects and Tardive Dyskinesia, 9/22/11 o MOSES – Monitoring of Side Effects 4/26/11 o SGSSLC Suspected Adverse Drug Reactions 1/27/11, Rev 11/17/11 o SGSSLC Pharmacy and Therapeutics Committee, 4/19/12 o SGSSLC Drug Utilization Evaluation 11/17/11 o SGSSLC Lab Matrix o Pharmacy and Therapeutics Committee Meeting Minutes, 2013 o Medication Variance Review Committee Meeting Notes, 2013 o Polypharmacy Committee Meeting Minutes, 2013 o Single Patient Intervention Reports o Notes Extracts o Adverse Drug Reactions Reports 2013 o Drug Utilization Calendar o Drug Utilization Evaluations • OTC Calcium Products • Vitamin D Use o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #127, Individual #386, Individual #222, Individual #185, Individual #23, Individual #248, Individual #148, Individual #339, Individual #279, Individual #14, Individual #48, Individual #285, Individual #352, Individual #137 o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #245, Individual #24, Individual #82, Individual #108, Individual #76, Individual #385, Individual #153, Individual #69, Individual #132, Individual #71, Individual #129, Individual #190, Individual #254, Individual #140, Individual #52, Individual #163, Individual #69, Individual #47, Individual #280, Individual #186,

	Individual #352, Individual #53, Individual #22, Individual #380, Individual #279, Individual #271, Individual #337, Individual #349, Individual #291, Individual #16, Individual #246, Individual #188, Individual #59, Individual #182, Individual #331, Individual #215, Individual #37, Individual #199, Individual #134 Interviews and Meetings Held: o Janis Rizzo, MBA, RPh Pharmacy Director o Sarah Dempsey, PharmD, Clinical Pharmacist o Isaac Pan, PharmD, Staff Pharmacist o Stanley Cal, MD, Medical Director o Albert Fierro, RN, Medical Compliance Nurse o Angela Gardner, RN, Chief Nurse Executive o Lisa Owens, RN, Quality Assurance Nurse o David Ann Knight, RN Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Pharmacy Department
	Facility Self-Assessment: SGSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each provision item the self-assessment listed a series of activities completed to conduct the self-assessment, the results of the activities and a self-rating. Overall, the assessment did a good job of using metrics similar to those used by the monitoring team. The pharmacy director should continue this type of assessment and expand it to include additional items based on the comments and recommendations of this report. The facility found itself in noncompliance with all eight-provision items. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: Over a period of years, the facility had struggled to meet the requirements of the Settlement Agreement for the provision of pharmacy services and safe medication practices. Serious deficiencies were highlighted in numerous reports over the past four years. A new pharmacy director was hired on 8/1/13 and a new pharmacist was hired on 7/25/13. During September 2013 compliance review, the monitoring team met with the pharmacy staff and discussed the

	requirements of the Settlement Agreement. There was no review of the provision during the September compliance review. Following the review, a clinical pharmacist began working, on 10/1/13. At the time of the compliance review, the pharmacy department had undergone a restructuring process. The pharmacy department was staffed with a full time pharmacy director, clinical pharmacist, staff pharmacist, and two pharmacy technicians. The pharmacy director reported that a great deal of effort was devoted to the logistics of providing basic pharmacy services. Changes in staffing and a lack of a clinical pharmacist for several months had worsened the existing deficits. The pharmacy director reported that while efforts were ongoing, progress was slow. Overall, there was some progress seen in the provision of pharmacy services. The monitoring team could appreciate that the department seemed positioned to move forward in most areas, but simply had not had enough time to do so. There was documentation of communication between the pharmacists and providers, but this documentation was inadequate and fluctuated monthly. It was reported that the pharmacy workload prevented the documentation of communication. When documentation was completed, it was often inadequate. The Intelligent Alerts were implemented, but the reports generated were limited to three medications. The QDRRs that were completed were quality evaluations, but there were serious issues related to compliance with timelines. At the time of the review, 40% of individuals had current evaluations. In addition, many of those individuals were due for the next evaluation, however, 60% of individuals had no current assessment. The facility did not have an adequate system to review psychotropic polypharmacy and there was no consensus on how that would be achieved. Eleven percent of the population was identified as diabetic, but it appeared that there may have been individuals with metabolic syndrome that remained undiagnosed. In previous visits, individuals with metabolic syndrome were identified and tracked, but that was no longer occurring. There were numerous problems related to completion of the MOSES and DISCUS evaluations. The prescriber reviews were not completed using AVATAR. Even when the hard copies were completed, there were substantial delays between the evaluations and prescriber reviews. The facility continued to have under-reporting of ADRs based on documents reviewed and there was no training done to address this. DUEs were completed, but the reviews will need a considerable amount of work to meet an acceptable standard. Finally, the facility's medication variance system remained problematic. The monitoring team identified clear incidents of prescribing errors that failed to be reported and facility staff appeared unclear on the proper categorization of variances. The types of data presented to the monitoring team and reviewed in the medication variance committee meeting were inadequate for assessing the magnitude of the medication variance problem within the facility.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The facility made progress in documenting communication between the pharmacists and prescribers. The pharmacy director submitted notes extracts and single patient interventions as documentation of communication between prescribers and pharmacists. It was acknowledged that work was needed in these areas because interventions were not adequately documented and when they were, there was not always evidence of closure. The single patient interventions and notes extracts were reviewed. There were 151 entries entered in the document. Several of the entries stated "intervention," but did not provide any information. Other entries documented clinical interventions, but failed to provide any follow-up of the event. The majority of the interventions were related to drug-drug interactions, allergies and order clarifications. Overall, 151 entries was a small number of entries for a six month period since clarification of physician orders was to be documented in the WORx system. The pharmacy director reported that this problem was due to the heavy workload of the pharmacy. There were many problems with physician order writing that could be detected through a review of these documents. As had been noted in all previous reviews, the medical staff continued to prescribe medications when allergies were clearly outlined in the active records and the pharmacy staff did not report these as prescribing errors. There was documentation of the inappropriate use of medications. For example, the pharmacist documented a second attempt to have the PCP discontinue a potassium sparing diuretic in an individual with chronic kidney disease and hyperkalemia. The facility had implemented the Intelligent Drug Alert Module. The pharmacy director reported that the state-required drugs were monitored. The monitoring team observed that the eight-page report included only three drugs - levothyroxine, carbamazepine, and warfarin, leading to the suspicion that perhaps the IA module was not working as expected. Moreover, SGSSLC had not expanded the list to include any additional drugs. The medical director was not reviewing the IA report and both the medical and pharmacy director did not appear to be familiar with the requirement to expand the IA list to meet the needs of the facility. The lack of documentation of communication between the pharmacists and prescribers and the need to ensure that outstanding issues are resolved resulted in this provision item remaining in noncompliance. <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	Noncompliance

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		recommendations for consideration: 1. The pharmacy director will need to continue to address the lack of documentation of communication. 2. The pharmacy director should review the alerts generated by the IA module to determine if it is working as intended. 3. The pharmacy director should address the comments noted in the text above.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	Fifteen QDRRs were assessed to determine the compliance rating for this provision item. Additionally, the QDRRs included in the record sample listed in section L were reviewed. The documents were evaluated for compliance with the timelines for completion and content. For the record sample selected by the monitoring team, zero of 10 (0%) records had current QDRRs. Excluding the two records reviewed for deceased individuals, three QDRRs were completed in February 2013, one in March 2013, one in May 2013, three in July 2013, and one in December 2013. It was reported that 40% of the individuals had a current QDRR. This was a serious problem because the requirement to complete quarterly medication reviews is a fundamental regulatory requirement and is essential for individuals with complicated medication regimens. While the pharmacy director verbally reported a plan was in place to address this, the monitoring team was concerned because over the course of two years, egregious delinquencies with QDRRs have been reported and the monitoring team had been informed during multiple previous visits that corrective action plans were implemented. Yet, at no point has there been any real improvement with regards to compliance. Corrective action plans implemented to address state licensing survey deficiencies in 2013 were not effective in resolving the overall problem. Given that the clinical pharmacist arrived on 10/1/13, and only 40% of individuals had current QDRRs at the time of the compliance review, it stands to reason that correcting the deficit will be a difficult task for one clinical pharmacist to complete. Notwithstanding the extraordinary lapses in timelines, the QDRRs that were reviewed were very well done. The format was an excellent one because it addressed all key elements required. In accordance with state policy, the pharmacy assessment included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug-drug/food/disease interactions, and adverse reaction potential. The comments section elaborated on the topics of polypharmacy, anticholinergic burden, benzodiazepine use, chemical restraints, stat medication use, and MOSES/DISCUS reviews. Each of these sections was thoughtfully completed indicating that the clinical	Noncompliance

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		pharmacist carefully reviewed the records to complete the initial assessments. The component that made the evaluations particularly well done was the discussion of disease management. That is, for every disease for which a medication was prescribed, the pharmacist provided the relevant clinical information. For example, if an individual received psychoactive medications, the drugs were listed along with the relevant monitoring parameters. When the individuals had hypertension, medications were listed followed by weights, blood pressures, and labs associated with the drugs. For the diagnosis of osteoporosis, the medications were cited along with lab values and diagnostics completed (or needed). Relevant consults were also listed. The evaluations also included tables listing laboratory values and all parameters of the metabolic syndrome inclusive of the values for the individual. An overall statement regarding metabolic syndrome was also included. The concerns with the QDRRs reviewed were minimal and were limited to relatively minor issues. • Monitoring for all disease categories treated with medications was not seen in every QDRR. This was a rare occurrence. • More attention was needed in monitoring the use of iron supplementation and making the recommendation to assess the need for continued use. • Hypertension monitoring should always provide specific blood pressure ranges instead of slightly high and heart rates should be provided when beta-blockers are used. Lab values for renal function should be listed particularly when ACE/ARB inhibitors are prescribed. • Drugs with a narrow therapeutic index, such as lithium, should have all monitoring parameters clearly defined. Each of the QDRRs made a series of clinically valid recommendations. The following examples highlight a few of those recommendations as well as some areas that the monitoring team believes are worthy of attention: • Individual #222, 12/10/13: This individual received KCl supplementation. The clinical pharmacist noted that the last KCl on 4/19/13 was 4.9 (high). A recommendation was made to evaluate the need for KCl supplementation. The PCP discontinued the KCl. The use of Lasix and KCl requires laboratory monitoring of serum potassium. Moreover, the individual had a history of hypertension, which required regular monitoring of renal function. • Individual #386, 12/15/13: The clinical pharmacist noted that the individual had several criteria for metabolic syndrome. The PCP was requested to evaluate. • Individual #185, 12/3/13: The clinical pharmacist noted that on 10/3/13 lorazepam was used as a chemical restraint, but there was no IPN documentation	

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		to support use. It was also noted that the vitamin D level needed to be decreased and the LFTs that were ordered in September 2013 were not done. The PCP wrote an order to obtain LFTs and discontinue the vitamin D on 12/19/13. • Individual #148, 12/9/13: The individual received ferrous sulfate, but there was no iron level documented and no recommendation made to assess if ferrous sulfate was still needed. The individual received beta-blockers for HTN, but the heart rate was not documented. Blood pressures were documented as slightly high. The individual received three medications for a psychiatric diagnosis, but it was stated that there was no psychotropic polypharmacy. • Individual #279, 12/2/13: The monitoring for lithium was not explicit and it should be due to the narrow therapeutic index. Lipid monitoring was not mentioned. The last BMP was May 2013. The clinical pharmacist made a recommendation to obtain labs for lithium use. The provision remains in noncompliance due to the significant number of delinquent reviews. <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 facility must take several actions: 1. Continue the corrective action plan to complete the QDRRs within the specified timeframe. 2. The issues related to clinical content discussed above, should be addressed.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. The clinical pharmacist made particular note of the response to the use of the agents and the documentation that was found in the IPN. The use of prn meds/chemical restraints is discussed further in section J. <u>Polypharmacy</u> Medication polypharmacy was addressed in the QDRRs. At the time of the compliance review, the facility did not have an adequate process to review psychotropic polypharmacy and there was no consensus on how this would be achieved. Psychotropic polypharmacy is discussed in detail in section J11.	Noncompliance

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	to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Anticholinergic Monitoring Each of the QDRRs commented on the anticholinergic burden associated with drug use. The plans to address the ACB were usually documented, such as management plans for constipation. Monitoring Metabolic and Endocrine Risk The facility monitored individuals for the metabolic risk through the QDRRs. The QDRR included several monitoring parameters, including glucose, HDL, triglycerides, waist circumference, and blood pressure. Each QDRR report included a specific statement when the individual was thought to be at risk. In those instances, the PCP was requested to evaluate the individual for the presence of metabolic syndrome. The clinical pharmacist did an excellent job of identifying these individuals, which was good because it appeared that there might have been some individuals with metabolic syndrome who were unidentified. Previous monitoring reports highlighted problems related to identification of individuals with diabetes and those at risk for metabolic syndrome. It appeared that these problems had yet to be resolved. The June 2012 report documented that the facility's database contained the names of 64 individuals with the diagnosis of diabetes or metabolic syndrome. This was nearly double the number of individuals reported from the December 2011 review. Most of these individuals received atypical/new generation antipsychotic medications. At that time, the medical director attributed the increase to improved accuracy of databases. The 56% increase in the number of individuals with the diagnosis of diabetes/metabolic syndrome prompted the monitoring team to recommend that the facility further review this area to ensure that drug use and monitoring for all individuals currently diagnosed with diabetes and/or metabolic syndrome and those at risk was appropriate. During the follow-up visit in December 2012, 23 individuals were reported to have the diagnosis of diabetes mellitus. The facility was no longer tracking those individuals with metabolic syndrome even though the importance of doing so was emphasized in previous reports and was clearly necessary for good medical practice. The facility currently had identified 24 individuals with diabetes mellitus. Given the importance of metabolic syndrome as a risk factor in subsequent development of type 2 diabetes and/or cardiovascular disease, it is imperative that individuals with the diagnosis be identified for the purpose of appropriate risk mitigation. This provision remains in noncompliance due to the lack of an appropriate system to address all aspects of medication polypharmacy and the need to properly identify individuals with the diagnosis of metabolic syndrome and others who are at risk for development of the syndrome.	

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		Compliance Rating and Recommendations In order to move towards substantial compliance, the facility will need to take a number of actions: 1. The facility will need to address the important area of monitoring for metabolic and endocrine risk. As noted above, data should be reviewed for those individuals who are risk to make a determination regarding status. The medical staff should identify in the Annual Medical Assessments when an individual is at risk. The risk assessment should include mitigation of risk as well as a plan of care when mitigation is not possible. There should be a plan of care to address the active diagnosis of metabolic syndrome. 2. The facility needs to address the issue of psychotropic polypharmacy.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the providers' responses to both prospective and retrospective reviews. Prospective Recommendations Prospective recommendations were generated at the time new orders were written. The recommendations were documented in the Single Patient Interventions and Review of Physician Orders. The pharmacists did not consistently document the outcomes of the discussions with the prescribers. Retrospective Recommendations The clinical pharmacist also made formal recommendations when completing the QDRRs. Assessing this aspect of this provision item was difficult due to the fact that as noted in section N2, none of the active records in the record sample had recent QDRRs. While the responses to the recommendations in the facility submitted sample are reviewed, the monitoring team uses the record sample to determine if the providers follow-through on the proposed actions such as changing medications and ordering labs, etc. The monitoring team will need to further assess this provision item during the next compliance review. Compliance Rating and Recommendations This provision remains in noncompliance. In order for the facility to move towards substantial compliance: 1. Primary care providers and psychiatry providers must review the QDRRs within the appropriate timeframes. 2. There must be evidence that the medical staff continue to accept and implement the recommendations of the pharmacists. 3. The medical staff should clearly note on the QDRR form a clinically justifiable explanation when recommendations are not accepted. When prospective	Noncompliance

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		recommendations are not accepted, a similar explanation should be documented in the IPN.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Achieving substantial compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. While nursing conducted the reviews, the evaluation required review and completion by a physician. The facility submitted a sample consisting of 15 MOSES and 15 DISCUS evaluations. The most recent evaluations included in the record sample were also reviewed. The findings are summarized below: Twenty-five MOSES evaluations were reviewed for timeliness and completion: • 22 of 25 (88%) evaluations were signed and dated by the prescriber • 18 of 25 (72%) evaluations had no prescriber review (blank) • 3 of 25 (12%) evaluations documented no action necessary • 4 of 25 (16%) evaluations included other comments related to medication changes such as drug changes or improvement noted Thirty-one DISCUS evaluations were reviewed for timelines and completion: • 29 of 31 (93%) evaluations were signed and dated by the prescriber • 11 of 31 (35%) evaluations had no prescriber review (blank) • 2 of 31 (6%) evaluations documented the presence of tardive dyskinesia • 15 of 31 (48%) evaluations documented no tardive dyskinesia • 2 of 31 (6%) evaluations documented other comments The facility implemented the electronic version of the evaluations. The samples submitted included a mix of the AVATAR completed evaluations and the manually completed forms. The forms completed via AVATAR were almost universally incomplete. They were printed and provided to the physicians who reviewed them. The prescriber review did not print on the form, if not completed electronically. For the evaluations reviewed, the prescribers added hand written comments and many were signed without the addition of any comments. When comments were added they usually did not meet the requirements for the prescriber review. In addition to being incomplete, a significant	Noncompliance

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		number of the evaluations were not reviewed in a timely manner. Delays of weeks and in some instances more than one to two months were observed between the time of evaluation and prescriber review. Although these rating instruments served as a valuable source of information, record reviews did not reveal any documentation, on the part of the primary providers, of discussion of this relevant information. Recent AMAs included comments from some PCPs that future evaluations would be reviewed with psychiatry. The MOSES and DISCUS information did not appear to be reviewed by the neurology consultant, as they made no comments on this information. The monitoring team has and continues to recommend that the primary care providers and neurologists review this information and appropriately utilize it in clinical decision-making. As already noted, the intent of the provision is to ensure that evaluations monitoring for side effects of medications are completed and the information utilized. <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 facility must take several actions: 1. The evaluation tools must be completed in a timely and adequate manner. 2. Problems related to the use of AVATAR and the prescriber review must be corrected. 3. The information should be utilized in clinical decision-making. The information from the evaluations should be incorporated in the assessments completed by primary care providers and neurologists. Primary providers should review the information and acknowledge results. This could be in the form of an IPN entry, quarterly reviews, or annual assessments. The neurology consultant should be provided the data and <u>encouraged to review</u>.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility reported a total of 18 ADRs in 2013. Three ADRs were reported for the reporting period of September 2013 - November 2013. During the Pharmacy and Therapeutics Committee meeting attended by the monitoring team, one additional ADR was discussed. This ADR occurred outside of the facility. It was acknowledged that there was under-reporting of ADRs and staff required training regarding the requirements for reporting. However, this training had not occurred. During the Pharmacy and Therapeutics Committee meeting, the pharmacy director and clinical pharmacist discussed a plan to provide training to the medical staff, nursing, and direct care professionals. Consideration was being given to including ADR training in the NEO curriculum.	Noncompliance

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		The lack of ADR reporting was evident in the many documents reviewed during the conduct of this review. The monitoring team encountered ADRs, such as hyponatraemia, hyperprolactinemia, anemia, antibiotic allergic reactions, and thrombocytopenia that were attributed to medication use, but were not documented as adverse drug reactions. One antibiotic allergic reaction, discussed in section L1, was documented in the record and on the 180-day physician orders, but still was not reported. The lack of reporting as well as the overall lack of training provided to staff resulted in this provision remaining in noncompliance. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-assessment rating of noncompliance for this provision item. To move in the direction of substantial compliance, the monitoring team recommends consideration of the following: 1. There should be increased reporting by the medical staff. 2. ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form. The form should indicate who initiated it (reporter). 3. All <u>suspected ADRs s</u>hould be reported to the Pharmacy and Therapeutics Committee. This committee is charged with reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. The ADR form should reflect the final determination by the P&T Committee and should be signed by the chair. The committee should also receive follow-up on the status of the corrective actions. 4. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate discipline-specific training on the recognition of ADRs and the facility's reporting process. 5. The facility should revise the ADR policy, outlining the process and requirements for facility staff. The policy should include a requirement for a more in depth review of serious cases based on a risk threshold. The criteria for review should ensure that cases are appropriately reviewed in a timely manner and the findings formally presented to the Pharmacy and Therapeutics Committee.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of	The facility maintained a DUE calendar and completed one DUE each quarter. A DUE on Vitamin D use was completed and presented during the October 2013 Pharmacy and Therapeutics Committee meeting. The DUE report was reviewed. The objective and rationale for completing the evaluation were not clear. The DUE reported that 184 of 211 individuals supported by the facility received vitamin D supplementation and the majority of the individuals received the supplementation for the indication of immune support. Seventeen percent of these individuals received supplementation without any documentation of a vitamin D level in the medical records. The DUE identified 60	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individuals with vitamin D levels greater than 50, but there was no plan to address this finding. The 10/18/13 minutes documented this was still within normal range. However, the DUE highlighted that levels greater than 50 were associated with adverse outcomes. Discussion during the P&T meeting attended by the monitoring team indicated that the clinical pharmacist was in the process of addressing high levels of vitamin D through the QDRRs. This was observed to be consistently done in the QDRRs reviewed. The DUE provided some good information related to basic information on vitamin D guidelines. It also provided information about vitamin D use in the facility. Overall, however, the study lacked the appropriate structure for a good DUE. The monitoring team could not determine the objective of the DUE or why the facility chose to complete the study. There was no description of the methodology or sample size. There was no conclusion or recommendations included in the study. Moreover, the P&T minutes did not document any definite plan of correction to address the findings of the study. The facility's second DUE on OTC Calcium Products was presented during the Pharmacy and Therapeutics Committee meeting. Similar issues were noted with this evaluation, however, the DUE did state that calcium was one of the most commonly used OTC meds at the facility, which was presumably the reason the DUE was completed. The evaluation presented data on the National Institutes of Health calcium recommendations, calcium equivalents, and the facility's calcium use and indications. Recommendations were included in the DUE. During the meeting, there was discussion of a plan to address the findings and the minutes reflected the plan. <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 recommends the consideration of the following: 1. The DUE policy should be revised to include requirements for the basic components of a DUE. 2. The DUE should specify the timeframe that the study is completed. 3. The P&T Committee minutes should document some elements of the DUE, such as the conclusion, recommendations, and corrective actions, if any, that will be required to address the findings of the evaluation. Corrective actions should be documented through completion.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The facility continued to report medication variances. The medication data provided to the monitoring team are summarized in the table below.

<table>
<tr><th colspan="7">Medication Variances 2013</th></tr>
<tr><th></th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th></tr>
<tr><td>Nursing</td><td>82</td><td>133</td><td>120</td><td>383</td><td>415</td><td>599</td></tr>
<tr><td>Pharmacy</td><td>0</td><td>0</td><td>0</td><td>47</td><td>48</td><td>62</td></tr>
<tr><td>Prescriber</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>82</td><td>133</td><td>120</td><td>336</td><td>463</td><td>661</td></tr>
</table>

The monitoring team requested variance specific data as part of the document request. As discussed in the medication variance committee meeting, in order to understand the magnitude of a particular variance, information regarding the node, type, severity, discipline involved, and dates that variance occurred must be known. These data were not provided in the meeting, were not discussed, and were not provided to the monitoring team as requested.

During the conduct of the medication variance meeting, it was clear that much work was needed in order for the facility to have an effective medication variance program. Staff needed training on the state policy because, during the meeting, it was noted that variances were not being categorized correctly. It was also quite evident that the facility did not report prescribing errors since none were documented for the six-month report period. There was evidence based on reviews of records and other documents that prescribing errors were occurring at the facility.

<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 appropriate parties should review every step in the medication use system at SGSSLC ensuring that best practices are in place and agency and state policy is being followed. That is, the facility should continue to work on all aspects of the medication use system. When problems are identified, the appropriate corrective actions should be implemented.
2. All clinical disciplines with documented medication variances should maintain the appropriate documentation of the variances, the corrective action plans that address the variances and the follow-up to closure.
The comments included in the body of report should be reviewed and addressed.</td><td>Noncompliance</td></tr>
</table>

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 Section O Presentation Book and Self-Assessment o Section O QA Reports o PNM Data Reports/Monthly Reviews o PNM spreadsheets submitted o PNMT Evaluation template o PNMT Assessment Audit tools o PNMT Meeting documentation submitted o Daily Provider Meeting minutes o Pneumonia Committee meeting minutes o Skin Integrity 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 List of individuals with Red Dot PNMPs o PNM spreadsheets o Individuals with PNM Needs 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 materials related to PNM o Pressure Ulcer Training by Maria DeLuna o Documentation of staff training submitted 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Fractures 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 related to choking event for Individual #173 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 APEN Evaluations for #203, Individual #90, Individual #128, Individual #217, and Individual #295 o PNMT Assessments and ISPs submitted for Individual #59, Individual #203, Individual #203, Individual #98, and Individual #78. o Information from the Active Record including: ISPs, all ISPAs, pre-ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o PNMP section in Individual Notebooks for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112.

	Interviews and Meetings Held: o Maria DeLuna, RN o Deanna Worden, RD, LD o Erin Bristo, MS, CCC/SLP o Dena Johnston, OTR o Judy Perkins, PT o Connie Whorton, RN o David Jolivet, MD o Various supervisors and direct support staff o PNMT meeting Observations Conducted: o Living areas o Dining rooms o ISPA Meeting for Individual #66
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, OTR, Habilitation Therapies Director, continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of OT/PT staff. Findings were reported 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. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Johnston and her staff continued to be on track to ensure that further progress will be made for the next review. Benchmarks should be established in measurable terms in order to address this and used to establish additional measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in substantial compliance for 0.1, 0.3, 0.5, and 0.7. The monitoring only concurred with continued substantial compliance with 0.1 at this time, though the facility was extremely close with 0.2, 0.3, and 0.5. Much of the concerns pertain to documentation related to elements of each of these.

	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. Substantial compliance was maintained for provision O1. There was a fully constituted PNMT and the current members were consistent over the last year, also with back-ups designated for each. Other strengths included regular attendance by the IDT members and Dr. Jolivet. The PNMT continued to refine their process and documentation. They were encouraged to review the established outcomes and discharge criteria to ensure they were measurable and clearly demonstrated progress and stability of health concerns before transitioning them from the active caseload. The team seemed to have established key clinical indicators that noted when specific actions were to be implemented. These were the kinds of clinical indicators expected in the IHCPs that were lacking or weak in provision O.7. There were several instances of these actions happening as planned, but these should not be confused with benchmarks that would justify discharge. Further, criteria that may indicate a need for another referral to the PNMT should be clearly outlined for the IDT as well. The PNMT was encouraged to track the occurrence of health issues to ensure that timely referral to the team was possible. They had taken this a step further and were tracking and trending these issues across the facility and presented in Administrative IDT meetings, as well as others. They are to be commended for recognizing the importance of this process and taking action to implement their current process. It should be noted, however, that this should not be merely a PNMT function, but rather a key element to comprehensive and integrated facility wide quality review and system analysis for the identification of trends, the development and implementation of action plans to address concerns and to set benchmarks for improvement. There were overall improvements related to mealtimes noted. The mealtime coordinator system had been implemented, but there were many logistical issues to be worked out and extensive training for these staff. The mealtime committee should conduct observations with unit leaders to assist the homes in refining this process. Staff assignment should take into consideration the number of individuals who require one to one physical assistance during meals, as well as, those who require physical and verbal prompts related to rate of eating and bite size, for example. In many cases staff could not sit a distance away and be appropriately ready to intervene quickly when an individual takes a large bite, drinks too fast, or takes food from someone sitting nearby. They could not ensure proper timing of prompts to prevent a potentially dangerous outcome. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 14 individuals, 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 five individuals who were assessed or reviewed by the PNMT over the last six months, not included in Sample O.1. 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.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on 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	The facility had a comprehensive PNM policy that addressed the scope of PNM issues outlined below, but also through a combination of facility policies, guidelines and procedural documents, generally outlined a complete and comprehensive system of Physical Nutritional Management. 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 Habilitation Therapy Policy (5/30/13). The following elements were addressed: o Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); o The annual review process of an individual's PNMP as part of the individual's ISP; o 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; o The roles and responsibilities of the PNMT; o 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; o Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); o The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; o Requirements for continuing education for PNMT members; o Referral process and entrance criteria for the PNMT; o Discharge criteria from the PNMT; o Assessment process; o Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; o The PNMT consultation process with the IDT; o Method for establishing triggers/thresholds; o Evaluation process for individuals who are enterally fed; o PNMT follow-up;	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	o Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; o A comprehensive PNM monitoring process designed to address 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. o A system of effectiveness monitoring; and o Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <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 DeLuna, 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.	

#	Provision	Assessment of Status	Compliance
		Consultation with Medical Providers and IDT Members The current medical staff, David Jolivet, MD, Brad Baker, MD, Scott Lindsey, FNP, and Stanley Cal, MD were listed as the physician consultants to the team, though Dr. Jolivet was listed as the primary PNMT member. He attended the meeting held during the week of this onsite review. • For 5 of 5 individuals for whom evaluations had been completed in the last six months (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. As the core team physician, Dr. Jolivet attended 83% of the meetings held and a back-up attended on one occasion for an overall attendance rate of 87% over 23 meetings for which minutes were submitted (6/5/13 – 11/20/13). He also signed six of the seven PNMT evaluations reviewed by the monitoring team. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to demonstrate their availability to the PNMT were also noted. As described below, the RN Case Manager and other IDT members 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 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, skin integrity committee, and in the daily medical provider meetings. These meetings addressed both individual-specific issues and systems issues as well. Daily medical provider meetings were held and a PNMT member was present at 100% of these meetings for which minutes were submitted. Medical and IDT staff attended these meetings, as well, serving as an excellent medium to ensure timely communication with other team members related to the individuals served by the PNMT and to identify others who would benefit from these services. • For 23 of 23 PNMT meetings (100%) held from 6/5/13 to 11/20/13, there was evidence of participation by IDT members. The PNMT consistently reviewed their findings with the IDT upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT, as needed. This provided significant alternate opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. The PNMT did not act outside of the IDT, by report. The initial meeting included the IDT meeting in which risks, rationales, and action plans were discussed, and actions were assigned. The PNMT's function was to provide support to the IDT, which included providing education and knowledge through	

#	Provision	Assessment of Status	Compliance
		recommendations, evaluation, and treatment. Action plans were the responsibility of the IDT as well as the PNMT. Action plans were also integrated into the IRRF and the IHCP. <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. Collectively, the five team members had over 80 years of experience in their respective fields and, together, approximately 42 years with individuals with intellectual disabilities. The back-up team members had 95 years of experience in their respective fields and approximately 21 years with individuals with intellectual disabilities. <u>Continuing Education</u> • 5 of 5 PNMT staff (100%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. This team had no new members since the previous review. Back-ups for each position had been assigned. A number of relevant courses were attended by team members: • Erin Bristo, MS, CCC-SLP (12.5 contact hours in the last year) • Maria DeLuna, RN (12.5 contact hours in the last year) • Judy Perkins, PT (23.5 contact hours in the last year) • Dena Johnston, OTR (12.5 contact hours in the last year) • Deanna Worden, RD, LD (20.5 hours in the last year) These included the following: • Surgical Interventions for Dysphagia • Case-Studies- Surgical Intervention • Oral Motor Assessment • Case Studies-Positioning for Dysphagia • Return to Oral Eating • Do Energy Drinks Live up to the Hype? • Getting Off the Chronic Disease Merry Go Round • Advance Glycation and Products in Food • EXPO Briefings • BAP and Health- Is Any Exposure Safe? • BAP and Health: Is Any Exposure Safe?	

#	Provision	Assessment of Status	Compliance
		• Clinical Concepts • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities 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. The facility is commended for supporting this critical aspect of PNM supports and services. <u>PNMT Meetings</u> • Since the last review, the PNMT met on 23 of 25 weeks (92%) from 6/5/13 to 11/20/13 (meeting minutes submitted for that period). Based on review of the minutes, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: o RN: 19/23 (83%) by core member, 2/23 (9%) by back-up, and 91% overall. o PT: 23/23 (100%) by core member, 0/23 (0%) by back-up, and 100% overall. o OT: 23/23 (100%) by core member, 0/23 (0%) for back-up, 100% overall. o SLP: 20/23 (87%) by core member, 2/23 (9%) for back-up, 96% overall o RD: 19/23 (83%) by core member, 1/23 (4%) for back-up, 87% overall Attendance was above the criterion of 80% for core team and generally above the 90% criterion overall, with the exception of the RD. The RD and the back-up for the dietitian were contract positions, while all others were state employees and this likely affected their attendance. o Since 6/5/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (d) PNMT actions, (e) follow-up, and (e) outcomes/progress toward established goals and exit criteria were clearly outlined on a consistent basis. The meeting minutes were maintained in a table format and included the following: o Member attendance o Individual reviewed o Current weight o IBW o Level of PNMT Involvement o Reason for referral o Recommendations o Due date o Next review date	

#	Provision	Assessment of Status	Compliance
		An episode tracker was maintained with review of individuals who presented with a change of status and/or presented with health concerns that may trigger a need for referral. A follow-up tracker also permitted the team to review referral information and dates of follow-up to permit ready reference to specific meeting minutes • 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. They addressed the following: 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 are 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 Morning meeting, QA/QI meeting): 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. Examples of identified system issues addressed included an extensive policy related to the choking event process (10/28/13), the mealtime coordinator process, and the threshold system developed by the PNMT. Section O required that the PNMP be reviewed at the individual's annual individual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. Also, the PNMP was to be developed based on input from the IDT, home staff, medical and nursing staff, and the PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are actually reviewed in O.3 below. The monitoring team determined that the facility continued to be in substantial compliance with this element of section O.	

#	Provision	Assessment of Status	Compliance
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<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. • Some of the individuals with PNMPs were reported to be fully independent, but only had a helmet related to seizures, for example, yet a PNMP was provided (Individual #153). This required an annual assessment and at least quarterly review. The monitoring team encouraged Habilitation Therapies to consider if this need could not be more effectively addressed via the ISP process rather than the provision of a PNMP and assessment. Some individuals required only mealtime instructions and, appropriately in those cases, only a Dining Plan was provided. • There were approximately another 69 individuals identified with no PNM needs. These lists were maintained and updated as required. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 55 individuals, (b) were dependent on others to eat: 9 individuals, (c) had difficulty swallowing: 59 individuals, and/or (d) were considered to be at medium or high risk of choking (approximately 107 individuals) or aspiration (approximately 56 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 99% were listed with a PNMP. Those not listed with a PNMP included Individual #214 and Individual #56 who were both listed at medium risk for aspiration as of 12/18/13. There was one incidence of choking requiring abdominal thrusts (Heimlich) documented since the previous review (Individual #173). Follow-up documentation was submitted. Assessment by the SLP occurred on 10/5/13, the same day as the incident. His diet was downgraded to puree with thin fluids and a MBSS was requested. The physician wrote the order for this also on that date. Individual #173 was not referred to the PNMT, but the SLP who conducted the assessment was a PNMT member and he was discussed per the meeting minutes on 10/9/13, the first meeting after this event. He was assigned oversight intervention by the PNMT SLP. Per the meeting minutes dated 11/6/13, a MBSS was conducted on 10/31/3 and he presented with mild to moderate oral pharyngeal dysphagia. The SLP met with the IDT on 11/7/13 with recommendations for moist ground diet with extra gravy and sauces to moisten. Thin liquids via Provale 5 cc cup or nectar thick liquids. Alternating small bites and sips were recommended. While the	Noncompliance

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		follow-up for this was generally acceptable and timely, it was of concern that the IDT meeting did not occur for a week after the MBSS was conducted. Improvements were noted in the completion of the risk rating tools, as evidenced by the ISPs observed during this onsite review and based on review of the IRRFs. Though as described in other sections, IDTs did not take sufficient time to discuss the programming aspects of the ISP, based on the meetings observed by the monitoring team. There should be a balance between appropriately addressing the health needs as well as program needs. The plans to address specific health risk issues were generally included in the IRRFs and IHCPs consistent with current state policy and practice. <u>PNMT Referral Process</u> Per the SGSSLC Physical Nutritional Management policy, individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and were not stable and for whom the IDT needed assistance in the development of a plan, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. More specific criteria guidelines were outlined, though individual circumstances and risk levels would dictate more or less stringent criteria: • 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 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 or the physician wrote an order, though a timeframe was not established.	

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		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 August 2013 to December 2013, there were eight individuals referred to the PNMT with two referred twice during that period (Individual #104 and Individual #238). Several of these were listed as self-referrals, with others written as orders by the PCP. Reasons for referrals listed included the following: • Recurrent cellulitis and chronic lymphedema • Aspiration pneumonia • Weight loss • Pressure ulcers • Non-healing wounds There were seven individuals listed on the current active caseload for the PNMT (Individual #78, Individual #180, Individual #134, Individual #38, Individual #287, Individual #98, and Individual #238), though Individual #287 was also listed as discharged from the team as of 2/6/14. It could not be determined from the list submitted how many of these were self-referred versus those referred by their IDT, though only two of these had been referred since the previous review. Fifteen others were listed as referred since 8/1/13, but were not included on the active caseload. Individuals in Sample 0.1 were reviewed for incidence of the concerns identified as requiring PNMT referral since August 2013: • 8 of 8 individuals (100%) were appropriately referred to the PNMT based on the criteria included in the facility policy, as well as other criteria indicating significant PNM needs. Though not formally referred, numerous other individuals who presented with PNM issues were also identified via the episode tracker and reviewed by the PNMT in a timely manner (e.g., Individual #173). • 0 of 8 individuals (0%) were referred within five days of the ISPA meeting in the case that they experienced a change in status that would warrant referral to the PNMT. In most cases, there was no evidence of an ISPA related to the reason for referral to the PNMT. In most cases, the referrals were self-initiated based on the post-hospitalization assessment by the PNMT RN, issues identified in the episode tracker and/or PCP referral. • There were other individuals not referred, but appeared to have met the criteria listed above (Individual #265 related to weight loss, for example). A PNMT episode tracking log was maintained. It tracked the incidence of health issues that may have required referral to the PNMT. Ideally this need should be recognized by the IDT in a timely manner. Otherwise, the PNMT identified these concerns and solicited a	

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		referral at that time. This system appeared to be effective in most cases. There were no individuals who had received enteral tube placements since the previous review, as such, the following metrics were not applicable: • % of individuals who received a feeding tube 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 included in the Episode Tracker for easy reference for PNMT tracking and review. Consideration of at least the following issues for tracking was consistently indicated per the meeting minutes: • Weight loss • Fractures • Falls • Skin Breakdown • Pneumonia • MBSS • Choking • New or Possible Enteral Tube Placement • Feeding tube clogged • Hospitalizations/Change in Health Status <u>PNMT Assessment</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. Assessments completed in the last six months as submitted included the following: o Individual #180 (8/16/13) o Individual #98 (10/3/13) o Individual #59 (6/30/13) o Individual #203 (8/13/13) o Individual #78 (5/6/13) • 5 of 5 PNMT assessments (100%) were initiated at a minimum within five working days of the referral, per the dates identified in those assessments. Each of these was initiated within 24 hours of the referral. This was consistent with the previous review.	

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		• 1 of 5 PNMT assessments (20%) was completed in 30 days or less of the date of referral, per the signature dates. Only the assessment for Individual #98 was completed within this timeframe. Other completion dates ranged from 45 days (Individual #59) to nearly six months after the referral (Individual #203). This was a decrease from 60% in the previous review. Based on review of these assessments, the following elements were addressed: • Date of referral by the IDT (or self-referral), including the referral source (5 of 5, 100%). This was consistent with the previous review. • Date the assessment was initiated (5 of 5, 100%). This was consistent with the previous review. • Evidence of review and analysis of the individual's medical history (5 of 5, 100%). This was consistent with the previous review. • Identification of the individual's current risk rating(s), including the current rationale (5 of 5, 100%). This was an improvement from 80% in the previous review. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data. An ISPA was held for each at the time of referral to conduct an updated risk assessment collaboratively between the PNMT and the IDT (5 of 5, 100%). This was an improvement from 80% in the previous review. • Discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (3 of 5, 60%). This was consistent with the previous review. • Assessment of current physical status (5 of 5, 100%). This was consistent with the previous review. • Information about the individual's current respiratory status based on a physical assessment (5 of 5, 100%). This was consistent with the previous review. • Assessment of musculoskeletal status (4 of 5, 80%). This was an improvement from 40% in the previous review. • Evaluation of skin integrity (5 of 5, 100%). This was an improvement from 60% in the previous review. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning (5 of 5, 100%). This was an improvement from 80% in the previous review, • Positioning that may impact PNM status including during bathing and oral hygiene based on observations of these activities (0 of 5, 0%). This was consistent with the previous review. • Evaluation of motor skills (4 of 5, 80%). This was an improvement from 40% in the previous review. • List of medications with potential side effects listed with individual allergies. This	

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		did not include drug/drug or drug/nutrient interactions and/or actual side effects, however (5 of 5, 100%). This was an improvement from 80% in the previous review. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects (5 of 5, 100%). The assessments did identify medication changes that had occurred in the previous quarter. This was consistent with the previous review. • Evidence of review/analysis of lab work (2 of 5, 40%). This was an improvement from 20% in the previous review. • Identified residual thresholds, if enterally nourished (2 of 3, 67%). This was not applicable in the previous review because none were enterally nourished. • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (3 of 5, 60%). This was an improvement from 40% in the previous review. • Evidence of observation of the individual's supports at their home and/or day/work programs (5 of 5, 100%). This was consistent with the previous review. • Nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule (5 of 5, 100%). This was an improvement from 60% in the previous review. • Evaluation of current assistive equipment (5 of 5, 100%). This was an improvement from 0% in the previous review. • Evidence that the PNMT conducted hands-on assessment (5 of 5, 100%). This was consistent with the previous review. • Identified the potential causes of the individual's physical and nutritional management problems (5 of 5, 100%). This was consistent with the previous review. • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations (5 of 5, 100%). This was an improvement from 60% in the previous review. • Recommendations for measurable skill acquisition programs, as appropriate (5 of 5, 100%). This was an improvement from 20% in the previous review. • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP) (5 of 5, 100%). This was an improvement from 80% in the previous review. • Recommendations for monitoring, tracking or follow-up by the PNMT (5 of 5, 100%). This was an improvement from 80% in the previous review. • Discussion as to whether existing supports were effective or appropriate (5 of 5, 100%). This was an improvement from 80% in the previous review.	

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		• Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT (4 of 5, 80%). This was an improvement form 60% in the previous review. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (4 of 5, 80%). This was the same as in the previous review. • Signatures of all core team members (or alternate) with dates (4 of 5, 80%). This was an improvement from 20% in the previous review. There were improvements noted across 18 of the elements. There were decreases across only two (completion within 30 days and establishment of clinical baseline data). Others remained consistent with the previous review. The facility had instituted an assessment audit system with a tool that matched the elements outlined above. This will continue to be effective in shaping the quality of these assessments in the future. 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. For example, key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. These should be integrated into the IHCPs. These will not likely be the same objectives for discharge from the PNMT. The IHCPs and PNMPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, if staff were adequately trained, etc. If the team determined that 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> Though there were five assessments submitted as completed by the PNMT since the previous review, the ISPs submitted for Individual #59 and Individual #78 did not include key components, the IRRF and IHCP. Plans resulting from PNMT recommendations included the following components: • In 0 of 5 (0%) individual plans reviewed, identified PNM needs as presented in the PNMT assessment were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. • The PNMT assessment for Individual #203 was completed on 8/13/13, per the	

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		signatures on the report, though it had been initiated in January 2013. The risk ratings were reviewed with the IDT and these were not consistent with the assessment completed by the IDT during her annual ISP on 8/20/13. There was limited reference to PNMT involvement. There were limited recommendations beyond re-evaluations for HOBE, wheelchair positioning, and gastric residuals. It was not clear why these were not completed with definitive recommendations in the seven months of assessment by this team. • The assessment for Individual #98 was completed on 10/3/13. It was reported that a new risk assessment was completed on 9/24/13, the date this assessment was initiated. There was no evidence of this in her record. Further, there was no ISPA reflecting review of the completed assessment and integration of PNMT findings into the ISP and other associated documents. • The assessment for Individual #180 was completed on 8/16/13. An ISP was held on 9/19/13 to address the recommendations. Though the recommendations were generally listed, there was no evidence that the IHCP or IRRF were updated to reflect this. For example, his IRRF on 7/3/13, rated him at high risk for aspiration and indicated that he received non-oral intake with trials for oral intake. The recommendation from the assessment included allowing him to drink his meals. The IRRF and the IHCP further indicated that a HOBE would be conducted, but the results were not in this plan or the IHCP. • For 0 of 5 (0%) individuals for whom HOBE assessments were conducted, the recommendations were integrated into the individual plans. • For 0 of 5 (0%) individuals there were appropriate, functional and measurable objectives outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCP and PNMP. • In 0 of 5 (0%) individual plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 0 of 5 (0%) individual plans reviewed, the specific clinical indicators of health status to be monitored were included. • 0 of 5 (0%) individual plans defined triggers. • 0 of 5 (0%) individual plans identified the frequency of monitoring. <u>PNMT Follow-up and Problem Resolution</u> Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion with timely implementation. Recommendation logs were submitted for four individuals (Individual #38, Individual #78, Individual #180, and Individual #287). • For 4 of 4 individuals, implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For 4 of 4 individuals, action plan steps had been generally completed within	

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		established timeframes. Rationales for delays were not consistently noted. The format of documentation continued to improve and a recommendation log made it easier to track original recommendations and those required as a function of ongoing review. Intervals of PNMT review were clearly stated, and these appeared to occur on a timely basis. IPNs were consistently entered by the PNMT, and generally reflected actions taken, outcomes, and dates of completion consistent with the meeting minutes and recommendation log. <u>Individuals Discharged from the PNMT</u> Discharge was noted for Individual #203, Individual #294, Individual #59, and Individual #287. There was no evidence of the following: • There was an ISPA meeting to discuss the discharge of the individual from the PNMT to the IDT for 0 of 1 individual for whom ISPAs were available for review (Individual #203). • A discharge summary provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP for 3 of 4 individuals. There was no discharge summary submitted for Individual #287. • There was evidence of ISPA documentation and/or action plan that included clinical indicators to track health status and criteria for referral back to the PNMT, particularly if they differed from the criteria included in the PNMT policy, for 0 of 4 individuals. As stated in previous reports, an effective PNM program requires that the referral to the PNMT 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 through action steps taken, but written assessments were still not completed in a timely manner. The team is commended for its hard work, expertise, and follow-up, though continued efforts related to the content and thoroughness of the documentation of their work is indicated as outlined above. The facility self-rated this provision in noncompliance 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:	

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		• Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. • Ensure that the PNMT assessments address the essential elements outlined above. • Ensure that discharge from PNMT service is reflected in an ISPA.	
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> As described above, at least 99% of individuals who required a PNMP were provided one. The Settlement Agreement (in O.1, but reviewed here) 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 ISP meeting. Teams are also required to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT, PT, and/or SLP clinicians. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. For individuals in Samples O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. • For 10 of 13 individuals (77%), the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. There was no signature sheet submitted for Individual #134. Individual #265 did not require a PNMP at the time of this review. • For 5 of 8 individuals for whom pre-ISP required attendance sheets were submitted, the designated team members were present for the ISP meeting per the sign-in sheet. No sign-in sheet was submitted for Individual #134. • A dietitian was designated as required to attend the ISP meeting for only one individual. An RD was present at that meeting, but not for any others. The PCP was not designated to attend in any case and did not attend for any individual in Sample O.1. This was of concern to the monitoring team, as most of the individuals in the sample presented with health, medical, and nutritional concerns which should be addressed in the ISP. The facility needs to clearly establish a rationale for attendance by all team members and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided.	Noncompliance

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		Regarding PNMP review: • 13 of 14 PNMPs (93%) were reviewed by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs were thorough and specific, and were related to changes required and efficacy. Even though Individual #265 did not have a PNMP, this was clearly stated in his ISP. The one exception to this review by the IDT was for Individual #203. The consistency of this practice was good evidence that the process used (collaboration across disciplines related to assessment and PNMP development, as well as Habilitation Therapy representation) was effective to ensure adequate and appropriate review during the ISP meeting. • For 0 of 9 (0%) individuals in Sample O.1 for whom the changes needed to be made to the PNMP, revisions based on the IDT discussion were documented in an ISPA, including rationale, and plan and timeline for implementation. The majority of ISPAs pertained to trust fund withdrawals and clothing purchases rather than comprehensive review of supports and services. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 13 of 13 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 13 of 13 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 3 of 13 PNMPs (23%), there were large and clear photographs with instructions. These were submitted only for Individual #203, Individual #98, and Individual #180. Some photographs for other individuals were submitted, but these were not current. This was an improvement from 7% in the previous review. • 13 of 13 PNMPs (100%) identified the assistive equipment required by the individual with rationale and purpose. This was consistent with the previous review. • In 3 of 4 PNMPs (75%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided for Individual #203, Individual #98, and Individual #180 only. No photographs other than the one in her Dining Plan were submitted for Individual #294. • In 13 of 13 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was consistent with the previous review. • In 13 of 13 PNMPs (100%), the type of transfer was clearly described, or the	

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		individual was described as independent. This was consistent with the previous review. • In 13 of 13 PNMPs (100%), bathing instructions were provided. This was consistent with the previous review. • In 12 of 13 (92%) PNMPs, toileting-related instructions were provided, including check and change. This was consistent with the previous review. No instructions were provided for Individual #38. • In 13 of 13 (100%) 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 an improvement from 0% in the previous review. • In 13 of 13 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 12 of 13 individuals' (92%) Dining Plans were current within the last 12 months. Individual #104's Dining Plan had expired on 2/5/13. This was a decrease from 100% in the previous review. • 2 of 13 individuals had feeding tubes with no oral intake. 2 of 2 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was an improvement from 0% in the previous review. • In 13 of 13 PNMPs (100%) and 13 of 13 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 11 of 11 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was identified as positioning for Individual #134 in his PNMP, dated 10/22/13. This was consistent with the previous review. • In 11 of 11 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was identified as positioning for Individual #134 in his PNMP, dated 10/22/13. This was consistent with the previous review. • In 11 of the 11 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 consistent with the previous review. • In 13 of 13 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 13 of 13 PNMPs (100%), oral hygiene instructions were included, including	

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		general positioning and brushing instructions. This was consistent with the previous review. • 13 of 13 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). This was an improvement from 40% in the previous review. The PNMPs reviewed were generally very good, with continued comprehensive content or improvement noted in all areas with the exception of the one recently expired Dining Plan for Individual #104 as noted above. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> • For 0 of 13 individuals, or 0% (Samples O.1), ISPA meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. As stated above, there were very limited ISPAs that documented review of changes in status, such as hospitalizations or other changes in health status. There was little to no evidence that the IDT reviewed the PNMP at that time to determine the need to modify these plans. The ISPA should state that no changes were required, or delineate what specific changes were required. • For individuals for whom the PNMP was revised, there was supporting documentation that 100% of the revised PNMPs had been implemented. The changes were made, in most cases, that day or within 48 hours. Other non-critical changes were made in less than 30 days. The monitoring team did not concur with the facility that they were in substantial compliance with this provision. To continue 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. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPAs. 2. Documentation of changes to the PNMP should also be more consistently documented in the IPNs to alert all team members that changes were made. 3. Full implementation and review of the pre-ISP process is necessary to ensure that the appropriate IDT members are present for continued review of the PNMP. 4. Continue with the existing audit process as this, as well as the training, clearly affected positive changes in the content of the PNMPs.	

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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 generally readily available in the dining areas (with few exceptions) and PNMPs were included 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: • 26 of 40+ individuals' (65%) dining plans were implemented as written. • 35 of 40+ individuals' (88%) 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 3 (33%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. • 2 of 2 (100%) individuals' oral hygiene plans were implemented appropriately or consistent with the PNMP. Some additional comments: • Concerns noted related to implementation of PNMPs/Dining Plans were: o presentation techniques o mealtime position o pace of presentation o re-positioning techniques o bite size o use of verbal and physical prompts. The facility had implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in each of the homes. Standardization of this process is essential to ensure adequate competency of these key staff. Unit directors need to be intimately involved in the implementation and oversight of the program. Essentially, only one of the Mealtime Coordinators appeared to understand their role and the training process. Most did not set up the environment properly to ensure that supervision and supports were appropriate throughout the meal. Numerous errors were observed by the monitoring team that went unnoticed by the MTCs (Individual #266, Individual #237, Individual #130, Individual #31, Individual #218, Individual #383, Individual #294, Individual #118, and Individual #145).	Noncompliance

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		Eight of 10 (80%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. 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: • Staff are 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 and, as such, information should be fresh on their minds. The monitoring team concurred with the facility's self-rating that they were not in compliance with this provision. The rate of errors observed continued to be too high, particularly related to mealtimes. 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. Fully implement the Mealtime Coordinator system. Review the process for training these key staff to ensure consistency and to document competency. 2. Ensure there is further focus on strategies for assigning staff duties to ensure that all individuals who have a need for prompts and cues throughout the meal are supervised by staff in a manner that executing these supports is readily available in a timely manner. 3. The current system used to monitor staff compliance at mealtimes was not adequate based on the observations during this review. This system must be reviewed and revised as indicated.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time related to PNM went across two full days to two and half days. 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 is addressed in section R of this report. There was a presentation of foundational skills, with modeling by	Noncompliance

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	competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	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 competencies (non-foundational skills or "red dot" system implemented in December 2013). 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 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. There were 217 staff listed as required to take the training, but it was reported that several of them did not complete the training and were terminated. It was reported that 185 had passed the core competencies for PNM (85%). It was not clear whether the other 15% had been terminated or were working as direct support staff without passing the required check-offs. This could not be determined from the documentation submitted. Failed skill drills and staff who failed more than one skill drill were tracked for each area. Staff who failed more than one skill drill per month were required to attend a corrective action training. <u>PNM Core Competencies for Current Staff</u> Refresher courses for all existing staff (117 staff) were required annually for lifting and transfers and eating skills. Skill-based competencies (check-offs) were provided in the	

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		following areas during annual refresher: • PNMP/dining Plan review • Safe mealtime management • Positioning in wheelchair • Positioning in bed • Positioning during activities • Communication • Assisted mobility and transfers • Lifting 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. The number of staff listed as passing was identified as 217 and was not consistent with the number required to take the training. Home managers had access to a database of trained staff for assignments and if no staff were available, they were to contact Habilitation Therapies. There was a system to establish and maintain competency for staff who provided the training, conducted by the Director on an annual basis. • 7 of 19 staff (PNMPCs and Home Managers) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundation skills) prior to training other staff. This was renewed at least annually. There was no evidence of training for the 12 Home Managers listed as responsible for training other staff. • The facility had a process to validate PNMPCs responsible for training other staff and their competency to assess the competency of others. This was not clearly established for the home managers assigned this role, however. • A training module related to this training had been developed, but implementation of this training was reported to be in process with a projected completion date of 3/30/14. <u>Individual-Specific Training</u> All staff who completed the NEO training received individual-specific training related to PNMPs during the on-home time following classroom instruction. Changes in the PNMP requiring staff training was conducted by the PNMPCs for foundational skills. Non-foundational skills were addressed by licensed professional staff.	

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		Individualized Non-Foundational Training In December 2013, the facility implemented a red dot system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. This training and check-offs were conducted by professional staff only. Competency-based training sheets were submitted for a group of individuals, but they were not individuals in Sample O.1 as requested, so this could not be reviewed at this time. There were only a few individuals that would require this for implementation of their PNMPs. Home managers had access to a database of trained staff for assignments and if no staff were available, they were to contact Habilitation Therapies. There was no system to ensure that pulled staff were trained to competency to implement plans. The facility self-rated substantial compliance with this provision, but the monitoring team did not concur based on the findings outlined 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. Develop system to address training for pulled staff. 2. Continue to focus on staff performance through training, coaching, and monitoring. 3. Reinforce the role and responsibilities of the Mealtime Coordinators as well as supervisory staff in identifying and correcting staff performance errors. 4. Ensure that home managers are competency-based trained to train others and assess their competency related to PNMP strategies.	
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.	Facility's System for Monitoring of Staff Competency with PNMPs The monitoring tools used were unique forms for each element of the PNMP requiring monitoring for staff compliance with implementation. The elements were adequately discrete measures of staff competence and some had been weighted to better analyze staff performance. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP. • There were sufficient instructional guidelines for those using the forms to monitor. • Monitors (PNMPCs) were competent to monitor the PNMP elements based on the training submitted. Implementation of PNMPs was monitored for staff compliance. The monitoring team routinely requested compliance monitoring forms that were completed for individuals included in Sample O.1 for the last three months (November 2013 through January 2014). Completed forms were submitted for only 7 of the 13 individuals in Sample O.1 with	Noncompliance

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		PNMPs. The monitoring conducted did not address all aspects of the PNMP as follows: • Positioning in bed: 8 completed for three individuals • Positioning during activities: 6 completed for six individuals • Assisted transfers and Mobility: 3 completed for three individuals • Wheelchair positioning: 5 completed for fine individuals • Safe mealtime management: 2 completed for two individuals • PNMP review: 3 completed for two individuals Based on this submission the routine frequency could not be determined. A list of individuals for whom PNM monitoring tools were completed was requested and submitted, but this did not appear to relate to compliance monitoring, but more likely the effectiveness monitoring conducted by the licensed professional staff, rather than the PNMP Compliance Coordinators. SGSSLC's system included compliance monitoring that was focused on staff performance and did not necessarily include every individual with a PNMP. Program effectiveness monitoring was a separate process that focused on the individuals with PNMPs and was completed by licensed therapy staff. A component of this was staff compliance. Assistive equipment was reviewed on a monthly basis to ensure that it was available and in good working order/condition. This was consistently and clearly documented in a log. It was noted, however, that the PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase other PNM risk, based on: • Meals • Bed positioning • Wheelchair positioning • Medication administration • Oral care • Bathing • Transfers This is a very critical aspect of PNMP implementation and perhaps skewed the perception of compliance due to the small sample. As described above, there were issues related to staff performance of transfers, re-positioning, and mealtime assistance. The monitoring team concurred with the facility's self-rating of 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:	

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		1. Identify and correct issues related to the monitoring process to include the monitoring related to all aspects of the PNMP (tooth brushing, bathing, and medication administration, specifically). 2. There did not appear to be a system to ensure that all staff were compliant with implementation of PNMPs, particularly for those at highest risk. Consider review of the existing system of monitoring, to ensure more comprehensive and frequent monitoring of staff assigned to individuals at greatest risk to ensure that the staff working with them are compliant with implementation of the plans and supports for which they were deemed to be competent.	
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>Monitoring by the IDT and/or PNMT to Assess individual Progress and Plan Effectiveness</u> • 10 of 14 (71%) IHCPs had indicators identified to assess the individual's PNM status, though most of these were marginal. • 12 of 13 individuals (92%) were monitored as to the effectiveness of PNMPs that included progress, health status, and other clinical indicators identified in the IHCP and risk action plans. • For --% of individuals receiving direct PNM therapy, there was documentation as to the review of the effectiveness of the intervention plan based on objective clinical data included in the plan. This was not applicable because no one in the samples received direct therapy not already addressed in section P below. • At least 8 of 14 presented with a change in status in the last six months. For four of these (50%), there was evidence that the IDT met, reviewed the existing interventions, and made changes in a timely manner. In some cases, it was not clear that both the IHCP and IRRF were reviewed and it was not evident that the IDT also reviewed the PNMP supports. There should be clear evidence of an ISPA that indicated review of each of these and identified the need or not to revise them. The revised documents should correspond to that process. • For at least eight individuals, there was evidence that the IDT identified the need for, and developed, individualized triggers as indicated. • Trigger sheets for 8 of 8 individuals (100%) included individualized triggers as indicated. • Trigger sheets for 3 of 8 individuals were completed correctly, for the most part (Individual #294, Individual #38, and Individual #112). The others were frequently incomplete and/or did not follow the written instructions. • Trigger sheets for 3 of 8 individuals were reviewed at least daily by the nurse. Though many were reviewed on multiple shifts, there were numerous blanks in the documentation suggesting that a nurse had not reviewed the data. Case Manager review was spotty for all, even though procedure dictated at least weekly review.	Noncompliance

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		Effectiveness Monitoring Staff compliance monitoring occurred across all time periods that the plans were implemented as staff compliance monitoring was completed by the PNMPCs. PNMPCs were scheduled to work outside of the hours of 8-5 and on weekends. This monitoring, by design, did not necessarily address all individuals who had a PNMP, including those at highest risk. The compliance monitoring conducted by the therapy clinicians for those individuals did not occur across all times at which the plan might be implemented outside of the usual work day for professional staff. The process in place allowed for the effectiveness of the strategies and interventions to be reviewed at a minimum of quarterly. Effectiveness of plans was reviewed, although all strategies and interventions may not be. The system of staff compliance monitoring was in place to review overall implementation and knowledge of supports and services. Monitoring schedules were recommended at the time of assessment and approved by the IDT as documented in the IHCP. The rationale was provided for the determination of the monitoring schedule within the assessment. Effectiveness monitoring should include intervention and program implementation across all environments and not only in the home. Staff compliance monitoring should occur across all time periods that the plan may be implemented and not only during the usual business hours of the clinician. While the overall monitoring system was significantly improved, the consistency of implementation was limited. Forms had been completed in the last three months for 12 of the 13 individuals with PNMPs (none was submitted for Individual #251). The monitoring team did not concur with SGSSLC's finding for substantial compliance with this provision. The process in place allowed for the effectiveness of the strategies and interventions to be reviewed at a minimum of quarterly. By report, effectiveness of plans was reviewed, although all strategies and interventions may not be. The system of staff compliance monitoring was in place to review overall implementation and knowledge of supports and services. Monitoring schedules were recommended at the time of assessment and approved by the IDT as documented in the IHCP. The rationale was provided for the determination of the monitoring schedule within the assessment.	
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	Evaluation of Individuals who Received Enteral Nutrition • The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals that identified eight individuals who received enteral nutrition (4% of the current census). All were listed gastrostomy tubes. Four received intermittent feedings, one received continuous, and three received	Noncompliance

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	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.	bolus feedings. Seven were identified as NPO and one received some level of oral intake listed as ground foods and regular liquids (Individual #180). A sample of 10 APENs was requested, as completed since the previous review. Only one was submitted, for Individual #203 on 7/29/13. An onsite request yielded three additional APENS (Individual #90, Individual #128, Individual #217), and Individual #295's was read as part of his ISP. Thus, there was a total of 5 APENs. The ISPs submitted did not include the IRRF or IHCP for any of these. • 5 of 8 individuals (63%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. Three APENs were not submitted, so this could not be determined for (Individual #66, Individual #98, and Individual #180). It should be noted, however, that the tube for Individual #180 was determined to be medically necessary per an ISPA dated 6/25/13. It was placed on 6/26/13, after his annual ISP. As Individual #98 was selected for review in Sample O.1, her individual record was submitted as requested. It was noted that there was no documentation of IDT deliberation as to the medical necessity of her tube in any of the ISP documents, including the IRRF and IHCP. • 0 of 5 individuals with APENs submitted (0%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. Most did not appear to present a determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake. Also, there was not sufficient oral motor review to address potential for any level of oral intake or interventions that may be indicated. By report, Individual #217 was provided pleasure feedings offered by nursing, but there was no evidence that an oral-motor assessment had been conducted that included observations of that process. Others determined that oral intake was not indicated based on previous MBSS findings, but without further assessment, there was no basis to determine if interventions were indicated on the continuum of return to oral intake. • For 0 of 8 individuals (0%), there was evidence of adequate discussion by the team related to the medical necessity of the team. • --% of individuals who received enteral nourishment and were admitted since the last review (NA) had a review of the medical necessity of the feeding tube within 30 days. No one who received enteral nutrition had been admitted to SGSSLC since the previous review. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • None of individuals who received enteral nutrition (Sample O.3) were adequately	

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		evaluated by the IDT to determine if a plan to return to oral intake was appropriate. It was noted that most did not clearly reflect assessment by the SLP and/or OT regarding oral motor status and as to whether the individual was a candidate for an oral motor treatment program (to improve potential for intake by mouth or for improved saliva control). Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. • --% of individuals who were identified as potentially benefitting from oral motor treatment and were cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. This did not apply to any individuals at this time. There were, however, two individuals identified with oral intake (Individual #217 and Individual #180), though oral motor intervention did not appear to have been implemented. There was no clear plan for Individual #217 outlined in her APEN. No other documentation for her was submitted as described above. The PNMP for Individual #180 identified all of the parameters for his oral intake. • 0 of the 2 individuals' (0%) plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP and the ISP or ISPA. Plans for oral intake were outlined in the IHCP for Individual #180, but there was no ISPA to indicate that oral intake was planned. • 0 of 1 individual's plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The Change of Status IHCP for Individual #180 was dated 7/3/13. This plan indicated that changes to the PNMP and Dining Plan were made, but there was no evidence of these changes until 7/29/13, per the PNMP on that date. The only Dining Plan submitted was dated 10/15/13 and reflected oral and enteral intake. • --% of staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. This could not be determined. • ---% of individuals monitored as outlined in the plan. This could not be determined. • None of the individual's return to oral intake plans was modified by the IDT. Individual #180's PNMP was modified a number of times since tube placement, but there was no evidence that the IDT met related to these. • For 0 of 2 individuals, IDT met and interventions in the return to oral intake plans were reviewed and changed, as appropriate, in a timely manner. There was no evidence of this. 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	

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		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 positioning plan that addressed positioning during enteral intake only, rather than a Dining Plan. The monitoring team concurred with SGSSLC's self-rating of noncompliance with this provision at this time. 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 protocol related to the completion of assessments, especially related to oral motor evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 2. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF and IHCP as appropriate. 3. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.	

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 o Section P Presentation Book and Self-Assessment o Section R and P audits Reports o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates o Completed Effectiveness Monitoring sheets submitted o Completed Compliance 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months 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 Documentation of competency-based staff training submitted o PNM/Assistive Equipment Maintenance Log 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: Individual #82, Individual #286, Individual #343, Individual #80, and Individual #93. o OT/PT Assessments, ISPs, and ISPAs for the following individuals: • Individual #222, Individual #130, Individual #120, Individual #57, Individual #123, Individual #125, Individual #389, Individual #328, Individual #183, Individual #85, Individual #379, Individual #25, Individual #271, Individual #194, Individual #185, Individual #118, Individual #76, Individual #68, and Individual #190, Individual #266, Individual #298, and Individual #237. o OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #383, Individual #310, Individual #132, Individual #217, Individual #78, and Individual #22. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o PNMP section in Individual Notebooks for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Erin Bristo, MS, CCC-SLP o Connie Whorton, RN o OTs, PTs, Hab technicians and PNMPCs o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas

	o Dining rooms o ISP Meeting for Individual #66
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, OTR, Habilitation Therapies Director continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of OT/PT staff. Findings were reported 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. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Johnston and her staff continued to be on track to ensure that further progress will be made for the next review. They were very close to achieving substantial compliance in P.4, with a needed focus on consistency of effectiveness monitoring. It was positive that the facility tracked the effectiveness of plans and programs, but based on this review, they did not appear to be consistently completed in a timely manner. In addition, documentation of direct services was absent or very limited. Benchmarks should be established in measurable terms in order to address this and used to establish additional measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in substantial compliance with in continued compliance with P.1 and substantial compliance with P.4. The monitoring concurred with P.1, but while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team determined that P.2, P.3, and P.4 were not in substantial compliance.
	Summary of Monitor's Assessment: There was continued progress toward substantial compliance in all aspects of provision P. Substantial compliance maintained for P.1, and continued efforts to improve the content of assessments and timeliness were noted. There were few intervention plans and SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries. Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report with regard to content. Attendance at ISPs needed to be more consistent with the determinations by the IDT and supports and services needed to be more consistently reflected in the ISP document. The Essential Elements guide used by the therapists, appeared to be effective during the meeting, but did not result in consistent documentation of PNM and OT/PT supports and services.

	Samples for Section P: • Sample P.1a: 14 individuals for whom an individual record and the most current OT/PT/SLP assessment were submitted. • Sample P.1b: assessments submitted by clinicians as most current • Sample P.2: 5 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 6 individuals who were provided direct OT and/or PT services per the list submitted.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	Assessments Completion of assessments was based on the ISP schedule and reevaluation was to be conducted on an interval established per policy. Assessments of Current Status were to be completed for individuals who received supports and services in years that a Comprehensive Evaluation was not required. ISP dates, assessment due dates, and timeliness of completion were tracked in the tracking log for individuals with ISPs scheduled from 1/1/13 to 12/20/13. There were approximately 171 individuals listed as having been provided an assessment during that time, with 63 of those completed since from 8/1/13 through 12/20/13 (i.e., since the previous review). There were 31 Comprehensive Assessments and 32 Assessments of Current Status completed. The log identified when the assessment was to be initiated (45 days prior to the ISP) and date due (15 days prior to the ISP per established department guidelines). Of those listed with assessments during that period, approximately 84% had been completed within 15 working days prior to the ISP per the established facility deadline. Each of the three delinquent assessments was completed before the date of the ISP. There were six individuals listed who were provided OT/PT services, but did not have an assessment current within the last 12 months; the others either had a current assessment or were listed as not requiring services. The self-assessment reported that 100% of the assessments from June 2013 to December 2013 were completed within 10 days of the ISP, though this was reduced slightly in January 2014 due to confusion regarding the holidays. This was since reconciled and adjusted, by report. The self-assessment identified that 13 assessments were required that month and 100% were completed on time. The assessment log identified 14 individuals with services who should have received an assessment in November 2013, plus one individual provided an assessment, but did not receive services per the log (Individual #93). Approximately 80% of these were completed on time per the 15 calendar day deadline listed. Individual #14's assessment was not completed and Individual #343's was completed after the deadline, but prior to	Substantial Compliance

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		the ISP. In December 2013, the log listed 12 assessments due (based on the provision of services) and the self-assessment listed 20. The self-assessment reported that 90% were completed in a timely manner. Assessments for three individuals who were listed without services were completed (Individual #47, Individual #227, and Individual #297) and two individuals listed with services were not provided an annual assessment (Individual #318 and Individual #129) per the log submitted. Of the 15 assessments completed per the log submitted, 80% were completed by the 15 day due date. The following individuals in Samples P.1a and P.1b had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): 1. Individual #150 (4/13/13) 2. Individual #112 (5/21/13) 3. Individual #237 (12/5/13) 4. Individual #310 (9/11/13) 5. Individual #120 (8/26/13) 6. Individual #57 (8/19/13) 7. Individual #298 (7/31/13) 8. Individual #266 (10/11/13) 9. Individual #190 (10/11/13) 10. Individual #125 (10/25/13) 11. Individual #68 (10/1/13) 12. Individual #222 (11/22/13) 13. Individual #389 (11/29/13) 14. Individual #76 (10/21/13) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record: 1. Individual #203 (7/16/13) 2. Individual #104 (4/18/13) 3. Individual #134 (3/27/13) 4. Individual #251 (8/28/13) 5. Individual #238 (5/14/13, missing two pages in copy submitted) 6. Individual #38 (4/16/13) 7. Individual #382 (11/8/13) 8. Individual #180 (7/9/13) 9. Individual #273 (1/28/14) 10. Individual #98 (4/10/13)	

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		11. Individual #265 (8/15/12), no further assessment was indicated per this update ACSs submitted for individuals in Sample P.1 for whom individual records were requested also included Individual #153. The comprehensive assessments for Individual #180 and Individual #273 were dated in 2011, with no subsequent update in 2012 as would be expected based on needs. The most current OT/PT evaluations were Assessments of Current Status, dated 7/9/13 and 1/28/14 respectively. There was no Comprehensive Assessment submitted for Individual #153's ACS (4/25/13). It was of interest that many evaluations considered to be "most current" were over seven months old and completed prior to the previous review. The ACS submitted included the following: 1. Individual #194 (7/26/13) 2. Individual #185 (not dated) 3. Individual #271 (6/28/13) 4. Individual #379 (7/30/13) 5. Individual #85 (7/8/13) 6. Individual #183 (9/10/13) 7. Individual #328 (9/25/13) 8. Individual #130 (7/30/13) <u>Timeliness of Assessments</u> Sixteen individuals were admitted to SGSSLC since the last review. A Comprehensive Evaluation was submitted for five of these as requested (Individual #80, Individual #82, Individual #93, Individual #343, and Individual #263). • 5 of 5 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the signature dates of the assessments submitted for review. The following metric was not applied because SGSSLC did not use an OT/PT screening for individuals newly admitted to the facility, so no screenings were submitted for 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. There were 34 current OT/PT evaluations submitted for individuals in Samples P.1a and P.1b. The most current update for Individual #265, as stated above, was from 2012, but further OT/PT assessment was not indicated due to his functional skill performance and, as such, was not included in the analysis below. Also, ISPs were submitted for all individuals in these samples, though the ISPs for Individual #76, Individual #68, Individual #190, Individual #266, Individual #237, Individual #118, and Individual #185	

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		were not current within the last 12 months. Timeliness of the current OT/PT assessments was as follows: • 23 of 26 individuals' OT/PT assessments or updates (88%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 74% in the previous review. • As described above, there were approximately 171 individuals listed as provided an assessment in the assessment log submitted. At least 63 of those were completed from 8/1/13 through 12/20/13 or since the previous review. Of those listed with assessments during that period, approximately 84% had been completed within 15 working days prior to the ISP per the established department deadline. Each of the three delinquent assessments was completed before the date of the ISP. • 33 of 33 assessments (100%) were current within 12 months for individuals in Sample P.1a and P.1.b who were provided PNM supports and services. <u>OT/PT Assessment</u> Only current Comprehensive Evaluations included in Sample P.1a and P.1b were included in the following analysis (14). 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. The analysis for comprehensiveness of the OT/PT/SLP assessments was as follows: • 13 of 14 assessments (93%) were signed and dated by the clinician upon completion of the written report. This was decrease from 100% in the previous review. • 14 of 14 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 14 of 14 assessments (100%) included medical history. This was consistent with the previous review. • 14 of 14 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. • 13 of 14 assessments (93%) addressed health status over the last year. This was an improvement from 89% in the previous review. • 13 of 14 assessments (93%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. • 14 of 14 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This was consistent with the previous review. • 14 of 14 assessments (100%) listed medications and potential side effects relevant to functional status. This was consistent with the previous review. • 14 of 14 assessments (100%) included individual preferences, strengths, and	

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		needs. This was consistent with the previous review. • 14 of 14 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was consistent with the previous review. • 14 of 14 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. • None of the individuals in the samples reviewed required a wheelchair. So this metric was not applicable for this review. • 11 of 13 assessments (85%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This was consistent with the previous review. • 14 of 14 individuals' OT/PT assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. • 13 of 13 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels. This is a new metric since the previous review. • 14 of 14 assessments (100%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 84% in the previous review. As was true in the previous review, however, this was usually a general statement related to overall potential for learning rather than specifically related to new motor or self-help skills. Very few individuals were recommended for services beyond that of the PNMP. • 14 of 14 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was consistent with the previous review. • 13 of 13 assessments (100%) included a monitoring schedule. This was an improvement from 95% in the previous review. • 14 of 14 assessments (100%) included a re-assessment schedule. This was consistent with the previous review. • 12 of 14 assessments (86%) made a determination about the appropriateness of transition to a more integrated setting. This was a decrease from 100% in the previous review. • 6 of 14 assessments (43%) detailed the supports and services needed for successful community living. This was an improvement from 37% in the previous review. As was true 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	

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		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. • 14 of 14 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. The Assessment of Current Status was considered an update to the previous Comprehensive Assessment. In that case, the existing Comprehensive Assessment should be available in the individual record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There were new assessment formats recently developed by the state and distributed. These contained standardized main headings were to be used by all disciplines. The facility had implemented these changes. There was some inconsistency, however, where specific information was included and it is recommended that this be reviewed. There were 12 individuals in Sample P.1a for whom individual records were submitted with current Updates/Assessments of Current Status, and all but Individual #153 had associated Comprehensive Assessments submitted and/or contained in the individual records. • For 11 of 11 individuals for whom Updates/Assessments of Current Status were completed (100%), the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. The exception was Individual #265, whose update had been completed in 2012 and further assessment was deemed unnecessary due to his functional status at that time. Further findings revealed continued improvements related to OT/PT assessments as follows: • There were improvements in four of the elements. • There was regression in two of the elements.	

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		• Twelve others were consistent with the previous review at 100%. • The average for all 14 assessments was approximately 95%. o 4 of 14 assessments (29%) contained 100% of the 22 elements listed above. ▪ Six assessments lacked only one element. Of these six, three did not address specific community recommendations, one did not include the assessor's opinion about referral to the community, one was not signed and dated, and one did not include monitoring results. o 13 of 14 assessments (93%) contained 90% or more of the elements listed above. o 14 of 14 assessments (100%) contained 85% or more of the elements listed above. o None contained less than 85% of the elements. There was continued overall improvement in the quality of OT/PT assessments for this review period, though the concerns expressed during the last review continued to be noted. The average for all evaluations in the sample was only 95% related to inclusion of the essential elements, and this was slight improvement from 92% in the previous review. There was an audit system in place involving self-assessments with additional review by the Director on a quarterly basis. This continued to be an appropriate approach as all clinicians were reported to have demonstrated competency with the elements identified above. There was a reported improvement of on-time assessments submitted at or near 100% submitted on or prior to the due date of 10 days prior to the ISP. SGSSLC maintained substantial compliance with provision P.1. The facility also demonstrated 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. 1. Ensure that assessments are completed by the due dates (10 days prior to ISP). 2. Ensure that the audit system promotes improvements in the content of OT/PT assessments at or near 90%, which is the standard held by the monitoring team, rather than 80% as identified by the facility. Consider setting benchmarks for the department as a whole as well as for individual therapists in order to continue to maintain this. 3. Clarify the function and format of the Assessment of Current Status.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Direct OT/PT Interventions: There were 20 individuals listed as participating in direct OT and/or PT and one of these was included for review in Sample P.3 (Individual #180). Documentation for six others was requested (Individual #383, Individual #310, Individual #132, Individual #217, Individual #78, and Individual #22). • For 4 of 7 individuals (57%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. The annual assessment, dated 9/11/13, for Individual #310 recommended continued direct PT services to improve overall strength, balance, and endurance for increased independence in mobility and to decrease fall risk. This evaluation stated that direct therapy had been unsuccessful in carry over for improved posture outside of therapy sessions, but that the frequency of falls had decreased. Assessments recommending direct therapy were also noted for Individual #22, Individual #78, and Individual #217. • 3 of 7 individuals had direct intervention plans (43%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety (Individual #22, Individual #217, and Individual #310). • For 0 of 7 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. Individual #383's ISP, dated 6/12/13, indicated that she would participate in occupational therapy one of two opportunities, but there were no functional goals stated. There was a reference to a referral, but the rationale for OT was not identified in the ISP or the annual assessment on 5/28/13. There was no OT present at the ISP meeting on that date. There was reference to OT and PT services in Individuals#78's ISP dated 5/6/13, but no specific goals and objectives. Per the treatment notes submitted, this service was not initiated until 8/1/13. There were IPNs indicating that Individual #180 was seen by PT for direct intervention. There were no goals or objectives identified related to this service. Some of the progress notes indicated that he was not making adequate progress, yet it was not clear how this was measured. He was seen from 7/3/13 to 9/3/13 by one clinician, but there was no discharge summary or note. On 10/21/13 a different clinician initiated direct PT again, but there was no related assessment with specific goals established. He was seen as well on 10/22/13, with no further documentation until 12/6/13, thereby, suggesting that he had continued to participate in PT. At that time, the recommendation was to continue to be seen five times a week for 12 weeks. There were also Habilitation Therapy Treatment Notes dated from 11/22/13 through1/17/14. These notes had long and short term objectives and appeared to have been filed in the Habilitation Therapy tab. The note on 1/17/14 stated that he would be assessed for discharge the next week. On 2/4/14, a discharge summary was written, reporting that he had failed to make any meaningful progress. Again, it was not clear how that was determined because previous notes indicated that progress had been made, though it was stated that return to	Noncompliance

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		ambulatory status was doubtful. The variation in types of documentation was confusing and did not suggest continuity of services. • For 2 of 7 individuals (28%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner (Individual #22 and Individual #310). OT for Individual #217 appeared to continue as of 12/10/13, but there was no documentation submitted related to interventions provided after that time through the week of this review. There was no evidence or rationale for discharge. There was no actual discharge summary written by the clinician. As described above, there was a discharge summary for the second round of PT, but there had been no goals established, so termination of services was not clearly justified. The system for documentation was somewhat inconsistent for each of the individuals reviewed. There was a combination of IPNs, weekly therapy progress reports, and habilitation therapy treatment notes. Further there was no evidence that actual therapy had been provided for Individual #383, Individual #132, or Individual #78. Progress notes/IPNs: • 4 of 7 individuals receiving direct OT/PT Services (57%) 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. <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 and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. <u>Integration of OT/PT Interventions, Supports and Services in the ISP</u> Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT and/or PT clinicians. As described above,	

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		none of the ISPs or ISPAs for individuals in the sample who participated in direct OT or PT services clearly established the need to begin or terminate therapy. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. Pre-ISP documentation and ISPs were requested for individuals included in Sample P.1a, P.1b, and P.3. The ISPs for Individual #76, Individual #68, Individual #190, Individual #266, Individual #237, Individual #118, and Individual #185 were not current within the last 12 months and, as such, were not included in the review below. Review of the ISPs submitted was as follows: • 81% (29 of 36) of the ISPs submitted were current within the last 12 months. • 97% (28 of 29) of the current ISPs had attached signature sheets (all but Individual #134). • 29% (8 of 28) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 36% (10 of 28) were attended by PT only. • 18% (5 of 28) was attended by OT only. • 18% (5 of 28) of the current ISPs had no representation by an OT or PT (Individual #180, Individual #130, Individual #125, Individual #298, and Individual #265), even though two individuals had PNM needs (Individual #180 and Individual #130. Of the 25 individuals for whom pre-ISP required attendance sheets and ISP signature sheets were submitted, 16 were attended as designated by the IDT (64%). The facility needs to clearly establish a rationale for attendance by all team members and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided. This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To continue 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 in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. Ensure that there is an assessment or consult that clearly establishes the need for OT/PT interventions and that states the goals and objectives. 4. Ensure that there is consistency across clinicians with regard to the manner in	

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		which services are documented. Audits for this may need to be established. 5. Ensure that there is a clear discharge summary (in the IPNs). 6. 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.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The facility had a current comprehensive OT/PT policy, that included all of the following elements and were in practice at the time of this review: • 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.	Noncompliance

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		Monitoring System The facility implemented a system for the adequate monitoring of PNMPs conducted by two PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. This was addressed in section O.6 and O.7 above. Lead therapist rounds were implemented to provide an additional oversight in the system of monitoring PNMPs. The Director of Habilitation Therapy, in conjunction with the dietitian and SLP, conducted rounds monthly across all areas of supports and the results were reviewed to identify system issues and the need for referrals or actions plans. The findings were also reviewed with the therapists during the Therapy Clinical Support meeting. Corrective action plans were developed as indicated. The system was integrated into the departmental policy. 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. There was a form serving as a worksheet for review and used for data entry, which had been revised and improved since the previous review. In most cases, there was also an IPN that stated effectiveness monitoring was completed, though findings were not always documented there. The policy outlined the required content of these notes, though very few actually met those requirements. Based on the submission, effectiveness monitoring was documented for 13 of 14 individuals in the sample (93%), though consistency with quarterly review was noted only for six of these. Gaps of more than three months were noted in the documentation for the other individuals. The clinician who completed the monitoring could not be determined on three of the forms submitted (Individual #273 (5/7/13), Individual #150 (11/26/13), Individual #265 (6/18/13), and Individual #382 (6/15/13). The form completed for Individual #265 indicated that his PNMP had been discontinued. Thirteen of these had been completed by a therapy assistant. In some cases, the monitoring was conducted by a therapy assistant. Per the previous review, the facility reported that therapy assistants were allowed only to complete chart review and staff	

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		interview for program effectiveness monitoring. Therapy assistants were not allowed to document program effective analysis in the active record, by report. Therapists were to complete the analysis and to document program effectiveness in the active record. It was noted, however, that these forms were marked by the assistant as to whether or not the supports were effective in each case. Again the facility is cautioned as to this practice, as it was not within the scope of practice for an assistant to make judgments of this nature. The facility reported that therapists were involved and that a signature indicating so would be included on the forms in the future. • Based on the monitoring team's direct observation of over 30 individuals, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Based on review of the maintenance log, individuals for whom adaptive equipment was noted to be in disrepair or needing replacement, equipment was repaired or replaced within 30 days, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. All equipment was checked at least monthly for presence and condition in addition to the compliance and effectiveness monitoring systems. 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 O.5 and O.6 above. While there was an established system of effectiveness monitoring, compliance with this, at least quarterly, was not substantially in compliance the established facility policy and criterion for substantial compliance. 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 benchmarks and a tracking system and schedule for quarterly effectiveness monitoring by OTs and PTs. 2. 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: Dental Services, dated 8/17/10 o SGSSLC Dental Procedures Manual, 5/31/13, revised 8/19/13 o SGSSLC Organizational Charts o SGSSLC Self -Assessment Section Q o SGSSLC Action Plan Section Q o SGSSLC Provision Action Plan o SGSSLC Procedure, Missed Dental/Medical Appointments and Day Program Attendance, 9/15/11, 4/8/13 o SGSSLC Policy/Procedure, Comprehensive Provision of Dental Assessments, 8/30/10, revised 10/24/13 o SGSSLC Procedure, Pretreatment Sedation Notification and Referral to Assessment Process 2/22/11, 11/26/13 o SGSSLC Policy/Procedure, Dental Radiographs, September 2012 o SGSSLC Policy/Procedure Dental Care -Suction Toothbrushing, 5/18/10, revised 5/1/12 o SSLC Nursing Protocol: Post Anesthesia Care, June 2010, reviewed December 2013. o SSLC Nursing Protocol: Pretreatment and Post sedation Monitoring, revised December 2013. 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 Annual Dental Assessments for the following individuals: • Individual #371 Individual #346Individual #162, Individual #140, Individual #290, Individual #343 Individual #103 Individual #353Individual #97, Individual, #378 o Annual Dental Summaries for the following individuals: • Individual #117, Individual #100, Individual #190, Individual #141, Individual #266, Individual #80, Individual #125, Individual #248, Individual #76, Individual #285, o Oral Surgery Consultations for the following individuals: • Individual #140, Individual #394 Interviews and Meetings Held: o William Todd Walker, DDS, Dental Director o Belinda Lendermon, RDH o Stanley Cal, MD, Medical Director o Lisa Willingam, RDH

	o Sierra McCutchen, Dental Assistant Observations Conducted: o Dental Department o Administrative IDT Meeting o Daily Medical Provider Meetings o Observation of treatment in clinic, Individual #37
	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. The facility's lead described, for both provision items, a series of activities engaged in to conduct the self-assessment. The self-assessment was completed using a state issued template that had been used for the past several reviews. Overall, it reflected the major items reviewed by the monitoring team. Some data elements would be more helpful with data that are more specific. For example, the number of staff trained does not provide as much information as the percentage of staff that has completed training. Likewise, the self-assessment indicated that 27 individuals had suction toothbrushing plans. It would be important to know, based on audits, what percentage of individuals received treatments as prescribed and if the treatment impacted the outcomes of the individuals. Moving forward, the facility's lead and dental director should review the comments and recommendations of this report and make any appropriate changes to the self-assessment. The facility rated itself in substantial compliance for both provisions. The monitoring team found the facility in noncompliance with both provision items.
	Summary of Monitor's Assessment: The facility continued to make progress in the provision of dental services. There was a change in the dental assistant position. All other positions remained the same. The dental director continued to be 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. The clinic's full time registered dental hygienist served as the facility's lead for the Settlement Agreement. She was responsible for much of the logistics related to Settlement Agreement activities. There were a number of accomplishments noted in this review: (1) compliance with annual assessments was increasing, (2) oral hygiene ratings were improving (3) compliance with obtaining radiographs was significantly increased and (4) the number of missed appointments decreased. There were also some areas of importance that will need attention. The facility did not have a

	comprehensive set of policies and procedures related to the use of TIVA in the facility. Record reviews indicated that the appropriate monitoring was not completed. The facility utilized post sedation standards and not the post general anesthesia standards. The facility did not have any formal desensitization plans in place, but reported that 12 behavioral rehearsal plans were active. However, there was little information about the status of the plans. Documentation reviewed indicated that that a lack of communication regarding progress of the plans resulted in a request for a corrective action plan in January 2014. The number of refusals significantly increased in December 2013. Overall, a great deal of progress was seen and the facility was on the brink of achieving substantial compliance with both provisions of this section. Removal of the barriers will involve additional collaboration and further integration with other clinical services.

#	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 and dental director. <u>Staffing</u> The dental clinic staff was comprised of a full time dental director, full time hygienist, and full time dental assistant. A new dental assistant began in September 2013 following the resignation of the previous assistant in August 2013. 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>Annual Assessment</u> The monitoring team requested a list of annual assessments completed in the last six months, listed by month. The facility submitted a list of assessments completed each month. Assessments were completed within 365 days of the previous assessment. The data from the documents submitted are presented in the table below.	Noncompliance

Annual Assessment Compliance 2013

	Jun	Jul	Aug	Sep	Oct	Nov
No. of Exams Completed	23	6	7	6	14	7
% Timely Completion	83	67	86	83	93	100

The table reflects data provided in the document request. The data and compliance scores in the document request differed from those presented in the self-assessment for the months of June 2013 and August 2013. Compliance was reported as 100% for

#	Provision	Assessment of Status	Compliance
		August 2013in the self-assessment, but was correctly reported in the document request as 86%. The average compliance score for the reporting period was 85%. This was essentially unchanged from the previous review's average compliance score of 84%. However, compliance scores were trending upward. Ten Annual Dental Examinations were submitted as part of the complete records. The Dental Record Annual Examination included information on behavior classification, oral hygiene, tissues, management needs, medical/physical limitations, medical history, intra-extra oral exam, periodontal disease, caries, radiographs and risk ratings. The 10 evaluations reviewed were thoroughly completed. In addition to the completion of the evaluation form, the dentists also documented in the IPN. The IPN 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. 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 continued to be very good and provided good information for the IDTs. The assessment form did not include information on positioning or provision of oral hygiene instructions. The dentists did, however, comment on positioning in the SOAP IPN entries and the hygienist documented that oral hygiene instructions were given with each prophylactic appointment. State office issued a new annual exam template just prior to the compliance review. It was essentially an update of the template used by SGSSLC that added sections for positioning, oral cancer screening, suction toothbrushing, and a signature line. The Annual Dental Summary was a chart review completed in preparation for the ISP. A state issued template was implemented in December 2013. This summary included information on current oral hygiene, tissue status, and use of sedation. It also documented periodontal condition and each assessment included an odontogram. The use of the odontogram key required a color copy for interpretation. It was not helpful in black and white copies. Comments related to preferences, strengths, goals, and community living and services were also included. Copies of 10 Annual Dental Summaries were submitted for review. The following summarizes the data included in those documents: • 10 of 10 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use • 10 of 10 (100%) documented oral hygiene status	

#	Provision	Assessment of Status	Compliance
		• 10 of 10 (100%) documented oral cavity tissues • 10 of 10 (100%) included a completed odontogram • 10 of 10 (100%) documented treatment recommendations • 10 of 10 (100%) documented risk ratings specific to periodontal disease and caries • 10 of 10 (100%) included comment on community and living services • 7 of 10 (70%) included comments on preferences, strengths, and goals. None of the summaries reviewed included a signature, so it could not be determined who actually completed the documents that were submitted to the IDT. In reviewing various meeting minutes and other documents, it appeared that various clinic staff, including the dental hygienist and dental assistant appeared to work on this document. State policy did not define the responsible party. However, the dentist completed this assessment at other SSLCs. <u>Initial Exams</u> Nineteen individuals were admitted during the reporting period. Data for compliance with completion of initial assessment within 30 days is listed in the table below.	

Initial Assessment Compliance 2013						
	Jun	Jul	Aug	Sep	Oct	Nov
No. of Exams Completed	3	2	2	3	6	3
% Timely Completion	33	100	100	100	100	100

With the exception of the month of June 2013, all individuals completed initial assessments in a timely manner. Data reported in the self-assessment documented that 15 individuals were admitted to the facility during the reporting period.

<u>Oral Hygiene</u>
The facility continued to monitor the oral hygiene ratings of the individuals. 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 and prophylaxis and were done twice a year. The following data were reported:

Oral Hygiene Ratings (%)			
	Good	Fair	Poor
Jun	75	16	9
Jul	64	22	14
Aug	83	3	14
Sep	78	18	4
Oct	81	12	7
Nov	79	18	3

#	Provision	Assessment of Status	Compliance
		Individuals with a poor hygiene rating were seen in clinic the following week. If the poor rating occurred for three consecutive weeks, the individual was enrolled in the weekly toothbrushing program in the dental clinic. The QIDP was notified that an SAP was required if not already in place. Once the individuals achieved a hygiene rating of good or fair for three consecutive appointments, the individual was discharged from the weekly toothbrushing program. The SAP remained in effect and the individual was seen monthly for oral hygiene assessments for 90 days. If hygiene status remained adequate, the individual was fully discharged from the program and placed on a three- to four-month recall. Individuals with fair and good hygiene ratings were seen twice a year. Suction Toothbrushing The habilitation department identified individuals who were at high risk for aspiration and would benefit from suction toothbrushing. The primary care physicians wrote the treatment orders. Twenty-seven individuals received this treatment, which was provided by direct support professionals who underwent competency-based training. Individuals received treatment two times a day. The dental hygienist (facility lead) continued to conduct quarterly audits of the required documentation to ensure that treatments occurred as ordered. Staff was introduced to suction toothbrushing during NEO training. The nurse educator provided training to nurses in the homes. The facility lead had a plan to conduct additional monthly training with the residential staff. Modified Consistency Fluoride Program This program continued for individuals who received a modified diet and required thickened liquids. PreviDent, a neutral pH sodium fluoride was prescribed. This process was a collaborative effort between the dental clinic, habilitation therapies, and the QIDPs. Preventive, Restorative, and Emergency Services 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. As of 9/30/13, the facility utilized the services of a new dental anesthesiologist who provided services two days each month. Individuals who required treatment that was more extensive were referred to a local oral surgeon. Data related to the provision of services was tracked in the state issued dental database. The total number of clinic visits and key category visits are summarized below. Clinic Appointments 2013 | | Jun | Jul | Aug | Sep | Oct | Nov | | Oral Hygiene Instructions | 26 | 38 | 30 | 39 | 34 | 28 |	

#	Provision	Assessment of Status	Compliance

Preventive	25	38	30	39	34	28
Emergency	0	0	0	0	0	0
Extractions	0	1	1	8	2	0
Restorative	23	11	11	15	35	23
Total	153	148	126	125	153	110

The facility continued to identify individuals and provide restorative treatment. The number of extractions was decreasing. Individuals who were appropriate candidates for dentures and partials were also identified.

Emergency Care

Emergency care was available at SGSSLC during normal business hours. The contract dentist provided 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.

Radiographs

The monitoring team discussed the requirement for radiographs with the dental director. Generally, a full mouth series or panoramic radiographs were completed every three to five years. Bitewing radiographs were completed annually. The facility reported data for compliance with radiographs. Those data are presented in the table below.

Radiograph Compliance 2013						
	Jun	Jul	Auf	Sep	Oct	Nov
Radiographs Due	24	6	7	7	14	10
Completed	18	4	7	15	13	9
% Completed	75	67	100	67	93	86

Significant progress was made in updating the radiographs of all individuals. All of the annual assessments reviewed included documentation of current radiographs. Overall, compliance for the reporting period was 81%. The facility was obtaining radiographs in accordance with the general ADA guidelines.

Oral Surgery

Two individuals were referred to the oral surgeon for treatment. The consults for those individuals were reviewed. Individual #394 was evaluated for a cystic lesion. Individual #140 had extraction of all four 3rd molars. An opacity was identified in the left nasal cavity for which an ENT consult was recommended. The status of that problem could not be determined from the dental records.

Sedation/General Anesthesia/TIVA

The facility used very little pretreatment sedation. Prior to September 2013, TIVA was

#	Provision	Assessment of Status	Compliance
		last utilized in January 2013. Data were tracked for both. The number of individuals who utilized TIVA or sedation is summarized in the table below.	

General Anesthesia/Minimal Sedation						
	Jun	Jul	Aug	Sep	Oct	Nov
TIVA	0	0	0	4	4	2
Oral Sedation	1	0	0	1	0	0
Total	1	0	0	5	4	2

Nursing services maintained two policies related to sedation monitoring. One was the policy SSLC Nursing Protocol: Post Anesthesia Care, adopted in June 2010 and reviewed in December 2013. According to this policy, the registered nurse will monitor the individual in the infirmary or other designated area observation area until a REACT score of 8 or greater is reached. Vital signs and REACT scores will initially be monitored every 15 minutes for the first hour, then every 30 minutes for the second hours with pulse oximetry/blood pressure machine. Documentation will be made on the vital signs flow sheet. Vital sign monitoring continued, in the designated area or home, every hour for two hours, then every shift for 72 hours.

The other was the Nursing Protocol: Pretreatment and Post Sedation Monitoring was revised in December 2013. This protocol applied to individuals receiving pretreatment sedation. Post sedation vital signs were to be monitored q 30 min x 2, q 2 hours x 2, then q 4 hours for a total of 24 hours from the time the medication was administered.

The records for five individuals who completed dental work with TIVA were reviewed. The facility used the restraint checklist "post sedation" monitoring, which used the same vital sign monitoring criteria listed in the post-sedation guidelines. As a result of using this set of criteria, none of the restraint checklists reviewed had vital signs completed in accordance with the post anesthesia care policy. There were also no pre-procedure vital signs for Individual #144 documented on the restraint checklist.

The medical and dental departments did not have a specific policy that outlined the scope of sedation that could be utilized at the facility and the process for determining candidates for these services. Dated policies regarding the use of inhalational drugs remained in effect (discussed in section L4). The dental director reported that there were some general criteria used such as age <60 years, BMI <35, weight <225 pounds, and no enteral tubes. These criteria were not defined in policy. There had been no process to ensure that the appropriate monitoring criteria were being used following anesthesia. The monitoring team strongly recommends that the dental and medical directors draft comprehensive policies and procedures that specify:

1. Scope of services provided, such as level of sedation permissible, use of TIVA,

#	Provision	Assessment of Status	Compliance
		use of only minimal sedation and TIVA) 2. Indications for use of anesthesia 3. Who are candidates for TIVA 4. Who are candidates for referral to hospital for treatment 5. Criteria for TIVA implementation, such as board certified anesthesiologist, ACLS certification, etc. 6. Evaluation of individuals prior to anesthesia 7. Post-anesthesia monitoring of individuals. As part of it's quality efforts, the dental clinic should also track and document adverse events that occur following sedation and TIVA, such as individuals who require admission to the infirmary or transfer to acute care facilities within 72 hours of procedures. <u>Staff Training</u> 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 on the total number of staff trained was provided. In addition to this, the facility should indicate the percentage of staff that have completed training. <u>Compliance Rating and Recommendations</u> This provision remains in noncompliance. Although the facility made considerable progress in most areas, the issues related to TIVA need to be addressed. The facility did not adequately outline the process in policy and failed to ensure that appropriate monitoring of individuals occurred in the immediate post anesthesia monitoring period. It was not recognized that, in practice, post anesthesia monitoring was not conducted in accordance with policy. The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team, makes the following recommendations: 1. The Annual Dental Summary should be signed by staff completing the document, as should all official summaries and assessments. 2. There should be increased clinical oversight of the suction toothbrushing program to ensure that treatments are occurring in a timely manner. 3. The facility should address concerns related to TIVA as noted above, including the development of specific policy. 4. The facility must ensure appropriate monitoring during the peri-operative period.	

#	Provision	Assessment of Status	Compliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	<u>Policies and Procedures</u> The monitoring team requested all facility (local) policies related to the provision of dental care via the document request. The lack of submission of policies and procedures has been documented in previous reviews. The monitoring team requested during interviews a copy of all policies and procedures. Staff indicated that all policies and procedures were submitted, but this would be verified. The document request included three policies: • Comprehensive Provision of Dental Assessments, 8/30/10, revised, 10/24/13 • Pretreatment Sedation Notification and Referral for Assessment Process, 2/22/11, 11/26/13 • Missed Dental/Medical Appointments and Day Program Attendance, 9/15/11, 4/8/13 The facility submitted two additional policies and procedures related to dental care: • Dental Radiographs • Suction Toothbrushing The dental department needs to have a dental department manual that includes all policies, procedures, and guidelines involving the provision of dental services to ensure that all aspects of dental services are covered. That manual should be readily retrievable and available for review by staff. Topics should include, but not be limited to: • General operations of clinic and staffing • Informed consent • Dental radiographs • Oral hygiene tracking • Dental recall • Dental sedation • Anesthesia - medical clearance, recovery • General anesthesia personnel • Infection control • Training • Dental emergencies • Oral care Some policies may not be under the purview of the dental department, however, policies such as informed consent and the HRC review process should also be included the manual. Local policies should be updated to reflect changes in state dental policies. The department should also ensure that policies are <u>reviewed on an annual basis and updated as required.</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Failed Appointments The guidelines issued by state office required reporting of missed/no show 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 clinic also recorded rescheduled/cancelled appointments. However, none occurred after August 2013. The number of appointments as identified and reported by SGSSLC are summarized in the table below:	

Failed Clinic Appointments 2013						
	Jun	Jul	Aug	Sep	Oct	Nov
Missed/No show	42	44	19	21	14	7
Refused	10	11	16	10	20	9
Rescheduled	12	15	1	0	0	0
Failed	64	70	36	31	34	16
% Failed	41	47	28	24	22	14
Total Appointments	153	148	126	125	153	110

The number of missed appointments decreased significantly over the past six months. It was reported that clinic staff were required to call if the individuals did not keep the clinic appointment. The majority of the missed/no show category had no explanation. Four of the missed appointments were due to staffing issues and medical clearance was listed as the reason for one missed appointment. The reschedule date was the same as the date of the appointment missed so timeliness of follow-up could not be determined.

The failure rate for the reporting period was 29%. This was a decrease from the average failure rate of 31% reported during the previous review. The timeliness of the re-scheduled appointments could not be determined because it was the same as the missed appointment. The failure for he last three months of the reporting period, with no clinic cancellations and decreasing no shows, was 20%. Thus, for the last three months, the clinic was successfully completing on average 80% of clinic appointments. It appeared the facility was moving forward in decreasing missed appointments.

#	Provision	Assessment of Status	Compliance
		Sedation and Dental Restraints The facility documented that for the reporting period 5% of the average census used general anesthesia and 1% required sedation. The use of both modalities required the approval of the Human Rights Committee. The approval was obtained for all individuals. The dental department did not utilize mechanical restraints. Strategies to Overcome Barriers to Dental Treatment The refusal rate for the reporting period was 9%. This was an increase from the average of 5.6% reported during the previous compliance review. The number of refusals increased to 16 in December 2013. The clinic staff contacted the home for every no show and refusal. The home staff was required to contact behavioral health services for every refusal. While policy required a referral be made to behavioral health services after three refusals, this usually occurred much sooner. The facility lead sent a referral to the home behavioral health specialist requesting an assessment for systematic desensitization or strategies. At the time of the compliance review, there were no formal desensitization plans. There were 12 behavioral rehearsal programs. A document listing behavioral rehearsal programs and other data were submitted, but appeared to be a re-production and was not usable. The monitoring team noted in the January 2014 QA minutes that the dental department requested a corrective action plan related to the behavioral rehearsal programs due to the lack of communication between behavioral health services and the dental department regarding the progress of the plans. It appeared that there was still a considerable amount of work that needed to be done since treatment in the clinic hinged upon the progress of the plans. Compliance Rating and Recommendations The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director should address the need to develop a comprehensive dental clinic manual. 2. The facility will need to continue to address the refusals and provide evidence that the behavioral rehearsal plans are effectively implemented.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** 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 Section R and P audits Reports o Communication Services Monthly Reviews o Current SLPs, license numbers, ASHA 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 List of individual with PBSPs 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 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 form template o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessment for individuals recently admitted to SGSSLC: Individual #53 o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #78, Individual #386, Individual #385, Individual #185, Individual #339, Individual #118, Individual #189, Individual #325, Individual #294, Individual #266, Individual #130, Individual #165, Individual #211, Individual #194, Individual #283, Individual #374, and Individual #328. o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication therapy for the following individuals: • Individual #78, Individual #389, Individual #287, and Individual #266 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o PNMP section in Individual Notebooks for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #104, Individual #382, Individual #150, Individual #153, Individual #251, Individual #238, Individual #98, Individual #38, Individual #134, Individual #273, Individual #180, and Individual #203, Individual #265, Individual #112. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Erin Bristo, MS, CCC-SLP o Brittenee Valade, MS, CCC/SLP o Melissa McDonough, MA, CCC-SLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o ISP for Individual #66
	Facility Self-Assessment: The self-assessment completed by Dena Johnson, OTR, Habilitation Therapies Director and Erin Bristo, MS, CCC-SLP continued to improve. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team, though not all of elements were addressed and used to determine compliance. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of communication staff. Findings were reported 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. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Bristo and the other speech staff were on track to ensure that progress will be made for the next

	review. They were very close to achieving substantial compliance, especially in R.2, with a needed focus on timeliness of assessments. Progress had continued and the plan outlined was a sound one and combined with the findings of this report, should guide them to make greater strides over the next six months. Further, it was positive that the facility tracked the effectiveness of plans and programs, but based on this review, they did not appear to be consistently completed in a timely manner. In addition, documentation of direct services was absent or very limited. Benchmarks should be established in measurable terms in order to address this and used to establish additional measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in substantial compliance with in R.1, R.2, and R.4. The monitoring concurred with R.1, but while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team determined that R.2, R.3, and R.4 were not yet in substantial compliance.
	Summary of Monitor's Assessment: There was continued, steady progress toward substantial compliance in all aspects of provision R. There were currently three full time, very talented, speech clinicians on staff. Observations of these therapists during this and previous reviews verified that they understood what was needed to enhance and expand communication skills in individuals with severe intellectual disabilities. Efforts to improve the content of communication assessments were evident. Standardized assessment formats were implemented consistent with the state formats. These were intended to assist the IDTs in locating recommendations and rationale for supports and services. The instructional guidelines were also revised to ensure inclusion of all essential elements. Self-audits were conducted with reliability checks conducted by the lead SLP, Erin Bristo. Though improvements were noted, on-time completion of assessments continued to be problematic. There were a number of communication plans and SAPs in place for individuals with communication needs and also for those individuals with behavioral concerns in combination with severe communication deficits. While the collaboration between psychology and SLPs was a strength, continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. This was also needed related to the ISPs as well. Consistent documentation of direct supports and review of indirect supports was needed, using the guidelines outlined in this report, with regard to content. All of the SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC. It was noted, however, that numerous references to the need for cause and effect, as a prerequisite to benefit from AAC, were noted. For example, in one case, the individual did not respond to requests for identification of pictures and this was used as the rationale for not providing AAC. The descriptions in some of the assessments did not match the observations of clinician interactions by the monitoring team. This was a concern to the monitoring team; the clinicians need to further investigate more creative ways in which individuals could benefit.

	Assessments were not consistently completed 10 days prior to the ISP. The content of assessments was substantially improved with compliance with the 23 essential elements averaging approximately 97%. The staff and leadership are congratulated on this significant achievement. <u>The following samples were used by the monitoring team:</u> • Sample R.1: 14 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services (4)

#	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 three full time SLPs with responsibilities related to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were Erin Bristo, MS, CCC-SLP, Brittenee Valade, MS, CCC/SLP, and Melissa McDonough, MA, CCC-SLP. Erin Bristo was a core PNMT member, the lead speech clinician, and had reduced caseload responsibilities. There was no speech assistant to the full-time SLPs at the time of this review, because the previous position had been removed. There were three budgeted positions for speech language pathologists, with two listed as filled at the time of this review, though one of these was an audiologist and not responsible for communication services. By report, there was only one full time state SLP and the other two clinicians were contracted with an average of 106 hours per month (Document I.11), though they were described as fulltime elsewhere. As such, there was one unfilled position as budgeted. The FTEs were listed by the facility as two with a ratio of 1:107.5, based on the full time SLP and audiologist. The actual current ratio was 1:72.33, based on the current census and three full-time SLPs only, because the audiologist did not provide equivalent supports and services and could not be included in the ratio. 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. The speech staff were assigned caseloads as follows (totals based on individual list by home and based on census of 217): • Erin Bristo: Her responsibilities included Home 510B, PNMT member, dysphagia therapist, coordinator of contract SLP tasks, ISP/IDT attendance, assisting with section R provisions and action plans, mealtime monitoring, direct	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		therapy as recommended, and PBSP Committee member. • Brittenee Valade: Homes 502, 504A, 504B, 508B, 509A, 509B, and 516E (approximately 86 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. The level of communication-related needs for this group could not be determined from the documentation reviewed. She was also identified as the PNMT back-up team member. • Melissa McDonough: Homes 505A, 505B, 510A, 511A, 511B, 512A, 512B, and 516W (approximately 99 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. The level of communication-related needs for this group could not be determined from the documentation reviewed. She was also identified as the PBSP Committee back-up member. It was noted that Home 510B (15 individuals) was not included on the assignment lists for the clinicians. At least 12 of these individuals were listed with behavioral concerns and coexisting severe language deficits that would require communication supports.. There was a Master Plan that outlined the assessment frequency and timelines, but did not indicate assigned priorities related to the severity of individual communication deficits and communication assessment/support needs. Assessments were now appropriately completed per the ISP schedule rather than by need only, unless related to a change in status or special IDT request. Approximately 83% of all individuals had received a Comprehensive Assessment. The remaining 36 were scheduled for completion by 5/30/14, or three per week. Per the plan submitted, individuals newly admitted to SGSSLC were screened for communication needs and completed within five working days prior to the ISP. In the case that screening revealed areas of concern, the screening was discontinued and a Comprehensive Assessment was to be completed within 30 days. If needs were not identified, a repeat screening was completed every five years, at least 10 days prior to the ISP. Other individuals with no identified communication needs or who had a Comprehensive Assessment dated prior to November 2011, were provided a screening to determine the need for further evaluation. Again, a Comprehensive Assessment was to be completed within 10 working days of the ISP for any individual with a screening that identified a communication concern. All screenings were scheduled at least two months prior to the ISP to ensure that compliance with the established timelines was maintained. All individuals with indirect services were provided a Comprehensive Assessment every five years, though there was no such provision listed for those provided direct services. An Assessment of Current Status was to be provided annually in the interim for individuals who received both direct and indirect services.	

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		• SGSSLC used a reasonable process to establish appropriate caseloads for SLPs. It included the following: o Individuals with indirect communication supports (44 individuals) o Individuals with direct communication supports (6 individuals) o Individuals with severe language deficits and coexisting behavioral issues (31 individuals) o Individuals with PBSPs with communication supports and strategies (108 individuals) Valuations were assigned to each of these to weight the required level of services under each and a determination was made that a ratio of 1:68 was appropriate given the current staffing of three fulltime SLPs (both state and contract). Limiting SLP staffing to the actual budgeted positions (two) would not meet the criterion of approximately 1:60 individuals, established by the monitoring team for compliance with this provision. The addition of a speech assistant would ensure adequate coverage for all individuals. • SGSSLC provided an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services based on the process established by the facility, though two of the three were contract therapists. This was improved from the previous review. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 3 of 3 speech staff (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 3 of 3 SLPs (100%) held current American Speech and Hearing Association (ASHA) certification. This was consistent with the previous review. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 3 of 3 current speech staff (100%) had completed continuing education in the last year related to communication in an area that was relevant to the population served. Each had attended the two-day Habilitation Therapy Conference sponsored by DADS in Austin (10/31/13-11/1/13), in addition to a few other related courses listed below (likely NEO). This was consistent with the previous review. Continuing education attended by the clinicians appeared to be relevant to communication and included:	

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		• Measurable Goals-Skill Acquisition Programs • Integrating Communication and Behavior Support Strategies (Erin Bristo was a co-presenter with a SLP from LSSLC for this) • Scenarios for Programming for Individuals with Deaf-Blindness • AAC Assessment and Treatment • Sensory Diets • Communication Strategies for Individuals with Developmental Disabilities Contact hours for each of these were not specifically listed and none were non-state sponsored. 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 continue to seek continuing education courses beyond in-house training or DADS-sponsored courses 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. 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. Each of the following elements was sufficiently addressed in the policy in conjunction with other procedural documents and a well-established procedure was currently in practice: • 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. The current staff ratio and caseload size were adequate at the time of this review.	

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		Limitations to caseload size is critical to ensure that clinicians are able to complete assessments in a timely manner, provide appropriate direct interventions, provide sufficient training, modeling and coaching for the implementation of communication programs, and to adequately maintain the necessary equipment. There was a reasonable process to determine the number of qualified staff required and there were policies and procedures that outlined the roles and responsibilities of the SLPs as described above. The monitoring team concurred with the self-assessment of substantial compliance with this provision. The monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to aggressively recruit at least two fulltime SLPs (or retain the current contract staff who were excellent; both were highly knowledgeable and skilled). 2. Also consider the addition of a SLPA.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> The SLPs at SGSSLC completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status. At the time of this review, some changes had been made to the standard format for these reports per the state office and were to have been implemented as of 10/1/13. Completion of assessments was based on the ISP schedule and reevaluation was to be conducted on an interval established per policy/Master Plan described in R.1 above. Assessments of Current Status were to be completed for individuals who received supports and services in years that a Comprehensive Evaluation was not required. ISP dates, assessment due dates, and timeliness of completion were tracked in the tracking log for individuals with ISPs scheduled from 1/1/13 to 12/20/13. There were approximately 27 individuals listed as provided an annual communication assessment during that time. Of those listed, only 48% had been completed on time, or within 10 working days prior to the ISP. Seven were completed on or after the date of the ISP. There were 22 individuals who had been provided an assessment prior to November 2011, the facility-established date for assessments that included the required elements. Assessments completed prior to this date required review, screening, and/or re-assessment to ensure that the assessments were adequately comprehensive. None of these individuals had a more current Comprehensive Assessment and only six were provided an Assessment of Current Status (some of these were not current within the last 12 months, however) and none had been provided a communication screening. Of those with previous Comprehensive Assessments after November 2011, and on or before 12/20/12 (45 individuals), only 30 had been provided an update or Assessment of Current Status (ACS). A number of these were also not current within the last 12 months,	Noncompliance

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		indicating that a subsequent ACS was past due. There were 107 individuals listed as passing communication screenings, indicating that supports and services, including further assessment, were not required based on need. Though most were completed prior to the ISP (not necessarily 10 days prior), five of these were completed after the ISP date in 2013, however. Further, 18 individuals were listed with failed screenings (some over a year ago), but had not received a Comprehensive Assessment as of 12/20/13, that is, not within 30 days. This differed significantly from the findings in the self-assessment, reported as an average of 88% timely completion rate from 6/1/13 through 11/31/13. The data used for the self-assessment and that were reported in the log were inconsistent. For example in June 2013, the self-assessment reported that of 15 assessments due, 12 were completed on time, yet only four were listed in the assessment log (either Comprehensive Assessment or ACS) and only five screens were listed as completed in June 2013. In November 2013, there were again 15 assessments listed as due, with 13 of these reported to be on time. It was noted in the log that only three assessments and 10 screenings were listed as completed that month. The due dates (15 days prior to the ISP) listed in the tracking log submitted were established by the Habilitation Therapies Department to ensure improved compliance with completion by the 10-day due dates established by the facility. Though this may be true, the assessments and screenings listed in the log were not consistent with the numbers identified as completed in the self-assessment. <u>Assessments Provided</u> Communication assessments for individuals in Samples R.1 and R.4 were submitted as requested for the following (designated with * for date on first page if date of signature was not available): Speech Language Evaluation • Individual #150 (11/8/11)* • Individual #104 (4/11/11)* • Individual #287 (12/27/10)* Speech-Language Comprehensive Assessment • Individual #134 (6/29/12) • Individual #251 (9/4/12) • Individual #238 (10/30/12) • Individual #98 (7/12/12) • Individual #203 (8/20/13)	

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		• Individual #180 (4/22/13) • Individual #266 (10/23/13) Evaluation Update • Individual #265 (11/6/12) • Individual #150 (11/2/12) • Individual #104 (8/17/12) Assessment of Current Status • Individual #251 (9/4/13) • Individual #238 (6/11/13) • Individual #389 (12/5/13) • Individual #78 (4/22/13) Speech Language Pathology Screen • Individual #382 (11/12/13) • Individual #153 (5/3/13) • Individual #273 (1/31/14) Communication assessments were not in the records of Individual #38 and Individual #112. • 8 of 14 individuals (57%) in Samples R.1 and R.4, who received direct and/or indirect communication supports and services, were provided an assessment or update current within the last 12 months. Individual #265's assessment indicated that he did not require an annual update due to his functional communication status, as did the screenings for Individual #273, Individual #153, and Individual #382. The assessment submitted for Individual #238 (10/30/12) indicated that he required a re-assessment in five years. Given that he had a hearing loss and was provided a communication dictionary with quarterly monitoring, an annual update would be required. This should be clearly stated in his evaluation. An Assessment of Current Status was provided on 6/11/13, however. There were no assessments submitted for Individual #38 or Individual #112. This was a decrease from 100% in the previous review. • 12 of 16 individuals admitted since the last review (75%) received a communication screening or assessment within 30 days of admission. One individual newly admitted (Individual #199) was not included in the log dated 12/20/13. Individual #73 (12/16/13) was included in the log, though this was related to a previous evaluation completed on 2/27/13. This evaluation was current within the last 12 months, though an Assessment of Current Status or screening should have been completed with this most recent admission. Two others had not received an assessment upon admission (Individual #291 and Individual #80). The other 12 had been provided a screening within 30 days of	

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		admission and prior to their ISPs. It was noted, however, that three of these individuals were listed with a "failed" screening, indicating that further assessment was indicated (Individual #292, 9/17/13, Individual #209, 10/3/13, and Individual #101, 8/28/13). Even so, a Comprehensive Assessments had not been completed for any as of 12/20/13. This was a decrease from 82% in the previous review. • For 9 of 17 individuals (53%) in Samples R.1 and R.4 (a more current update was not indicated for Individual #265), assessments/screenings/updates were dated as having been completed at least 10 working days prior to the annual ISP. Assessments were not submitted for Individual #38 and Individual #112. This was an improvement from 40% in the previous review. It was noted that for assessments designated as the most current for each clinician (13 not already included in Samples R.1 or R.4), the on-time percentage was 46% (6/13). These percentages were based on the signature dates. It was reported that the on-time percentages calculated by the facility were based on dates that the assessments were entered into the electronic files (as listed in the assessment log). Unfortunately, the on-time percentage was slightly better, at 54% (7/13), but consistent with the other samples reviewed. • For 1 of 19 individuals identified with communication needs through a screening (5%), a comprehensive communication assessment was completed within 30 days of identification (based on review of assessment log). This was a decrease from 100% in the previous review, though the sample included only one individual. Three individuals included in Sample R.1 (Individual #382, Individual #273, and Individual #153) were provided communication screenings, but no further assessments were indicated. Individual #273's screening was not listed in the assessment log because it occurred after the date of the log on 1/31/14. Additional screenings and Comprehensive Assessments were submitted for four individuals as examples of individuals with "failed" screenings for whom full assessments were consequently completed. Two of these individuals were not listed with screenings in the assessment log, yet Comprehensive Assessment completion dates were included (Individual #266 and Individual #283). Two others (Individual #374 and Individual #395) were listed with failed screenings, but no Comprehensive Assessments were included in the log. Both of these individuals were listed as subsequently discharged from SGSSLC. **Name** / **Date of Screening** / **Date of Assessment** / **Within 30 days of Screening** Individual #374 / 2/12/13 / 2/18/13 / Yes Individual #283 / 7/8/13 / 7/22/13 / Yes	

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Individual #266	10/2/13	10/23/13	Yes
Individual #395	8/6/13	9/13/13	No

Based on review of the sample of assessments submitted and included in Samples R.1 and R.4, there were three individuals with current comprehensive assessments (Individual #203, Individual #180, and Individual #266). These were included in the analysis below. Two other assessments were submitted as current related to a different request and were included in this review (Individual #130, Individual #165, Individual #325, Individual #294, Individual #194, and Individual #328).

Four of the assessments reviewed had all of the essential elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. This was an improvement from the previous review. 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 total of nine communication assessments were as follows:

- 9 of 9 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review.
- 9 of 9 assessments (100%) included diagnoses and relevance of impact on communication. This was consistent with the previous review.
- 9 of 9 assessments (100%) included individual preferences and strengths. This was consistent with the previous review.
- 9 of 9 assessments (100%) included medical history and relevance to communication. This was consistent with the previous review.
- 9 of 9 assessments (100%) listed medications and discussed side effects relevant to communication. This was consistent with the previous review.
- 9 of 9 assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was consistent with the previous review.
- 9 of 9 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 previous review.
- 9 of 9 assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was consistent with the previous review.
- 9 of 9 individuals' communication assessments (100%) 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. This was an improvement from 75% in the previous review.
- 9 of 9 individuals' communication assessments (100%) included discussion of

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		the expansion of the individuals' current abilities. This was consistent with the previous review. • 8 of 9 individuals' communication assessments (89%) provided a discussion of the individual's potential to develop new communication skills. This was a decrease from the previous review. • 4 of 9 assessments (44%) included the effectiveness of current supports, including monitoring findings. This was a decrease from 67% in the previous review. Each thoroughly discussed the effectiveness of existing supports, but most stopped short of referencing the actual monitoring findings obtained. This should address both effectiveness monitoring and compliance monitoring. It is recommended that the clinician review the consistency of monitoring as well as the findings. • 9 of 9 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 9 assessments (100%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 90% in the previous review. • 9 of 9 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 80% in the previous review. • 9 of 9 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. • 9 of 9 assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. These were not consistently outlined in the assessment itself, but rather references were made to specific supports in which this information was contained, including the Communication Dictionary, SAPs, and/or AAC instructions. The clinicians should consider listing specific individual strategies in the assessment to ensure that these translate clearly to the ISP. This was an improvement from 40% in the previous review. • 9 of 9 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 9 of 9 assessments (100%) supplied a monitoring schedule. This was consistent with the previous review. • 8 of 9 assessments (89%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was consistent with the previous review.	

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		• 9 of 9 assessments (100%) made a recommendation about community referral and transition. This was an increase from 90% in the previous review. • 9 of 9 assessments (100%) included specific recommendations for services and supports in the community. This was consistent with the previous review. • 9 of 9 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: • 4 of 9 assessments (44%) contained 100% of the 23 elements listed above. • 4 of 9 assessments (44%) contained 96% of the elements listed. • 1 of 9 assessments (11%) contained 87% of the elements listed. • Assessment compliance with the essential elements averaged 97% overall. • Improvements from the previous review were noted in 17% of the 23 elements. Decreases were noted for two elements. All others (70%) remained consistent with the previous review at 100%. A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was well established and clearly effective. It was reported that 89 assessments were completed over a six month period from June 2013 through November 2013 and that 12 of these had been audited with an average of 95% of the required elements, consistent with the above findings by the monitoring team. This system involved self-audits by each clinician for a prescribed number of assessments each month. Inter-rater reliability audits were conducted by the lead clinician quarterly and averaged near 90%. Updates or Assessments of Current Status (ACS) were submitted for seven individuals included in Samples R.1 and R.4. Additional ACS assessments were submitted as the most current assessments for each clinician. These included those for Individual #189, Individual #118, Individual #185, Individual #208, Individual #385, Individual #386, and Individual #339 for a total of 14. • 10 of 14 updates (71%) were completed consistent with the established schedule, the individuals' need, and/or previous recommendations (Individual #251, Individual #185, Individual #238, Individual #389, Individual #265, Individual #385, Individual #386, Individual #208, and Individual #78). Individual #189's ACS (10/2/13) referenced a Comprehensive Assessment completed on 1/30/12, 20 months earlier. Per the assessment log, Individual #118 had a previous comprehensive assessment on 8/27/11, while her ACS was not completed until 11/26/13. Also per the log, Individual #339 had a previous comprehensive assessment on 8/27/11, while his ACS was not completed until	

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		11/26/13. There was no evidence in the individual records for Individual #265, Individual #150, and Individual #104 showing that previous comprehensive assessments had been completed, though each of the 2012 updates referenced comprehensives completed in 2011. No further annual updates, ACS, or other assessments had been completed since that time, though not indicated in the case of Individual #265 due to his functional communication status, clearly stated in the update (11/6/12). The log tracks only the comprehensive assessments and the most current ACS, so dates of other interim ACSs and other such information was not available to determine actual completion of these. • 2 of 7 updates (29%) had an associated comprehensive assessment that was consistent with the established format and content guidelines (Individual #238 and Individual #78). The ACS or update for the other five referenced a previous Comprehensive Assessment, or was listed in the assessment log, though these were not included in their individual records for review. The ACSs for Individual #265 and Individual #104 were not completed within a 12-month timeframe after the comprehensive, however. The ACSs for Individual #208, Individual #386, Individual #385, Individual #185, Individual #339, Individual #118, and Individual #189, were submitted as stand-alone current assessments, and as such, the comprehensives were not submitted. Per the assessment log and ACS only three of the four were completed within the 12-month timeframe. The Assessments of Current Status should include the following, at a minimum: • The individuals' current status • Description of the interventions that were provided • Effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year • Monitoring data from the previous year and monitoring and re-assessment schedules. <u>SLP and Psychology Collaboration:</u> There were 31 individuals identified with behavioral issues and co-existing severe language deficits (nonverbal or limited verbal skills). There were 108 individuals listed with PBSPs who also had replacement behaviors related to communication. Individual records for 10 of 14 individuals in Sample R.1 included a PBSP to address identified behavioral concerns. Two of these were not current within the last 12 months (Individual #382 and Individual #251) and others were not listed with these plans per Document VIII.12 (Individual #104 and Individual #150). The PBSPs for the other six were included in the individual records (Individual #134, Individual #203, Individual #153, Individual #112, Individual #203, and Individual #38) for a total of eight. Based	

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		on review of individual records with Positive Behavior Support Plans (PBSPs) the following was noted: • For 1 of 8 communication assessments (13%) in Samples R.1 for individuals with identified challenging behaviors (no current assessments were submitted for Individual #153, Individual #134, Individual #104, Individual #150, Individual #112, or Individual #38), there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. The update for Individual #265 was dated 11/6/12 and communication supports were not required, but the assessment should have addressed any relationship or lack of between behavior and his communication abilities. • 1 of 8 communication assessments and PBSPs reviewed (13%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • 1 of 8 communication assessments reviewed (13%) contained evidence of review of the PBSP by the SLP. • For 1 of 8 individuals (13%), communication strategies identified in the assessment were included in the PBSP. • For 1 of 8 individuals (13%) communication strategies related to behavior identified in the assessment were included in the ISP. Minutes for meetings held to review PBSPs during the last six months were not submitted in section VIII of the document request. As such, participation by the speech therapy staff in this process could not be determined. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the SLPs. 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. Significant progress was made in this provision, yet continued effort is indicated. The facility self-rated substantial compliance, though 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: 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. Clarify the function of the Comprehensive Evaluations versus the Assessments of	

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		Current Status. Ensure that the ACS is completed as per the assessment recommendations and based on supports and services provided. 4. Updated documentation related to behavior and the PBSP should be included in the ACS to ensure that the communication strategies and behavioral strategies are consistent and well-integrated.	
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.	Integration of Communication in the ISP: The following metrics were difficult for the monitoring team to determine because a number of individuals did not have a current communication assessment. Some of the ISPs reported information related to communication, but without the actual assessment for review, this could not be verified. Attendance at the annual ISPs for individuals was reviewed. No sign-in sheet was available for Individual #134's ISP and no ISP was submitted for Individual #251. Pre-ISP documentation was submitted as requested for most individuals (15). Based on these, a SLP was required to attend 12 of the meetings. • For 12 of 12 individuals in Samples R.1 and R.4 (100%), a SLP was in attendance at the ISP as designated by the required by the pre-ISP. Though SLP attendance was required in the cases of Individual #134 and Individual #251, actual attendance could not be determined due to the unavailability of the ISP and/or sign-in sheet. Pre-ISP required attendance sheets were not submitted for Individual #112, Individual #153, Individual #238, Individual #265, Individual #180, and Individual #382, though an SLP was present at the ISPs for three of these (Individual #180, Individual #238, and Individual #112). • For 5 of 12 individuals (31%), communication strategies identified in the assessment were included in the ISP. These were not needed for Individual #382 or Individual #265. There were screenings for Individual #273 and Individual #153 that indicated that they had no specific communication support needs. • In 6 of 15 ISPs for individuals with communication supports (40%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, strategies for staff use) were identified. These were not needed for Individual #273, Individual #382, Individual #153, or Individual #265, as per their assessments/screening. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 3 of 13 (23%), as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. Based on the communication dictionaries in the individual records, there was inconsistent evidence of review of these with updates in a timely manner subsequent to the ISP (Individual #203 and Individual #38, for example). • 10 of 18 ISPs (56%) included a description of how the individual communicated	Noncompliance

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		and how staff should communicate with them. • 4 of 15 ISPs (27%) contained skill acquisition programs to promote communication. For Individual #273, Individual #382, and Individual #265, SAPs were not needed due to the level of their communication skills, per their assessments/screening. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was not addressed in any case. The Habilitation Therapy ISP Essential Elements Checklist was used by the clinicians during the meeting to ensure discussion occurred among the IDT members. While this likely was effective during the meetings, this did not consistently translate to documentation in the ISP document itself. Continued inservice training for the QIDPs related to the above requirements was needed to ensure continued improvements in this area. <u>Individual-Specific AAC Systems:</u> Approximately 50 individuals were listed with some type of communication system. These systems were generally portable, functional, and individualized. Individualized AAC device instructions were developed in most cases to provide a picture of the device and to clearly outline the purpose with staff instructions for use and care of the device. Those reviewed were excellent. There were only four individuals listed as participating in direct communication therapy intervention at the time of this review (Individual #78, Individual #389, Individual #287, and Individual #266). Communication dictionaries (CD) were also provided to at least 58 individuals at SGSSLC. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This should enhance staff understanding of the individual and promote consistent responses, but does not specifically improve the individual's expressive or receptive skills. Changes needed to the SGSSLC CDs were noted on the Essential Elements Checklist in some cases, but this was not specifically outlined in the ISP. In some cases, changes were stated as needed, but not specifically outlined, even in the checklist. The following metric could not be determined: • % of individuals for whom the IDT directed a revision in the communication dictionary, the communication dictionary was revised within 30 days. The majority of the assessments for the individuals in Sample R.1 and R.4 reviewed above provided an adequate assessment of the individual's potential for AAC use.	

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		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 in 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> Observations were completed across a variety of homes to determine the presence and use of general AAC devices. There were a limited number of general use communication devices. All of the general use systems noted during this onsite review were operational, and had a clear function within the environment, though none were seen in use. Directions were not necessarily posted or available, though use of these was competency-trained in NEO. <u>Direct Communication Interventions:</u> There were only four individuals listed as participating in direct communication-related interventions provided by the SLP (Individual #78, Individual #287, Individual #389, and Individual #266). Records related to the provision of direct intervention for these individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 0 of 4 individuals (0%), a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. Though Individual #266 was listed as participating in direct therapy consistent with a recommendation in his communication assessment dated 10/23/13, there was no evidence that this had been implemented in any manner since that time. A service objective to for implementation of direct speech therapy was included in his ISP dated 11/6/13. There was no current communication assessment for Individual #287 though he was listed as participating in direct speech therapy. His ISP (2/6/13) indicated that he needed a comprehensive communication assessment. There was no evidence in his individual record that this had been completed as of the week of this review or that direct therapy was provided. Individual #78 was also listed with direct therapy services as recommended in his assessment, but there was no evidence that this had been implemented. By report, Individual #389 had been receiving direct speech therapy services at the time of his most current communication assessment dated 12/5/13. Specific measurable objectives were outlined at that time. Habilitation Therapy Treatment Notes were dated 10/7/13, 10/10/13, and 10/23/13. His progress in therapy was not reviewed in his assessment on	

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		10/23/13. Though it was indicated that direct therapy was to continue, there was no evidence that it did. On 12/5/13, the SLP documented that the IDT had met and approved continued direct intervention. The gap in service was not justified or explained and no further documentation was noted in the IPNs. • For 3 of 4 individuals (75%), the current SLP assessment identified the need for direct intervention with rationale. • For 0 of 4 individuals (0%), there were measurable objectives related to individual functional communication outcomes included in the ISP. • For 0 of 4 individuals (0%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). • For 3 of 4 individuals (75%), there was a description of the benefit of the device and/or goal to the individual. • For 0 of 4 individuals (0%), consistency of implementation was documented. • For 0 of 4 individuals (0%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For 0 of 4 individuals for who direct intervention had been discontinued, termination of the intervention was well justified and clearly documented in a timely manner. There was evidence of direct intervention for a brief time for Individual #389 only and there was no justification for lags in service or termination. • 0 of 4 (0%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the generally accepted indicators listed below: o Contained information regarding whether the individual showed progress with the stated goal. o Described the benefit of device and/or goal to the individual. o Reported the consistency of implementation. o Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. o Completed at least monthly. Monthly summaries were not completed in order to outline and conduct a comparative analysis of progress related to the measurable goals and objectives. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. AAC supports were identified in the annual assessment and described in AAC Instructions, which provided clearly stated instructions for staff, including	

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		pictures of specific devices as indicated. Other indirect supports were developed in the form of SAPs implemented by DSPs in the day program or work areas. There were a number of SAPs co-developed with psychology and the program developers for replacement behaviors. All involved are commended for this. Further, the SLPs worked with the program developers on new or existing SAPs to ensure that communication strategies were well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching. There was little to no evidence that these were reviewed by the SLPs via the effectiveness monitoring currently conducted. Programs for individuals who received indirect communication supports (SAPs) should include the following elements: • Implementation within 30 days of the plan's creation (typically as of the ISP or ISPA), or sooner as required by the individual's health or safety. • The current SLP assessment should clearly identify the need for indirect intervention with rationale. This was consistently noted for the assessments completed and reviewed. • Measurable objectives related to individual functional communication outcomes to be achieved through indirect intervention should be included in the ISP. • Staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. As described above these were generally provided. <u>Competency-Based Training and Performance Check-offs:</u> SGSSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included five hours only to address deaf awareness and AAC. The content, based on review of the curriculum materials, was comprehensive. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers 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:	

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		• Effective communication • Nonverbal communication • Benefits and use of AAC • Types of cues to enhance individual participation in routines throughout the day • Choice making opportunities • Communication on the PNMP Return demonstration was required. A competency check-off form was used to establish participants' abilities to communicate effectively, identify nonverbal 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 considered 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. One hour of class time was 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, though this was not included in the schedule submitted in document folder I. This 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 contained very good content, including the elements described above and the instruction previously observed was excellent.	

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		• 185/217 of new employees (85%) had successfully completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. By report, those that did not pass PNM training were terminated or were otherwise no longer employed at SGSSLC, though these were not identified. Per the existing system, all new employees were required to pass the foundational competencies. • 100% of staff required to take the Annual Refresher class successfully passed the competency check-offs, though this was difficult to verify from the documents submitted. Those who did not pass were required to retest, retake the class, and/or were terminated. • There was a system to establish and maintain competency for staff who provided the training. <u>Individual-Specific Competency-Based Training</u> 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. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO, though more skills had been added to the core training to address the most common supports. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized communication plans prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their communication plans (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though significantly improved, there was insufficient integration of communication supports and services into the ISP. The process of effectiveness monitoring was not conducted consistently and was poorly documented given the current system.	

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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. Ensure that the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and that there were no contradictory statements related to function or methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Address quality and implementation of direct and indirect supports and the consistency and necessary elements of documentation of review of these by clinicians. 4. Track that all staff (NEO and existing staff) had successfully completed the training related to communication.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at SGSSLC using the Communication – Home Competency/Compliance Tool. This form addressed the following: • Communication plan or PNMP was available. • Communication system(s) were available. • Staff were aware of the AAC device and could demonstrate how to use it. • Staff described the purpose or how the device or objective should be implemented. • Staff could demonstrate and discuss basic communication strategies including cues, choice-making, and nonverbal communication. Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1 with communication supports (nine individuals). There were only three forms, one each for three individuals submitted as completed in the last three months. Each was a compliance skill drill for staff who had completed annual refresher training. Each was completed by a PNMPC. Policy established staff compliance monitoring as 16 completed in each skill area. Staff compliance monitoring was based on staff skill, implementation, and knowledge. Effectiveness monitoring was also to be completed per policy and addressed compliance monitoring, but these were not consistently completed at the intended frequency. Compliance was as follows: • 100%: 1 • 90%-99%: 0 • 80%-89%: 1 • 70%-79%: 0 • 60%-69%: 0	Noncompliance

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		• 50%-59%: 1 • 40%-49%: 0 • 30%-39%: 0 • <30%: 0 For the staff who scored at less than 80% compliance, there was evidence of re-training and follow-up one month later. No other compliance monitoring had been completed. Compliance monitoring should be conducted routinely to address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. Communication dictionaries should be monitored for availability and whether staff understand how to use them. There was an extensive process to review and track findings based on the monitoring conducted, though this was very limited related to communication supports. Follow-up was clearly documented on the forms submitted. <u>Effectiveness Monitoring</u> This type of monitoring should address communication plans and AAC, dictionaries, and SAPs related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment. This should address any changes in risk or status of the individual since the previous review and staff compliance, as well as whether the supports and/or strategies effectively met the intended need. Frequency of these should be included in the ISP with documentation in the IPNs. These notes should include the following: • Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring that impact communication • Purpose and function of the device or support • Presence and condition of equipment • Staff knowledge and compliance, consistency of implementation • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion	

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		The tool used for effectiveness monitoring had been revised. This monitoring also tracks recommendations to ensure that previously identified issues had been addressed. Though noted, effectiveness monitoring was not consistently conducted. The current form appeared to be effective, and IPNs were generally written to document that the monitoring had occurred as these monitoring forms were not filed in the individual record. There was a significant lack of consistency related to the completion of these for individuals who were provided communication supports and there was a lack of reference to these findings and those for compliance in the communication assessments reviewed. The facility concluded that they were in compliance with this provision of section R though the monitoring team did not concur 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. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. 2. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings 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 #142, Individual #120, Individual #250, Individual #380, Individual #251, Individual #328, Individual #217, Individual #316, Individual #140, Individual #245, Individual #317, Individual #246, Individual #35, Individual #203, Individual #58 o Skill Acquisition Plans (SAPs) for: • Individual #317, Individual #246, Individual #35, Individual #203, Individual #58, Individual #183, Individual #236, Individual #346, Individual #372, Individual #362, Individual #68, Individual #381 o Functional Skills Assessment (FSA) for: • Individual #317, Individual #246, Individual #35, Individual #203, Individual #58 o Personal Focus Assessment (PFA) for: • Individual #317, Individual #246, Individual #35, Individual #203, Individual #58 o Vocational assessments for: • Individual #317, Individual #246, Individual #35, Individual #203, Individual #58 o Section S Presentation Book o Section S Benchmark analysis, July 2013- January 2014 o SGSSLC Home and community Activity policy and Procedure, 7/18/13 o SGSSLC Attendance Improvement Program, 11/21/13 o Engagement Monitoring form, 10/28/13 o Spreadsheet of assessments completed at least 10 days prior to the ISP meeting, July 2013-November 2013 o Skill Acquisition Program Competency Review, 1/5/14 o Summary of community outings per residence, June 2013- November 2013 o A list of skill training provided in the community by residence, June 2013-Novemeber 2013 o List of individuals employed on- and off-campus, undated o Description of on-campus and off-campus work programs, undated o Attendance Improvement Program procedures, 11/21/13 o List of individuals who were under age 22 and their public school educational status o ISPs, IEPs, and public school report cards for • Individual #35, Individual #99, Individual #43 o Documentation of review of public school report cards for • Individual #329, Individual #90, Individual #35, Individual #99 o Minutes from two meetings with Water Valley ISD public school

	Interviews and Meetings Held: o Veronica Barrientez, QIDP Coordinator; Vicki Hinojos, Director of Residential Services; Trisha Trout, Unit 1 Director; Tammy Ponce, Program Developer Supervisor o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors o Vicki Hinojos, Veronica Barrientez, and Chris Sandoval, public school liaisons Observations Conducted: o SAP peer review 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. The monitoring team believes, however, that some items in the self-assessment could better reflect the activities that the monitoring team assesses. For example, S2 of the self-assessment appeared to focus on ensuring that functional skills assessments, vocational assessments, and preference and strengths inventories were completed. Although this is important, the focus of S2 in the monitoring team's report is on determining if assessments were clearly used to select individual skill acquisition plans, and that these assessments were available to team members at least 10 days prior to the ISP. 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, the monitoring team noted several improvements since the last review. These included: • Continued improvements in the quality of SAPs reviewed (S1) • Improved collaboration between behavioral health services and the dental department to address barriers to completing necessary dental services (S1) • Program developers began to write replacement behaviors (S1) • Initiation of a day programming attendance improvement program (S1) • Improvements in the percentage of SAPs that were clearly based on assessment results (S2) • Increase in the percentage of individuals working on SAPs in the community (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that each SAP contains all of the components described below (S1) • Ensure that SAP data are accurately recorded (S1) • Increase the percentage of individuals that attend day programming (S1) • Improve individual engagement in the residences (S1) • Document that functional skills assessments, preference and strengths inventories, and vocational assessments are consistently completed at least 10 days prior to each individual's ISP (S2) • Consistently document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • 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	This provision item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SGSSLC. Although there was progress since the last review, more work (discussed in detail below) is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition plans (SAPs). These plans consisted were written by five program developers, and were implemented by direct support professionals (DSPs). Three SAP trainers trained DSPs in the implementation of SAPs, and monitored SAP progress.	Noncompliance

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	safety, security, and freedom from undue use of restraint.	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 preferences. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. As discussed in the last report, the facility recently established SAP review meetings. The purpose of these meetings was to review SAPs and ensure that they contained all the necessary components of an effective plan discussed below. The monitoring team observed a SAP review meeting and continued to be impressed with the quality of the reviews, and encourages the facility to continue to conduct these meetings. Twenty-eight SAPs across 12 individuals were reviewed to determine if they were functional and practical. In 23 of the 28 SAPs reviewed (82%), 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 reviews (39%, 62%, 80%). 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 #317's SAP for writing a check was that he wanted to learn to write checks so he was better prepared when he moved to the community This was judged to be a complete rationale because it was based on a preference. Individual #317's PSI and ISP documented that learning to write checks was a preference for him. The monitoring team cautions the facility, however, to avoid routinely stating a SAP is a preference as the rationale. As discussed in detail in S2, the monitoring team encountered several examples of rationales that indicated learning a SAP was a preference when there was no documentation that the individual wanted to learn the skill (e.g., Individual #35's SAP of styling her hair). The following is an example of a rationale that was judged to not be specific enough for the reader to determine if it was practical and functional for the individual: • The rationale for Individual #246's SAP for medication management only said she would benefit from managing her own medications. SGSSLC should ensure that each SAP contains a rationale that is specific enough for the reader to understand that the SAP was practical and functional for that individual. 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	

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		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 the SAPs reviewed contained all of the above components. Additionally, the quality of some of these components was improved. For example, all 28 of the SAPs reviewed (100%) included a complete plan for generalization. This represented another improvement over the last report when 85% of the generalization plans were judged to be complete. Some of the task analyses, however, were confusing. For example, Individual #203's task analysis to brush her hair required staff to manipulate her through each step. It was, therefore, not clear what skill she was acquiring with this SAP. Finally, 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. This system has the advantage of being a standardized method for implementing SAPs and recording data. A disadvantage is that it is limited to forward and backward chaining programs. Additionally, the implementation of these SAPs indicated that much more training and monitoring of SAPs at SGSSLC was necessary. For example, 10 of the 21 Murdoch data sheets reviewed by the monitoring team (48%) contained errors in recording the data. It is very important that the facility ensure that SAP data are consistently recorded accurately, and the SAPs implemented with integrity. The monitoring team was encouraged by the continued progress in the quality of the SAPs at SGSSLC. Over the next six months, it is recommended that facility ensure that all DCPs are trained in the recording of SAP data and implementation of SAP procedures, and that all SAPs contain all of the above components.	

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		Dental compliance and desensitization plans As discussed in the last report, the behavioral health services 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 a systematic desensitization plan) was then developed. No dental desensitization plans were written since the last review. The majority of plans to address refusal to allow routine dental exams appeared to be addressed with informal strategies designed to increase compliance. The dental department reported that the behavioral health services staff have been working cooperatively with them to ensure that individuals were getting necessary routine dental care. The overall use of sedating medications continues to be reviewed (see Q2) and will be used as measure of the success of these plans/strategies. At this point, SGSSLC appeared to be continuing to make progress in this area. 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. As discussed in K9, some of those replacement behavior SAPs appeared to be in the individuals' behavioral repertoire. Replacement behavior SAPs should only be used for teaching skills that the individual needs to acquire. Another improvement since the last review was that the program developers had begun to write the replacement behavior SAPs to ensure they were in the same format as all other 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). 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	

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		day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. As found in past reviews the ability to maintain individuals' attention and participation in the activities varied widely across the residential settings. For example, in home 509B, the staff were doing an excellent job of engaging individuals in meaningful leisure 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. Engagement continued to be consistently good in the day programs (it averaged 75%). Additionally, since the last review, the facility developed a performance improvement plan to improve day program attendance. Although a good start, the self-assessment indicated that only 38% of individuals were attending day programs during November 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%, identical to that observed during the last review. The facility recently modified their engagement tool, changing the observation intervals from 3 minutes to 10 seconds. This made the measure even more conservative and also put it in line with the way the monitoring team assessed engagement. The self-assessment indicated that 70% engagement was established as the goal level. Over the next six months, it is recommended that the facility work to improve individual engagement in the residences, and increase day program attendance. Improved engagement, including improved attendance at activities, should be attainable at SGSSLC. Two examples of observations by the monitoring team pointed to this. First, the self-advocacy committee was a well-attended (about 70 individuals), non-required activity. Obviously, the content and style of this activity was attractive to individuals and motivated them to eagerly attend. Perhaps characteristics of this activity could be replicated in other activities throughout the week at SGSSLC. Second, 11 women on home 504A sat at their three dining room tables waiting while their dinner meals were prepared and served to them. Meal preparation activities seemed to be a good	

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		opportunity for these capable women to be more engaged in an activity that they would likely enjoy participating in, even though it might take some planning and creativity to work meal preparation into the meal procedures at SGSSLC. Engagement Observations: Location Engaged Staff-to-individual ratio 516 W 1/2 0:2 516 E 0/5 2:5 516 E 2/5 1:5 504 A 2/3 2:3 502 2/3 1:3 504 B 1/7 2:4 511 1/2 1:2 509 B 1/1 1:1 509 B 1/1 1:1 509 A 2/4 0:4 509 A 2/2 1:2 Building Imaginations 0/1 0:1 Suzy Crawford Center 2/3 2:3 Building Imaginations 3/3 4:2 Building Imaginations 4/4 2:4 Vocational Building 4/4 2:4 Vocational Building 8/10 3:10 Educational Services SGSSLC continued to maintain an excellent working relationship with the Water Valley Independent School District. The new QIDP coordinator Vanessa Barrientez and the new QIDP educator (who was also the QIDP for the students) Chris Sandoval were newly appointed to be the facility's liaisons with the public school. Vicki Hinojos, Director of Residential Services, also provided support when/if necessary. The facility held periodic meetings with the public school's administration, most recently in January 2014. Relevant topics were discussed, such as communication, use of restraints, SGSSLC observations in the classrooms each month (this had been discontinued), graduation plans, and new students. The facility sent two staff each day to the public school campus (as well as at the SGSSLC on-campus classroom), plus additional staff if any one to one level of supervision was required. Eight students attended public school. Three were on schedule to graduate in May 2014. The goal was for all of the students to attend on the WISD campus. This was the case at	

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		the time of the last onsite review, however, due to some serious behavioral incidents, two of the students (recent admissions to SGSSLC) were now receiving their schooling at the WISD classroom on the SGSSLC campus. The number of hours of classroom instruction per week was quite low for both students (two hours on Mondays and Tuesdays). Other education-related activities were scheduled, such as vocational workshops and group therapy. The monitoring team suggests that the facility continue to re-visit this with the ISD to ensure that the students are receiving the amount of educational services to which they are entitled. Ms. Barrientez and Mr. Sandoval reported that the students at the WISD campus were fully included for art, music, and physical education. It was unclear if the facility sought out or supported inclusion in other classes as well. The monitoring team would like to learn more about this at the next review. Mr. Sandoval reported that all students were at an A or B average, which was good to see. The ISPs of three students were reviewed and all indicated that the individuals attended public school. All three also noted the types of objectives that the students were working on at school. The ISPs, however, did not include any action plans to perhaps support what was being learned in school with additional activities at home. Based upon the IEPs for the two of the students (the third was not submitted to the monitoring team), attendance by SGSSLC staff was evident at the annual ARD-IEP meeting. SGSSLC QIDPs continued to document review WISD progress reports and report cards as part of their monthly reviews. In most cases, an ISPA was also written for the review. The facility's classroom observation tool was discontinued, but there were plans to start doing it again. The monitoring team has one recommendation which is for the IDTs to consider whether any action plans should be implemented to support specific objectives being taught at school. The IDT may determine that this is not necessary and if so, a sentence in the ISP should indicate that it was considered.	
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	SGSSLC conducted annual assessments of preference, strengths, skills, and needs. Although there were improvements, this item was rated as in noncompliance because only 67% of SAPs reviewed were clearly based on assessments, and available documentation indicated that these assessments were not consistently available to team members at least 10 days prior to each individual's team meeting.	Noncompliance

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	of living, working, and engaging in leisure activities.	To assess compliance with this item, the monitoring team reviewed Individual Support Plans (ISPs), Functional Skill Assessments (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. The facility provided documentation that indicated that only 56% of FSAs and 75% of PSIs, and were completed at least 10 days prior to the ISP. There was no documentation available demonstrating that vocational assessments were completed at least 10 days prior to the ISP. SGSSLC needs to ensure that all assessments of individuals' preferences, strengths, skills, and needs are completed at least 10 days prior to the ISP. As discussed in the last review, the FSA appeared to be an adequate tool for assessing 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 worn, 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 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. The monitoring team was encouraged to encounter some documentation of the use of individualization of assessment tools to identify SAPs. For example, Individual #246's FSA summary indicated that she could dress herself, however, she chose the same outfit everyday. Therefore, a SAP was developed to teach her to select a different outfit everyday. Overall, these five individuals had a total of 21 SAPs, and 14 of those (67%) had clear documentation that assessments were used to develop them. This represented a sharp increase from the last review when 38% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of SAPs that were documented to use assessments to develop them included: • Individual #317's SAP to learn to cook was based on his preference (documented in his PSI and ISP) to cook some of his own meals. • Individual #246's FSA documented that she could dress herself, but wore the same outfit every day. Additionally, her PSI and ISP documented that she liked	

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		to look good. Therefore, a SAP to teach her to select a different outfit each day was developed. • Individual #203's ISP documented that her SAP to learn to communicate her wants and needs could replace her undesired target behaviors of disruptive behavior Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #317 had a SAP to manage his medications, however, there was nothing in his ISP or PSI that suggested that this was a practical SAP for him, or that it was based on any assessment data. • Individual #35 had a SAP to learn to style her hair. Her SAP indicated that this SAP was based on her preference and assessment results. Her FSA however, indicated she was independent in hair care, and nothing in her ISP or PSI indicated that styling her hair was a preference for Individual #35 • Individual #246 had a SAP to learn to do her own laundry. Her FSA, however, indicated that she was independent in laundry skills In order to achieve substantial compliance for this provision item, SGSSLC needs to ensure that all assessments of individuals' preferences, strengths, skills, and needs are completed at least 10 days prior to the ISP, and that there is 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	The parties agreed the monitoring team would not monitor this provision because the facility did not make compliance on this item. The noncompliance finding from the last review stands.	Noncompliance

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	needs, and		
	(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 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 individuals at SGSSLC participated in community recreational activities each month. Additionally, the self-assessment indicated that, over the last six months, 18% of community trips included SAPs. This represented an improvement from the last review when 4% of the community trips included training in the community. 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: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments o SGSSLC facility-specific policies regarding most integrated setting practices (no updates) • Continuity of Services, 2.1.01, updated 4/19/12 • Most Integrated Services, 2.1.31, 4/29/11 o SGSSLC organizational chart, January 2014 o SGSSLC policy lists, January 2014 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 12/1/13 o Blank statewide section T draft self-assessment, October 2013 o SGSSLC Action Plans, 1/28/14 o SGSSLC Provision Action Information, most recent entries for the most part were 9/9/13 o SGSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/17/14 o Community Placement Report, last six+ months, 6/1/13 through 2/14/14 o List of individuals who were placed since last onsite review (8 individuals, includes Individual #162 and Individual #310 who moved on Wednesday and Friday of the week of the onsite review) o List of individuals who were referred for placement since the last review (18 individuals) o List of individuals who were referred <u>and</u> placed since the last review (2 individuals [1 of whom was readmitted]) o List of total active referrals (19 individuals, not including Individual #162 and Individual #310) o Documentation for 2 of the 3 individuals who were referred for more than 180 days o List of individuals who requested placement, but weren't referred (8 individuals) • Documentation of activities taken for those who did not have an LAR (8) • Those who requested placement, but not referred due to LAR preference (none) o List of individuals who were not referred solely due to LAR preference (6 individuals) o List of rescinded referrals (7 individuals) • ISPA notes regarding each rescinding (6 of the 7) • Special Review ISPA Team minutes for each rescinding (3 of the 7, 2 are scheduled) • Other types of documentation (1 of the 7) o List of individuals returned to facility after community placement (4) • Related ISPA documentation (1 of 4) • PDCT forms (2 of 4) • Root cause analysis (0 of 4)

	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 • 4 of 22 individuals who moved since 2/1/13 o Completed Potentially Disrupted Community Transition forms (3) o List of individuals who died after moving from the facility to the community since 7/1/09 (4, 1 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (no data) o APC Department meeting minutes, 9/9/13 to 2/17/14 (14) o SGSSLC Transition Committee minutes, 9/24/13 to 2/18/14 (7) o List and job descriptions for APD staff o APC weekly reports • Detailed referral and placement report for senior management, (0) • Statewide one page weekly enrollment report (4) o Variety of documents regarding education of individuals, LARs, family, and staff: (reduced monitoring) • Provider Fair • Community tours • Work with local LA • Work with local providers (none) • Facility-wide staff trainings/activities • For individuals • For families (none) • Brochure and facility newsletter (none) • CLOIP and PP tracking tools (none) o Description of how the facility assessed an individual for placement (not reviewed) 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), (not reviewed) o List of individuals who had a CLDP completed since last review (8, though 3 were prior to last review) o SGSSLC CLDP supports prompt spreadsheet, 1 blank and 2 completed o DADS central office written feedback on CLDPs (0) o QA related activities and documents (not reviewed) o APC presentation packet to QI Council, 2/20/14, including 9 graphs, data through January 2014 o State obstacles report and SSLC addendum, (not reviewed) o PMM tracking sheet o Documentation of day of move items (0) o Transition T4 materials for: • (none reviewed) o ISPs for:

	• (none reviewed) o Pre-ISP draft used during the pre-ISP meeting: • (none reviewed) o Draft ISP used during the ISP meeting: • (none reviewed) o CLDPs for: • Individual #175, Individual #388, Individual #94 Individual #20 Individual #73, Individual #229, Individual #310 o Draft CLDP for: • Individual #194 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 #164: 45, 90 • Individual #80: P, 7, 45, 90 • Individual #304: P, 7, 45, 90 • Individual #255: P, 7, 45, 90 • Individual #45: P, 7, 45, 90 • Individual #166: P, 7, 45, 90 • Individual #311: P, 7, 45, 90 • Individual #123: P, 7, 45, 90 • Individual #175: P, 7, 45, 90 • Individual #388: P, 7, 45, 90 • Individual #94: P, 7, 45, 90 • Individual #73: P, 7, 45 • Individual #20: P, 7, 45, 90 • Individual #229: P, 7, 45 (monitoring team attended the 45-day) • Individual #162: P <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 Mandy Rodriguez, Unit Director, and now co-lead for section T o Roy Smith, Human Rights Officer, Zula White, Human Rights Assistant, Janet Smith, Assistant Independent Ombudsman, and Jalown McCleery, Incident Management Coordinator o Community provider agency staff: Daybreak Services, San Angelo, TX <u>Observations Conducted</u>: o CLDP meeting for: • Individual #194

	o ISP and pre-ISP meetings for: • Individual #331, Individual #66 o Community group home visit for post move monitoring for: • Individual #229 o Admissions and Placement Department meeting, 2/17/14 o Transition Committee, 2/18/14
	Facility Self-Assessment The self-assessment given to the monitoring team was the same self-assessment used in previous reviews, though with updated data inserted. As stated in those previous reports, this self-assessment format was insufficient for adequately conducting a self-assessment of section T because it did not guide the APC to look at the same items, in the same way, as did the monitoring team. This rendered the self-assessment results invalid. The APC, however, reported that they were no longer going to be using this self-assessment format because state office had issued a new self-assessment template. The monitoring team was given a blank version, which was clearly marked as a draft. It was much improved from the previous version. The monitoring team recommends that the self-assessment line up with the set of metrics and protocols that the Monitors submitted to the parties in October 2013 because the new self-assessment, although improved, did not fully line up with these metrics and protocols.
	Summary of Monitor's Assessment SGSSLC made progress in some areas of section T, primarily in the detail included in many of the CLDPs, the reduced length of time individuals waited for transition, and the continued transition and placement of individuals into the community. All of the admissions and placement department staff remained the same. Five provisions remained in noncompliance based upon an agreement between the parties and the Monitor made in the weeks prior to the onsite review due to self-reported lack of progress (T1b1, T1b2, T1b3, T1f, T1g). On the other hand, also based upon this agreement, four others remained in substantial compliance due to their substantial compliance status for a number of consecutive reviews (T1c2, T1c3, T1h, T4). 8 individuals had been placed in the community since the last onsite review. 18 individuals were on the active referral list. Of the 22 or so individuals who moved in the past 12 months, 2 had one or more untoward events that occurred within the past six months (9%). Of these 2, 0 (0%) were successfully resolved or managed; all 2 returned to live at the facility. In addition, 2 other individuals returned to the facility after failed placements of less than 1.5 years. Problems with placements and failed placements continued to occur at a high rate at SGSSLC. The APC and the facility continued to fail to do a thorough analysis of these failures in order to make improvements to the referral and transition processes at the facility.

	The facility and DADS proposed reduced or no monitoring for some provisions because they were acknowledged to be in noncompliance before the initiation of this onsite review. Thus, the most integrated setting practices related to ISPs, professional assessments and determinations, education of individuals and their LARs and staff, quality assurance, and obstacle identification and actions were not monitored or received reduced monitoring during this review. The facility assigned one of the unit directors to co-lead section T, specifically to focus upon this aspect of section T. CLDPs were developed for each individual who was referred. A CLDP meeting was conducted during the onsite review and was observed by the monitoring team. The individual was very engaged during the meeting, though there was little participation from team members. More information and detail regarding the training of provider staff, and preparation of the provider were necessary (T1c1). Discharge assessments were completed for all relevant disciplines, however, they did not focus upon the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings. The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive and worded in measurable, verifiable terms (T1e). Post move monitoring continued to be implemented as required and maintained substantial compliance. 39 post move monitorings for 14 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed up when action was needed. The monitoring team provided some suggestions for continued improvement in post move monitoring.

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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	<u>Placement Department Staff</u> The admissions and placement department (APD) continued to be led by Tim Welch, the Admissions and Placement Coordinator (APC). He held this role for many years and was knowledgeable of the requirements of section T and transition and placement processes. Four other staff remained in the same positions: the Post Move Monitor (PMM) was Denise Copeland, and the Transition Specialists were James Reid and Janet Jordan. The state office transition specialist was Donnie Varela. Five provisions remained in noncompliance based upon an agreement between the parties and the Monitor made in the weeks prior to the onsite review due to self-reported lack of progress (T1b1, T1b2, T1b3, T1f, T1g). On the other hand, also based upon this agreement, four others remained in substantial compliance due to their substantial compliance status for a number of consecutive reviews (T1c2, T1c3, T1h, T4).	Noncompliance

	transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	The APC continued to hold an almost-weekly meeting with his staff to review the status of referrals, each staff person's schedule, and any other relevant topics. The facility's transition committee continued to meet almost weekly, too. They reviewed upcoming transitions, including a somewhat detailed review of the status of each individual when his or her referral reached 90 days. The transition house, mentioned in previous reports, was still in the development and planning stage. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 7%. 8 individuals had been placed in the community since the last onsite review. This compared with 19, 18, 12, 13, 10, 10, and 17 individuals who had been placed at the time of the previous monitoring reviews. o This was the lowest number in the four years of monitoring. The APC and his staff also noted this, but did not have any explanation. A number of transitions were coming up, so this may be temporary. Referrals: • 18 individuals were referred for placement since the last onsite review. This compared with 28, 18, 12, and 23 individuals who were newly referred at the time of the previous reviews. o 2 of these 18 individuals was both referred and placed since the last onsite review (and 1 of these 2 was also re-admitted, Individual #73). • 18 individuals were on the active referral list. This compared with 19, 23, 27, 33, 27, 21, and 19 individuals at the time of the previous reviews. o 3 of the 18 individuals were referred for more than 180 days. This compared to 7 and 6 at the time of previous reviews. ▪ 0 of the 18 individuals were referred for more than one year. This compared to 2 and 1 at the time of previous reviews. Potential negative outcomes (compliance is addressed in T1f, however, given that T1f was found to be in noncompliance based upon the agreement between the parties and the Monitor, the monitoring team has provided some commentary here) • 4 individuals returned to the facility after community placement. This compared with 3, 4, 4, 0, 2, 0, and 1 individuals at the time of previous reviews. o This was a high number of failed placements. • 1 individual had died since being placed since the last onsite review. This compared with 0, 0, and 1 at the time of previous reviews. A total of 4 individuals had died since 7/1/09. • 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. These data were being obtained for a one-year period after moving. o The APC's data were not organized in an adequate manner regarding this topic. During the six months since the last onsite review, he changed the way he managed these data from a cumulative table/spreadsheet to a single bar chart with totals for each fiscal year. The set of graphs described in previous reports and which the APC had developed over the past few reviews, were discontinued. The monitoring team surmised that 22 individuals had been placed in the past 12 months and 2 of them had untoward events occur (9%) in the past six months. Both were not resolved successfully in the community, that is, both returned to live at SGSSLC. In addition, 2 other individuals returned to the facility after less than 1.5 years in the community. o There was a new statewide system and form for reporting these types of events, and for helping the APC to review these events. It was called the Potentially Disrupted Community Transition form. The monitoring team reviewed three examples. Overall, the format helped guide a review the case. One of the forms was completed fully (Individual #80). The forms for the other two were not completed fully (Individual #114, Individual #73). ▪ The completed PDCT review addressed what might be done differently for this individual in the future (which was good to see), but none of the three addressed what might be done to improve transition services for individuals at the facility. ▪ All cases should be reviewed 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. ▪ The PDCT form should be updated to prompt this type of discussion. Or it could be documented elsewhere. o Given the ongoing problems in community placements for many individuals, the APC and his department should conduct self-review, root cause analysis, and continuous quality improvement. This has been a recommendation for many years. Although there were some nods to working on this in the APD meeting minutes (e.g., 9/23/13), the department was unable to engage in this type of analysis in any meaningful way as evidenced by the incomplete PDCT process and the minimal discussion in the APD minutes regarding Individual #114 and Individual #73 (12/9/13), Individual #112 (12/16/13), and Individual #363 (1/6/14). The monitoring team believes that the APC and his staff	

		would benefit from training in this matter. Alternate discharges (compliance is addressed in T4) • (Not applicable) individual was discharged under alternate discharge procedures (not reviewed). <u>Determinations of professionals</u> Professional members of the IDT are required to state their opinion regarding the most integrated setting for each individual in their annual assessments, during the ISP meeting, and in the written ISP document. Compliance is addressed in T1b3. <u>Placement and referral not opposed</u> a. In reviewing the CLDPs and ISPs for 8 individuals who were on the referral list or who had been placed, 8 (100%) individuals and/or LARs did not oppose transition to the community. <u>Responding to individual requests and rescinded referrals</u> There were 7 rescinded referrals since the last review. This compared to 9, 4, 9, 2, 3, 5, and 4 at the time of the previous reviews. Documentation (ISPA notes, ISPs, or SRT) was provided for 7 of the 7 individuals regarding the reasons for the rescinding. b. Of these 7, the reasons for the rescinding appeared to be reasonable for 6 (86%). • Three were rescinded following behavioral problems during a provider site visit and/or subsequent increase in behavior problems at the facility. • Two were rescinded for medical reasons. • One was rescinded for a combination of medical and behavioral issues. • The reasons were not known for one. An adequate review to determine if changes in the referral and transition planning processes at the facility was conducted for 0 (0%) of the rescinded referrals. Of these reviews, actions were recommended in n/a (--%) cases. Of these, actions were implemented for n/a (--%). This was surprising, given that 3 of the 7 were due to increases in serious behavior problems subsequent to being referred, and given that the APC and his staff noted this as a problem. This was an example of an observation that should have been followed by some planning and perhaps changes to the referral, transition, and placement process at SGSSLC. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. A review for quality improvement purposes, however, should be conducted for all. 8 individuals were described as having requested placement, but were not referred. This	

		compared with 14, 17, 13, 27, 21, 44, and 80 individuals at the time of the previous reviews. It seemed that the count of 8 were individuals identified since the last onsite review, that is, it was not a full count for the entire facility. Further, the list given to the monitoring team contained 5 names; the monitoring team identified 3 other individuals, thus, calling into question the accuracy of the APC's data set. c. Of the 8 individuals who requested placement, but were not referred, 0 individuals had an LAR who made this decision. Of the remaining 8 individuals, an appropriate review, appeal, and or lack of consensus review was conducted for 8 (100%). The list of individuals not being referred solely due to LAR preference contained 6 names. This compared to 6, 67, 1, 12, 5, and 8 individuals at the time of the previous reviews. This appeared to be the most accurate count done at SGSSLC since monitoring began. <u>Systemic issues</u> d. There were no systemic issues delaying referrals (at the state and/or facility level). (Not applicable: If there were any, there (were/were not) actions being taken to resolve them.) e. There were no existing and/or potential systemic issues delaying transitions (at the state and/or facility level). (Not applicable: There (were/were) not actions being taken by the facility to resolve them.) f. Funding availability was not cited as a barrier to individuals moving to the community. g. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The monitoring team observed this at the QI Council meeting during the week of the onsite review. The APC reported that he gave an update once each month at QI Council meeting, however, the monitoring team found these updates in the monthly QA reports for only three of the past six months (50%). <u>Pace of transitions</u> h. Transitions were not occurring at a reasonable pace (i.e., metrics i., j., and k. below did not meet criteria). 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 the 8 individuals placed since the time of the last onsite review, 4 (50%) were placed within 180 days of their referral (i.e., 4 were not). o Three of the 4 were placed within two to three weeks past 180 days. o For one individual (Individual #229), a history of difficulty of finding an appropriate provider was documented in previous monitoring reports. • At the time of the review, 18 individuals had been referred for community transition. 3 of these 18 individuals had exceeded the 180-day timeframe. o Of these, 0 individuals had exceeded one year. i. Reasonable activity and actions had occurred related to the transition and placement for 5 of the 7 (71%) individuals. IDTs met each month for the individuals who were past 180 days on the referral list. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 5 of the 7 (71%) individuals. k. Adequate justification was provided for the lengthier transition process for 6 of the 7 (100%) individuals. • Additional supplemental information was provided by the APC (e.g., ISPA minutes) and/or was found by the monitoring team in other documents, such as in the APD meeting minutes and transition committee minutes. In the future, this information could be included within the CLDP, most likely in section IV-B.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	<u>State policy</u> a. The state policy for most integrated setting practices was recently issued. The monitoring team will comment at the next compliance review as to whether the state policy adequately addressed all of the items in section T of the Settlement Agreement. <u>Facility policy</u> b. There were not facility policies that supported the state policy for most integrated setting practices. There were two facility policies related to most integrated setting practices. They had not been revised in a number of years and had not been updated to reflect the new state policy. The APC reported that state policy was adopted as facility policy. Instead, the facility should have updated policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. For this policy, examples include (but are not limited to) the way in which community tours are	Noncompliance

		managed, how educational activities are presented to individuals, how the admissions and placement department staff ensure that all supports and services are included in CLDPs, how the PMM conducts post move monitoring, and which staff are to review the CLDP prior to its submission to the facility director. The rating for T1b is based solely on the development of adequate state and facility 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.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. 1. Individualized plan: a. In reviewing ____ recently completed ISPs, ____ individuals had been referred for placement, and were engaged in the CLDP process. For the remaining ___, _____ (%) had a plan that addressed education about community options. Of these, ____ (%) were adequate: • As part of the reduced monitoring agreement, the monitoring team did not review this aspect of T1b2 given the recent changes to the ISP process and the recent appointment of one of the unit directors as section T co-leader, with her primary responsibility being to focus on the ISP-related aspects of	Noncompliance

		section T. The monitoring team refers the APC and unit director to the previous monitoring report for more detail. The monitoring team looks for the individualized plan in each ISP to contain the following: o Individualized and specifies what will be done over the upcoming year. The plan should go beyond a generic provision of information; it should reflect the specific concerns that individuals and families/LARs have raised about the community, as well as reflective of the individual's needs. 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. 2. Provider fair: b. The facility did hold a provider fair within the past 12 months (on 9/27/13). The facility did measure and evaluate outcomes, but did not discuss or propose making changes for future fairs. 3. Local MRA/LA: c. The facility did appear to maintain good communication and a working relationship with the LA, but did not participate in quarterly meetings with the LA (there was one meeting in the past six months, November 2013). The facility did ensure relevant topics were on the agenda for the LA meetings, however, there was no review or discussion of the CLOIP process. 4. 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). d. The facility did not have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, identified all individuals and whether or not each went on a tour). • The APC reported that the system and frequency of tours remained about the same as during the last review. The monitoring team refers the APC and reader to the previous report's details. To meet this aspect of T1b2, the facility needs to demonstrate that: o 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). o Places chosen to visit are based on individual's specific preferences, needs, etc. o Tours are for individuals or no more than four people o Individual's response to the tour is assessed (describe methodology and indicators)	

		e. Based on the facility's own report, of the ____ individuals at the facility for whom a tour was appropriate, __ (%) went on a tour appropriate to their needs within the past year. • The facility did not report this type of data. Instead, the total number of individuals who went on a tour was presented (57, similar to the total at the previous review). Data were provided for June 2013 through November 2013, that is, data for December 2013 and January 2014 were not presented. f. Of the ____ individuals in the sample for whom their teams had determined a tour was appropriate, __ (%) went on a tour tailored to their needs within the past year. • Due to reduced monitoring, this was not assessed by the monitoring team. <u>5. Visit friends who live in community</u>: g. The facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>6. Education activities at/by facility for individuals</u>: h. Since the last onsite review, other educational activities for individuals did occur during self-advocacy meetings (multiple times), did not occur during house meetings for individuals, did not occur during family association meetings, and did occur during any other appropriate situations or locations (the quarterly coffee houses with providers. <u>7. Education activities for direct support professionals (DSPs), clinicians, and managers</u>: i. --% of DSPs were documented to have participated in one or more activities (e.g., inservice, workshop, community tour). • The APC reported that 52 staff attended the LA inservice in November 2013 and that 46 staff attended community tours. The data, however, did not separate for DSP, clinicians, and managers and percentages were not provided. Therefore, the three metrics of this item #7 could not be rated. All new staff received a session on community living during new employee orientation. j. --% of clinicians were documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. --% of managers and administrators were documented to have participated in one or more activities (e.g., inservice, workshop, community tour).	

		8. Reluctant individuals/LARs learn about successes: l. Since the last onsite review, information about successful community placements was not shared with (a) individuals who were reluctant to consider community placement, and (b) LARs who are reluctant to consider community placement. • Successful community placements were shared and presented at self-advocacy meetings.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. This section relates to the activities of the IDT, QIDP, and the ISP process. SGSSLC recently appointed one of the unit directors to be the co-leader for this aspect of section T, along with the APC. This was likely to result in more progress in this section. The monitoring team conducted reduced monitoring, which consisted of observation of two ISP meetings. Review of ISP documents will be part of the full monitoring that will be conducted for the next review. 1. Professionals provided recommendation in assessments: a. Of the ___ ISPs reviewed, all of the assessments for ___ individuals (___%) included an applicable statement/recommendation. 2. Professional determinations presented/discussed at ISP meeting: b. In ___ of the ___ (%) written ISPs reviewed, and during ___ of the ___ (%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. • During both ISP meetings, independent recommendations were solicited from each attendee (100%). 3. Thorough discussion of living options at ISP or other IDT meeting: c. In ___ of the ___ (%) written ISPs reviewed, and during ___ of the ___ (%) annual ISP meetings observed, a thorough discussion of living options occurred. • A thorough living options discussion occurred during 1 of the 2 ISP meetings (50%) (for Individual #331). 4. IDT determination in written ISP: d. In ___ of the ___ (%) written ISPs reviewed, a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included. e. In ___ of the ___ (%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included.	Noncompliance

T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service 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 6 CLDPs completed since the last review. Of these 6, 3 were CLDPs completed before the last onsite review, though the individuals moved after the last onsite review. These 3 were, therefore, not included in this review. The monitoring team then discovered that 2 additional individuals had recently moved and included those in this review, making a total of 5 CLDPs. This was 100% of the CLDPs completed since the last review. The monitoring team reviewed 5 of the 5 (100%) CLDPs in depth. <u>Timeliness of CLDP</u> Initiation of CLDP a. 5 of the 5 (100%) CLDPs were initiated within 14 calendar days of referral. The monitoring team based this finding upon documentation of CLDP-related activity occurring within 14 days of referral, including the actual 14-day meeting minutes for one individual (Individual #20). • The need to include a CLDP initiation date on the first page of the CLDP was noted in the previous report, but the APC had not made this simple addition to the CLDP form. Ongoing development of CLDP b. 5 of the 5 (100%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. <u>IDT member participation in placement process</u> c. 5 of the 5 (100%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., 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 was a strength of the SGSSLC CLDPs, the IDTs, and of the collaborative work between the APD and the IDTs. <u>Coordination of CLDP with LA</u> d. 5 of the 5 (100%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. This collaboration did not appear to be more than the LA's attendance at the CLDP meeting and the provision of provider lists. On the other hand, there did not appear to be any activity that the LA was to engage in that he or she did not.	Substantial Compliance
	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	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. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 5 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by	Noncompliance

	coordinating the community living discharge plan with provider staff.	including documentation to show that all of the activities listed below, in the six closed 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 training required: i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), 5 of 5 (100%), ii. 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), 3 of 5 (60%), and iii. a competency demonstration component, when appropriate, 5 of 5 (100%). • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was noted in 0 of the CLDPs (0%). The APC reported that they no longer attempted to contact community psychiatrists because they had poor success in receiving return phone calls. The facility, however failed to explore this further for the psychiatry supports or for any of the other many clinical areas, such as psychology, rehabilitation, and nursing. Given the numerous post-placement problems, this should probably be explored further. If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 1 of the 5 CLDPs (20%), for Individual #229. • Collaboration between provider day and residential staff. This was not evident in any of the CLDPs (0%). • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not evident in any of the CLDPs (0%). If not needed, this should be indicated in the CLDP. • Collaboration between Post-Move Monitor and Local Authority staff. This may likely have been occurring, but was not noted in any of the CLDPs. <u>Documentation of day of move activities</u> b. 5 of the 5 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. Documentation for 0 of the 5 (0%) indicated that the activities did indeed occur. <u>CLDP meeting prior to moving</u> A CLDP meeting occurred for 5 of the 5 individuals (100%). It was described in each of the CLDPs c. During the CLDP meeting observed during the onsite review, an adequate and	

		complete CLDP meeting was conducted for Individual #194. The monitoring team observed the occurrence of the following activities (except for items 2 and 3, which could not be determined during the meeting). • Attendance by all relevant IDT members, community providers, and LA • Individual preparation occurred prior to the CLDP meeting, if appropriate to do so • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved • The post-move monitor actively participated to ensure that supports were adequately defined and required evidence specified. The monitoring team suggests that the APC consider the following observations made by the monitoring team. First, numerous times during the meeting, participants noted the importance of Individual #194 staying busy and being as independent as possible. There were, however, no post move supports specifically included to address these needs. Second, work-employment was noted as being very important, however, the only support included was to have a work evaluation. Third, Individual #194 had made great progress, especially regarding exhibition of challenging behaviors, however, the list of supports did not include those parts of the PBSP that helped her to be successful, such as the best ways to interact with her. Fourth, participants did not give their recommendations for discussion. Fifth, team member discussion points were filled in to the CLDP form before the meeting. This was surprising, especially given the detailed discussion described in other CLDPs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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. The following review was based on a sample of assessments from 5 of the CLDPs. <u>The assessments selected for completion are appropriate and none are left out</u> a. For 4 of the 5 CLDPs reviewed (80%), all necessary assessments were completed. • A psychiatry assessment appeared warranted for Individual #73. It seemed that at SGSSLC, the criterion for a psychiatry discharge assessment was only if the individual was receiving psychiatric medications, not if the individual had psychiatric support needs. Individual #73 had a long history of serious psychiatric problems and was not receiving any medication at the time of her discharge planning, however, a psychiatric discharge assessment would likely have been beneficial to the team. • There were between seven and nine assessment per individual. Only one individual, however, had an assessment from medical/physician. The APC should explore this. <u>Assessments done within 45 days of move date</u> b. For 5 of the 5 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. <u>Assessments are available for use by the APC and IDT</u> c. For 5 of the 5 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. <u>Assessments are of adequate quality</u> d. For 0 of the 5 CLDPs reviewed (0%), the assessments were of adequate quality based upon the following four closed bullets: • A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for most of the assessments for all 5 individuals contained relevant facts regarding the individual's stay at the facility. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o Most of the assessments for all 5 individuals were thorough enough to assist teams in developing a list of supports. Some, however, were extremely short (e.g., dental) and some were extremely long (e.g., OTPT). Full assessments accompany each discharge, therefore, discharge assessments should be designed specifically to help the team develop pre and post move supports, and to help the new provider to provide those supports.	Noncompliance

		o Problems with nursing discharge summary content is detailed in section M3 of this report. • 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 The assessments for 0 of the 5 individuals specifically focused on the new home or day settings. • 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. o The assessments for 0 of the 5 individuals specifically focused upon how the necessary supports might need to be provided in these new settings. o Also, see comments in section P1 of this report regarding inadequate community living commentary in OTPT assessments. The QIDP, home manager, and RN for Individual #310 made a 12-page informational document for the new provider. This was very good to see and probably will be very useful to the provider, but did not replace the need for the discharge assessments to include detail on the provision of supports in the new settings. The monitoring team suggests that the APC develop a tool to self-monitor the quality of discharge assessments. It should look at the quality by directly assessing the above four open bullets.	
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	The lists of pre-move and post-move supports were identified in the CLDPs. <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 5 CLDPs reviewed (0%), a comprehensive set of essential and nonessential supports was identified in measurable/observable terms. This finding was based on the following three numbered bullets. 1) The list is comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 5 of the 5 individuals, but was only demonstrated in 1 of the 5 (20%), for Individual #162. For the others, merely saying to continue the PBSP and to address replacement behaviors was insufficient. This was especially true for individuals with complicated psychiatric and behavioral histories, complex multiple psychiatric diagnoses, and severe behavior disorders (Individual #73). ▪ As appropriate, crisis intervention plans should be developed,	Noncompliance

	Facility before the individual's departure from the Facility.	and/or pre-move and post-move supports should define how the current methods for dealing with crises at the facility should be modified in a community setting. Only the CLDP for Individual #162 addressed the development of an emergency plan. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 5 individuals and was adequately done for 3 of the 5 (60%). Important medical conditions were not addressed for Individual #73 (weight, diet, GERD, seizures) and Individual #20 (safe eating, dining plan, incontinence). o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 5 and was adequately addressed for 1 of 5 (20%). For most individuals, their preferred activities or items were grouped into a single support, making it impossible for the post move monitor to determine if the individual really experienced all of his or her preferred activities and items. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment supports applied to 4 of the 5 individuals and were adequately addressed for all 4 (100%). o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of pre- and post-move supports. ▪ This was not addressed in any of the CLDPs (0%). Positive reinforcement applied to all individuals and probably played a role in their success at the facility. o There were pre-/post-move 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 addressed for all 5. For 2 of the 5, skill development was determined to not be applicable (Individual #229, Individual #162), and for 2 others, the skill list was insufficient. The skill list for Individual #20 was sufficient. o There were not pre-/post-move supports for the provider's <u>implementation</u> of supports. That is, the components of the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue were not included. Instead, there were general references to implementation of the PBSP, PMNP, and dining plan.	

		o All recommendations from assessments are included; or if not, there is a rationale provided. ▪ For the most part, recommendations were included. ▪ When they weren't, there was very good narrative describing the IDT's deliberations and discussion. ▪ This was a strength of the 5 CLDPs, especially for the most recent 3 of the 5 CLDPs. 2) The wording of every pre-/post-move support is in measurable, and observable terms. o Many were in measurable terms, however, many continued to include words, such as "assistance," "opportunity," and "access." 3) Every pre-/post-move support included 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 This was much improved and included references to checklists and direct observation. The PMM should guide the IDT to consider <u>three</u> general categories of evidence: direct observation, staff interview, and documentation (e.g., checklists). To improve, the monitoring team has recommended in the past that the APC create a self-assessment for the pre- and post-move support section of the CLDP. He can use the above items to create this checklist for himself and his staff. To that end, the transition specialists created a Pre and Post Move Support Spreadsheet to guide them. The monitoring team reviewed three completed spreadsheets, but the spreadsheet did not cover all of the items in the above list. <u>Essential supports were in place on the day of the move</u> b. For the 5 of 5 (100%) CLDPs reviewed for individuals who were placed, a pre-move site review was conducted by the facility. c. Of these 5, 5 (100%) were done timely and completely. d. Of these 5, 5 (100%) indicated that all of the essential supports were in place prior to the individual's move, or if they were not, identified the issue and showed that action was taken to remedy the situation. • The PMM (or whomever conducts the PMSR) should provide detail indicating if all of the aspects detailed in the CLDP regarding <u>training</u> occurred as per the CLDP, such as who, what, how, and documentation of competency. e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly (not applicable, none were observed by the monitoring team). The pre-move site reviews for 9 other individuals were also reviewed. All met the	

		standards in metrics b., c., and d. above.	
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 parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial	Substantial Compliance

	this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	compliance continues. a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review that included the following information: • Number and names of individuals transitioned to the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference	
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	SGSSLC maintained substantial compliance with this provision item. Since the last review, 39 post move monitorings for 14 individuals were completed. This compared with 39 post move monitorings for 20 individuals, 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 reviewed completed documentation for 39 (100%) post move monitorings for 14 different individuals. Of the 39 post move monitorings, all were	Substantial Compliance

	community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	completed by the post move monitor Denise Copeland. <u>Timeliness of Visits</u> For the 14 individuals, 39 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 39 required visits, 39 (100%) were conducted and 39 (100%) were completed on time. Of the 39 post move monitoring forms reviewed by the monitoring team, all 39 (100%) included dates showing that they were completed on time. <u>Locations visited</u> For the 39 post move monitorings reviewed, 39 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment; no individuals attended public school) were visited. <u>Content of Review Tool</u> 39 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. The PMM used the newest iteration of the form for the most recent 3 of the 14 individuals. The others were done using the previous iteration. The contents of the previous iteration's template were insufficient to meet the requirements of this provision item, however, the PMM added additional information that resulted in those completed forms meeting the requirements. 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 26 of the 26 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 39 of the 39. o The PMM should now provide detail in her report regarding: ▪ Whether she had evidence of all aspects of required training and inservicing, such as who, what, how, and documentation of competency (rather than merely stating training documentation was reviewed). o The PMM should report on three general categories of evidence for each support (except in those cases where it does not apply): that is, the PMM should be sure to indicate what she <u>observed</u>, what <u>documentation</u> she looked at, and the result of her staff <u>interview</u>. All three of these aspects were not included for every support. o Some supports required more detailed review by the PMM. For instance, community activity and home recreation supports usually contained a long list of items. The PMM should ensure that the	

		individual was provided with access to a range of these items. For example, going to a fast food restaurant might be one of a number of community activities, but if that was the only activity that occurred, it would not have met the intent of the support, even if it met the criterion of once per week. • There was adequate justification for findings for each support in 39 of the 39 (100%). • Detail/comment was included in 39 of the 39 (100%) reports for most every support. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 39 of 39 (100%). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements was provided by the PMM in 39 of the 39 (100%). o The PMM tended to put in general comments within the paragraph about the individual's satisfaction. The monitoring team recommends that a separate final paragraph be added at the end of the report. Additionally: a. 39 of 39 reports (100%) indicated the specific name and title of each person interviewed by the PMM. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 14 individuals who received post move monitoring, 12 (86%) transitioned very well and appeared to be having good lives. The two individuals who did not transition well ultimately returned to SGSSLC. As discussed with the APC, a root cause type of review needs to be done for any individuals whose placements failed or who had the kinds of problems noted in T1a. For instance, the monitoring's review of these cases found that: • There were problems with obtaining counseling, problems with finding a psychiatrist, and problems with the provider using checklists to document implementation. This was found for many individuals, not only those who had problems after transitioning. IDTs should strongly consider making these pre-move supports for future transitions (rather than post move supports). <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 22 of the 39 post move monitorings (57%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 11 of the 14 individuals (79%). Many of the problems were of a moderate level, such as a completing data checklists, adaptive equipment, and obtaining a Medicaid number. It is not unusual	

		for this type of follow-up to be needed. There was appropriate follow-up and correction for 19 of these 22 (86%). Follow-up was done in a timely and thorough manner, including calling for IDT meetings and following up with providers. The exceptions were: • Individual #45 was having numerous psychiatric incidents at her 45-day review. • Individual #166 was having sleep disturbances following medication changes at her 45-day review. • Individual #166 was having increased psychiatric incidents and delusional symptoms at her 90-day review Also, the monitoring team noted instances where the PMM called for a team meeting and for the IDT to do some follow-up with providers subsequent to the 90-day review. The PMM should include documentation in the individual's post move monitoring file showing that the IDT meetings happened and that follow-up by the IDT occurred (e.g., Individual #255 45-day, Individual #123 45- and 90-day). <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 9 out of 11 (82%) of post move monitorings for which an ISPA was appropriate to have been held. The two exceptions were for Individual #45 and Individual #166, as noted above.	
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 #229 for the 45-day review. The PMM, Denise Copeland, 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 Daybreak services. It was a very nice home and the two staff members were very knowledgeable about the individual. Individual #229 appeared to have a daily routine, know his way around the home, and be very comfortable interacting with the staff, Dwight and Sierra. Individual #229 was walking more than when at the SSLC and he said he was happy living here.	Substantial Compliance

		Both staff reported that they had worked many consecutive days at the home (much more than 7 days). That is OK for the short term, especially if there are staffing problems, but is not a sustainable or reasonable plan. It may ultimately negatively impact the services and supports provided to the individual. In these situations, the PMM should bring this to the attention of the provider's administration as well as back to the IDT. This is part of her role as PMM, that is, to be aware of anything that may impact the individual's success in his or her placement. The staff were using a checklist for recording activities and other post move supports. It was developed at SGSSLC and given to the provider. This is one way to increase the likelihood that a provider will use a checklist, that is, to create it and give it to them. Even more of Individual #229's supports could have been included on this checklist. The monitoring team has the following comments for continued improvement in post move monitoring and expects to see these implemented at the next review: • Do a medication review at all three review, not just 7- and 45-day. • Look at the actual medications, too, in addition to reviewing the MAR for completeness and comparing it to the list on the post move monitoring form. • As noted in T2a, look for the intent of the grouped-activity supports to have been met (e.g., community activities, home recreation). • Ensure that replacement behavior instruction and reinforcer use are documented.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations	This item does not receive a rating.	

T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

SECTION U: Consent	

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	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, January 2014 o SGSSLC policy lists, January 2014 o List of typical meetings that occurred at SGSSLC (not provided) o SGSSLC Self-Assessment, 12/1/13 o SGSSLC Action Plans, 1/28/14 o SGSSLC Provision Action Information, most recent entries for the most part were 9/9/13 o SGSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/17/14 o List of all staff responsible for management of unified records o Monthly home secretary meeting minutes, October 2013 to January 2014 (4 meetings) o Description of changes since the last onsite review (there were some) 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 1/22/14), individual notebooks (updated 1/22/14), and master records (undated) o List of all individuals and checks to indicate if each aspect of unified record was updated, 11/14/13 o Notes from meeting with RN casemanagers about filing, 9/18/13 o Reports to unit directors regarding gaps in data, monthly, October 2013 and November 2013 o Blank competency training question list for DSPs o List of items found missing by the monitoring team and the URC's response to each o URC's updating of the QA data list inventory for section V, monthly, October 2013-November 2013 o Email about ways to improve the usefulness of the secretary audits, 9/27/13 o Secretary audit data, summaries, and graphs, monthly, September 2013 to November 2013 o Blank: All About Me sheet, Gaps in observation notes/programming sheet, IPN injury report tracking sheet, IPN psychiatric tracking sheet o Policy tracking log, undated o An 8-page spreadsheet that listed state and facility-specific policies and also showed various information regarding training (e.g., who, how, data/numbers), 2/19/14 o Four 1- or 2-page spreadsheets regarding facility specific policies and staff training, 7/18/13-11/21/13 o Description of the unified record audit process o Blank unified record audit tools, (none) o Blank unified record audit assistance tools and completed examples: All about me check sheet,

	Gaps in observation notes/programming, IPN injury report, IPN psychiatric tracking, medical in-town consultations o List of individuals whose unified record was audited by the URC, June 2013 to January 2014 o Completed audits for 10 individuals, October 2013 and November 2013 • Audit tool for active record and individual notebook, including six questions related to V4 • Audit of master record • Shared drive/All about me electronic folder • Gaps in observation notes/programming o Data regarding inter-rater agreement o Description of the actions that occurred following an audit o Full set of emails to responsible staff, November 2013 o Monthly audit recommendations list and tracking of status, including a set of graphs for the month, June 2013 to November 2013 o Monthly summary data and graphs for all 9 audits, June 2013 to November 2013 o QA report for section V, monthly, including many graphs and summaries, September 2013 to January 2014 o Six packets of documents for each of the six components of V4, including • secretary and campus administrator chart checks (#1) • comparison between All about me folder and the active record (#2) • gap tracking findings (#3) • psychiatric and injury tracking within the IPNs (#4) • results of V4 questionnaires (#5) • ISP meeting and other meeting reports (#6) o Active records and/or individual notebooks of: • Individual #350, Individual #328, Individual #126, Individual #7, Individual #362, Individual #236, Individual #223, Individual #103, Individual #26, Individual #250 o Master records of: • Individual #185, Individual #297, Individual #86 <u>Interviews and Meetings Held</u>: o Cary Lovelace, Unified Records Coordinator <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o Various meetings

	Facility Self-Assessment: The URC made improvements to the self-assessment. In general, she was now looking at items more in line with what the monitoring team looks at. She should, however, go through the report and self-assess each of the topics addressed in the report. This includes each header and each paragraph under each header. Now that more activities have occurred to address V4, the self-assessment should report on the specific activities done for each. The facility self-rated itself as being in substantial compliance with V1 and V3; and in noncompliance with V2 and V4. The monitoring team agreed with these ratings.
	Summary of Monitor's Assessment: SGSSLC continued to make very good progress with all four of the items of provision V and maintained substantial compliance with two of the provisions, V1 and V3. 10 of 10 (100%) individuals' records reviewed included an active record, individual notebook, and master record. 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. Individual notebooks continued to be used for all individuals and as per state policies. A master record existed for every individual at SGSSLC. Overall, the individual notebooks and master records were in good shape. Recordkeeping practices remained a part of new employee orientation and trainings were being expanded to current employees, too. The URC continued to meet each month with the home secretaries. Home secretary audits were changed in two ways to make better use of the home secretary time. Nine reviews (audits) were conducted in each of the previous six months. Fifty-four reviews were conducted at SGSSLC in the six-month period August 2013 to January 2014. All of the reviews were done in a fairly consistent manner, and were neatly and clearly documented. Inter-rater agreement reliability checks were occurring regularly over the past six months. The system of conducting the audit, listing all errors (which were called recommendations), emailing to the responsible person, following up on each error (for two months and with timed prompts), and documenting the V4 interview continued in the same manner as described in some detail in previous monitoring reports. This continued to be a very good system that was easy to understand.

	The URC actively participated in the facility's QA program. She summarized and tracked her data in three reports. The monthly QA report was now about 20 pages long and contained a variety of graphs and narrative. Much of it was trended across a 12- or 13-month period; with data also drilled down and separated by homes, skills, and disciplines; and with data that were directly related to relevant recordkeeping activities and the Settlement Agreement The URC was very creative and thoughtful in coming up with specific activities, data, and criteria for each of the six areas of V4.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SGSSLC again continued to make good progress on all four of the items of provision V. The recordkeeping department at SGSSLC maintained substantial compliance with this provision and with V3 and made considerable progress with V4. This progress was due, in large part, to the leadership, actions, and creativity of the unified record coordinator, Cary Lovelace. Further, Ms. Lovelace took very seriously the comments in the previous monitoring report and made additional improvements in the facility's recordkeeping practices since the last review. In addition, progress was also a result of the actions of the home secretaries, unit secretaries, QA department, and facility administration. To conduct this review, the monitoring team examined aspects of the unified record for more than a dozen individuals, reviewed documents and reports, talked with various staff at the homes and day programs, and observed records in use, in the program sites, and during various meetings. In addition, the work of five different home secretaries across all three units at SGSSLC was reviewed in detail. State policy and facility-specific policies remained the same as in previous review. The URC reported that some updates were pending; to be completed once revised procedures were put into place (e.g., regarding filing). The active record and individual notebook tables of contents had some minor facility-specific changes since the last review. Recordkeeping practices remained a part of new employee orientation, taught by the URC. She was in the process of adding a new competency based component. It was a five-item quiz that sampled new staff's ability to correctly describe how, what, and where to make documentation entries. Her training sessions utilized a mock individual notebook, too. The URC had begun going home to home to repeat this training. Other home-specific trainings or discipline-specific trainings had not occurred since the last review.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The URC continued to meet each month with the home secretaries. Although the home secretaries reported to the unit directors, the URC worked very closely with the secretaries to ensure expectations were clear, to improve procedures, and to provide relevant feedback on their performance, concerns, and suggestions, including the presentation of data in graphed formats. In the October 2013 and November 2013 meetings, they focused on the new way they were doing peer audits. The URC actively participated in the facility's QA program. This included completing a monthly QA report, making a monthly presentation to QI Council, and reviewing her data list inventory with the QA department. These QA activities also served to help the facility with its performance in recordkeeping practices. Ten of 10 (100%) individuals' records reviewed included an active record, individual notebook, and master record. According to the URC and to a spreadsheet 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). <u>Active records</u> The status of the active records maintained since the last review. The monitoring team reviewed active records in each of the three units at SGSSLC. 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 monitoring team's onsite review of active records showed one to two errors/missing documents per active record. This was similar to what was found by the URC in her own audits (see V3). The ongoing improvement was similarly reflected in the URC's QA report which showed an easy-to-see downward trend in the number of missing, misfiled, old, and non-purged documents since December 2012 (see graph "Complete recommendations by month"). The monitoring team reported the missing documents found during the onsite review to the URC. Of this small number of problems, some turned out to be not applicable (e.g., a mammogram for a younger individual), incorrectly attached to another document, or incorrectly inserted into a plastic sleeve (e.g., PFCS and immunization record). The remaining missing items were to be corrected by the home secretaries (missing documents had to be obtained from the clinical departments, such as a behavioral health	

#	Provision	Assessment of Status	Compliance
		services monthly review). 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. The use of the green divider sheets helped to make the active records easier to use and certainly easier to audit. Even with good performance, recordkeeping practices at SGSSLC continued to evolve. New activities were initiated, some activities were discontinued, and many were modified. This ongoing approach to continually improve quality was good to see. Below are some highlights. • The system of documenting when a document was given to the home secretary by the department was expanded to all clinical departments. • Home secretary audits were changed in two ways to make better use of the home secretary time. That is, instead of doing a full review of one active record of another home secretary, each month, they now conducted: o A detailed follow-up review of one of the audits recently conducted by the URC to see if all of the errors were corrected (a recommendation from the previous monitoring report) and if the documents in the All About Me shared drive correctly lined up with the paper documents that were in the active record and individual notebook. o A review of one section (i.e., tab) of the active record of every individual on their caseload. Examples included a review of the content, accuracy, thinning, etc. for everything that was to be included in the ISP section. Another example was for the behavioral health services/psychology section (this also addressed V4 #2). • The URC met with all of the home managers and asked them to do further training on signatures and legibility. The URC's new data gap tracking system (see V3) assessed some of this (and also addressed V4 #3). • The URC met with RN case managers regarding various recordkeeping related topics on 9/18/13. • The URC created a report for the director of residential services and unit directors that focused on the gaps in data on many different documents, such as observation notes, SAPs, and PNMP documents. • The URC and home secretaries focused on active record availability. They implemented a check-out sign-out system and assessed its implementation regularly (this also addressed V4 #1). • Unit secretaries were no longer doing record audits. Limited benefit was obtained from this activity.	

#	Provision	Assessment of Status	Compliance
		An observation by the monitoring was worthy of additional highlighting here. The monitoring team found the water safety assessment for Individual #350 that was completed at the time of her ISP was accidentally stapled to the back of the PSI. A newer water safety assessment was completed a month or two following the ISP. The monitoring team surmised that an active record review must have identified that the water safety assessment as missing, and as a result, a new one was completed by the IDT. This was an example of the good outcome that resulted from the attention that SGSSLC provided to the content of the active records. As noted in section M, however, additional attention needs to be paid to nursing entries in the IPNs, such as regarding signatures legibility, appropriate and legible abbreviations, and the way temperatures and oxygen saturations were written. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. Some unnecessary items were removed from the individual notebooks to make them lighter. <u>Other binders/logs</u>: A number of mealtime documents were kept separate from the individual notebook (diet record sheets, mealtime SAPs, intake/output records, and trigger data sheets). This was due to the mealtime procedures that were implemented in December 2013. 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. Overall, the master records were in good shape. The URC and her staff were working on thinning the master records to meet the minimum requirements. Up to this point, the master records contained all of the required documents (three of the five sections), but also many additional documents that were not necessary for most individuals (the other two of the five sections). The URC continued the useful procedure of noting, on the minimum document requirement list, the status of any missing documents and any activities engaged in to locate them.	

#	Provision	Assessment of Status	Compliance
		The birth certificate and social security card activity described in the last report continued. Their goal was to have originals of both. A sign out sheet was recently implemented to indicate if any master record was removed from the master record room. This seemed to be working well. <u>Shared drive</u> The shared drive status remained the same. That is, all information in the shared drive was also to appear in hard copy in the active record and/or individual notebook. One of the URC's tools directly assessed this (the All About Me comparison tool). <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	This provision was managed by the QA director. Some progress was noted, particularly in the inclusion of additional policies into the primary management document. For the most part, however, this provision remained in the same status as at the time of the previous review. The facility had a process for reviewing and approving new and updated policies. This continued since the time of previous reviews and was a reasonable system. A spreadsheet that was now eight pages long listed every state policy and corresponding facility-specific policies 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 related to facility training on these policies. Four other spreadsheets were submitted. They listed new or revised policies and their status related to training. The monitoring team could not figure out what these four spreadsheets were, how they related to the overall set of facility policies at SGSSLC and to each other, or how they were tracked and managed. Perhaps this can be clarified at the onsite review. 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. Complete all of the training and documentation activities now reported on in this spreadsheet.	Noncompliance

#	Provision	Assessment of Status	Compliance
		2. The facility now included an "as of" date. This was good to see. Some of the dates, however, were more than a year old. The facility should establish a criterion, such as these dates being updated every quarter. 3. 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.	The facility maintained substantial compliance with this provision and also made additional improvements to the quality assurance audit procedures. Five (or more) quality assurance reviews (audits) were conducted in each of the previous six months. In fact, the URC 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.) Thus, 54 audits were conducted in the previous six months. All of the reviews were done in a consistent manner, were reported to take about a half day to complete, and were neatly and clearly documented. Unified records chosen for audit allowed for one audit to occur per home secretary and for there to be no repeats of the same individual within a 24-month period. The review consisted of these parts: • The active record and individual notebook audit tool. It was lengthy, requiring the auditor to score every item on a variety of variables, all related to the table of contents, filing guidelines, and Appendix D of the Settlement Agreement. Many fields were prepopulated with n.a. for those that were not applicable. Thus, all of the open boxes on the form needed to be completed; there were more than 1,500, as noted in the previous report. The tool also contained six questions related to V4. • Checking for documentation of medical consultations for the past 12 months. • Assessing gaps in data entries on a variety of documents, such as observation notes, SAPs, PNMP logs, trigger sheets, dates, times, and signatures (this was a new addition). • Looking at the client injury reports and at the psychiatry department's scheduler to see if there were corresponding entries in the IPNs (this was a new addition). • Comparing what was in the active record with what was in the All About Me	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		electronic shared drive folder. The tool was updated to reflect the 365 day criterion for certain items. • 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 monitoring team recommends that the URC use the ISP to determine what SAPs should be in the active record and individual notebook. Inter-rater agreement reliability checks were occurring regularly over the past six months. Once each quarter, the QA program auditor chose one individual from the nine audits done that month to conduct an inter-rater agreement check. After doing so, the QA program auditor and the URC compared their results. Since the last review, as scheduled, there were two checks done. The ratings were 85% and 91%. The URC documented all of the differences and met with the QA auditor to review each one. Almost all of the discrepancies were items that the URC had rated as a no that the QA auditor had rated as a yes. The system of conducting the audit, listing all errors (which were called recommendations), emailing to the responsible person, following up on each error (for two months and with timed prompts), and documenting the V4 interview continued in the same manner as described in some detail in previous monitoring reports. This continued to be a very good system that was easy to understand. The URC summarized, analyzed, and reported on her data. She also engaged in actions to correct problems based upon her data and findings. Examples included addressing gaps in data collection, additional training for data entry, conducting additional training with specific disciplines or meeting with specific disciplines to discuss and problem solve (e.g., nursing), and doing more finely tuned follow-up on error correction. She actively participated in all QA program activities at SGSSLC. The URC summarized and tracked her data in three reports. One was a monthly audit recommendations database spreadsheet. The spreadsheet listed every recommendation and it included graphic summaries of that month's performance, such as number of recommendations and the number that were corrected. As the two months of follow-up proceeded, the number of recommendations increased to 100% (e.g., September 2013 report), as one would expect to see. A second report detailed the monthly recommendations related to document legibility, gaps, filing, etc. Graphic summaries were also provided. The third was her monthly QA report (described immediately below). This set of reports and presentations provided the URC, QA director, and facility	

#	Provision	Assessment of Status	Compliance
		management with a thorough and detailed description of the current, past, and trended performance of the facility in recordkeeping practices. The monthly QA report was now about 20 pages long and contained a variety of graphs and narrative. Much of it was trended across a 12- or 13-month period; with data also drilled down and separated by homes, skills, and disciplines; and with data that were directly related to relevant recordkeeping activities and the Settlement Agreement: • Master records: number of recommendations and the number of these that were for missing social security cards and birth certificates. The number of recommendations had steadily decreased over the past year, to zero for the past few months. • Percentage scores for the unified record audit tools, for the facility as a whole, and separated by home, by document presence (e.g., present, current), and by document completion (e.g., legibility). Scores were approximately 80 percent. This percentage was a combination of all of these variables. Thus, it could be possible to have zero documents missing, but score less than 100% if other variables were not met, such as legibility or data gaps. o The monitoring team recommends a graph showing the number of recommendations made per month trended across months. This can be pulled from the graph that shows the number of recommendations corrected. • Results of the peer audits (correspondence with All About Me electronic folder, and corrections of recommendations from recent audit). • Completion/correction of recommendations. Data showed near 100% correction. • Various data related to V4 (see below).	
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.	There are 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 continued to improve upon the way all six components were addressed, to document that these were being addressed, for their own review and for the monitoring team's review. The URC was very creative and thoughtful in coming up with specific activities, data, and criteria for each of the six areas of V4. Moreover, 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. The facility was in substantial compliance with three of the six items (50%). This was an	Noncompliance

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		improvement from the previous review when the facility was in substantial compliance with one of the six items. Moreover, for the three items not yet in substantial compliance, the facility and URC had made good progress, were close to substantial compliance, and were likely to achieve it by the time of the next review. In general, the URC had an initial set of ways to self-assess the status of this provision, however, V4 requires more than only self-assessing, that is, it also requires that facility "utilize such records in making care, medical treatment and training decisions." That is the next step, as detailed below. Below, the six areas of this provision item are presented, with some comments regarding SGSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> Each home had a record check-out/check-in clipboard. During direct observations in the home, the monitoring team examined these check out/in clipboards in 511A, 516E, 508A, and 512A and found numerous entries on the check out/in forms, and 100% of the active record volumes to be present in three of the four homes. In the one home, 508A, eight records were not present and seven of them were signed out correctly. <u>Each day</u>, each home secretary checked on all of the active record volumes on her caseload and scored if each one was present or not present. If not present, she also scored whether it was checked out correctly. The URC collected these data and graph trended the data across the past 11 months in her monthly QA report. She showed that the number of records that were not signed out correctly decreased over the course of the year. Moreover, she identified the homes in which occurred most often (e.g., 1 of the 17 homes) as well as showing that it did not occur at all in the past quarter for 12 of the 17 homes. Each day the campus administrators checked the presence and/or check-out of the records during the overnight. Their data was also graph trended for the past eight months. The graphs and narrative showed that no records were missing over the past month. Record accessibility during meetings is addressed in item #6 below. The monitoring team also observed that: • Records were accessible to medical staff. • Records were accessible to psychiatrists and available during psychiatry clinic. • Records were consistently available and accessible to nursing staff.	

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		• Records were available to the habilitation therapies clinicians and to the PNMT. • 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 <u>all</u> records reviewed. o The monitoring team commends the facility's efforts at ensuring that ISPs were accessible to all staff designated to implement the plan. • Individual notebooks were generally accessible and available to direct support professionals. When asked, DSPs reported that the individual notebooks were readily available to them. • 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. Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to be in substantial compliance. <u>2. Data are filed in the record timely and accurately</u> For 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). SGSSLC was assessing this during the monthly audits, that is, when the record clerks indicated whether a document was in the record, up to date, and in the right place. As noted above in V1, the monitoring team found that more than 90% of the documents were filed timely and accurately. The URC and secretaries also compared what was in the electronic shared drive (called the All About Me folder) with what was in the active record to determine if the most up to date version was present in the active record (typically the electronic folder held the most recent documents). This tool assessed nine different documents. She graph trended these data over the past nine months for the set of nine documents as well as for each of the nine documents separately. She found that approximately 90% of the documents matched. For any documents that did not match, the URC or secretary updated the active record to be correct. Each month, the secretaries were assigned one section of the active record to review for every individual on their caseload (e.g., psychiatry, pharmacy, ISP). She presented the data as number of documents reviewed versus number of documents accurately filed (e.g., present, current). She also drilled down to show detail within each section, such as	

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		initial psychiatry assessment versus psychiatry quarterly reviews. Moreover, she reported on whether each of these items in the section review were filed in a timely manner and separately if they were filed in an accurate manner (e.g., ISP, IHCP, IRRF, ISPAs). The secretaries contacted the responsible person for any documents that needed to be submitted, corrected, or updated. Each month, the secretaries were assigned a recent URC audit. For this audit, the home secretary was responsible for checking to see if every recommendation from the audit was corrected. If not, they did further follow-up. A document submission sheet continued to be used to record when documents were given to the recordkeeping department or to the secretary. The monitoring team also observed that: • Medical documents were filed in a timely and accurate manner. • Psychiatry documents were filed in a timely and accurate manner. • Nursing documents were filed in a timely and accurate manner, except for acute care plans, which were sometimes not located. However, the monitoring team could not determine if this was due to filing delays or failure of nursing to complete the plans. • Habilitation therapies documents were filed in a timely manner. Many of the IPNs were handwritten and completed at the time of the contact. In some cases a type written individual program plan with treatment progress notes, monthly summaries and discharge summaries were generally filed in the Habilitation tab, though some were also noted in the IPNs. • Data provided by the facility indicated that ISPs were not always filed within 30 days of the annual ISP date. As noted in section F2f, 23 of 33 (70%) ISPs were filed within 30 days of development. The facility reported a decrease in the timely filing of newly developed ISPs over the six month review period due changes in the QIDP department related to the appointment of three new ISP facilitators. This percentage was, therefore, likely to increase. Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to be in substantial compliance. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The URC looked to see if SAP data and observation notes in the active record were fully completed. She did this while conducting her nine audits and then she included the data	

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		in her QA reports and presentations. Errors in this were captured within the overall percentage scores during the audits. In addition, since the last review, she created and implemented a review called Gap Tracking. This looked at a much wider variety of documents to see if data were being recorded up to date and if completed data sheets had any missing spaces. A large number of documents were assessed: observation notes, SAPs, daily self care sheets, sleep charts, intake output sheets, trigger sheets, diet records, and PNMP logs. She graph trended these data over the past five months and separated the data per shift, type of gap (date, time, signature), type of document, and home. Based on the data and because this was a new tool that provided a new type of feedback to managers, she met with managers, did additional training, and implemented a competency test for all staff. • In addition to assessing a set of completed data sheets, she also checked the set of data sheets at the time she did each of the audits. This was also very good to see being done. The monitoring team also found that: • Various documents were directly observed by the monitoring team in a number of homes and day programs. Current SAPs and other data sheets were being completed in a timely manner. • Some nursing related documentation was not consistently documented timely on the record, such as Neurological Checklists and Aspiration Data Sheets contained omissions (blanks) for daily monitoring. • Only 44% of behavior data cards directly observed by the monitoring team were recorded in a timely manner, that is, within the previous hour. o Interestingly, the facility's own data (managed by the behavioral health services department) were 93% in June, 100% in July, 88%, 90% in August, 90% in September, 89% in October, and 82% in November 2013. o The monitoring team suggests that the difference in these numbers be explored by the URC and director of behavioral services. The monitoring team rated this item to not be in substantial compliance based upon the above monitoring team findings and observations. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The URC was awaiting guidance from state office regarding criteria for IPNs. Then she planned to create a process for training and monitoring IPN quality.	

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		Even so, she implemented a process to assess two aspects of the IPNs as it related to this item of V4. That is, for the nine monthly audits, she looked at injury reports and then looked to see if the IPNs contained corresponding entries, and she also looked at the psychiatry department's schedule and then looked to see if the IPNs contained corresponding entries for those psychiatry activities. • She reported on her findings in her QA report and found low percentage of corresponding entries. This led to discussion at QI Council in January 2014 with follow-up planned and implementation of a CAP if not improved. In addition, the monitoring team observed that: • Most IPN entries included adequate information while others consistently lacked the required documentation. For those that lacked the required documentation, vital signs, and pertinent positive and negative findings were consistently not documented. • The IPNs did not include information that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries and prior assessments or medications pertinent to the acute illness or injury as part of their evaluation and/or when they made care, treatment, and training decisions. • There was clear review of the active record in the PNMT, OT/PT and SLP assessments. This was a new measure and showed good effort and creativity by the URC, however, the monitoring team rated this item to be in noncompliance because of the above monitoring team observations and because of the facility's own review (of two types of IPN entries) that indicated poor performance. Based upon the facility and the URC's performance over the past year, however, the monitoring team believes this will be addressed and improved over the next six months. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The URC continued to implement 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. In addition, since the last onsite review, she created and implemented a five-item competency quiz for all new employees as part of NEO. She reported her findings in her	

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		QA report. Overall, all documentation was done correctly, except for signatures on the sample observation note. Feedback was immediately provided to these new employees. She even more recently began to implement this competency quiz with tenured staff. It had been done in one home (516W). She reported her findings that indicated frequent signature errors on a number of different forms. The URC pulled data from the daily Administrator on Duty staff interview tool. Some of the items were recordkeeping-related. Overall, the scores were high. In addition, the monitoring team observed that: • A random sample of 13 nurses were asked about how they used the individuals' record to make care, treatment, or training decisions. They reported that during their quarterly and annual assessments and during the completion of audit/monitoring tools they reviewed the individuals' records, and made decisions regarding whether or not individuals received care in accordance with Nursing Protocols, ACPs, IHCPs, and Health Care Guidelines. o However, this was not found, as most entries for acute illness and injury did not contain pertinent information in accordance with Nursing Protocols (see section M). Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to not be 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 drew data from the section F ISP monitoring tool. It included items regarding presence of the active record and individual notebook and whether they were utilized if needed. She graph trended these data over the past year and found high scores. She also found high scores of the records being used during most every ISP meeting. Since the last review, the URC pursued assessing record presence at other meetings. She reported that PNMT members were willing to report on this, but stated that it was never	

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		a problem. Therefore, recording data at PNMT meeting was not necessary. At the time of this review, the URC was working with the HRC and Transition Committee to come up with a way to easily record this information. The monitoring team found the following: • The QIDP provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #331 and Individual #354. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. • Two pre-ISP meetings were observed. The QIDP used information in the unified record to update IDT members, to determine which assessments were needed prior to the annual meeting, and to review progress towards outcomes. • Active records were used during the PNMT meeting; the physician and others were able to document at the time, as needed. Extensive review of records was conducted by each team member prior to the meetings and details were reported and added to the meeting minutes. • Active records were used during pneumonia review. • During psychiatry clinics, the monitoring team observed use of the unified record to make treatment decisions for most, but not all, of the sessions because sometimes the most current data were not brought to the clinic by staff. • The active record and individual notebook was present and used at the transition committee meeting for Individual #140 and 108. • The active record and individual notebook was present and used at the CLDP meeting for Individual #194. • The monitoring team did not observe any instances during which inaccurate information was presented and not corrected. Further, the monitoring team observed that data and other information from the record was used in meetings rather than relying on impressions. Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to be in substantial compliance.	

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
ACB	Anti Cholinergic Burden
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ACS	Assessment of Current Status
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
ART	Administrative Review Team
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
CMD	Choking, Modified Barium Swallow Study, and Dysphagia Committee
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
COS	Change of Status
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
DDI	Drug Drug Interaction
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)
EBWR	Estimated Body Weight Range
EC	Enteric Coated
EC	Environmental Control
ECG	Electrocardiogram
ED	Emergency Department
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
GA	General Anesthesia
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
H&P	History and Physical
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HCV	Hepatitis C Virus
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
IRT	Incident Review Team
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology

ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
JNC	Joint National Committee
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
LTBI	Latent TB Infection
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
MCC	Medical Compliance Coordinator
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
MIT	Mealtime Improvement Team
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
MTC	Meal Time Coordinator
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 Instructions
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
PMR	Protective Mechanical Restraint
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
RPN	Risk Priority Number
RPO	Review of Physician Orders
RPO	Rights Protection Officer
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
TLSO	Thoracic Lumbar Sacral Orthotic
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
VP	Ventriculoperitoneal
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
VZV	Varicella Zoster Virus
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