United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: August 18-22, 2014

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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, again did an outstanding job, before, during, and after the onsite review. She ensured that the monitoring team received documents, and she assisted with scheduling. Moreover, she had extensive knowledge of the facility and an excellent collaborative working relationship with the QA department.

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

- The facility met substantial compliance with five of the eight provisions of section C. There were 454 restraints used for crisis intervention involving 65 individuals between 2/14/13 and 7/31/14. Individual #329 accounted for 111 of the 454 (24%) restraints used for crisis intervention. Eleven individuals at the facility had 10 or more restraints during the past six months and another 45 individuals had three or less restraints. Concerns regarding the high number of chemical restraint administered for crisis intervention over the past six months (110) are addressed in further detail in section J of this report.
- A log of all dental/medical restraints provided by the facility included 46 instances of dental/medical restraint for routine medical care typically provided without sedation from 2/1/14 through 6/31/14. This did not include mechanical restraints used to promote healing.
- The facility reported that two individuals at the facility wore protective mechanical restraints (PMRs) for SIB. The facility was reviewing those restraints and had developed protective mechanical restraint plans.
- Ensuring that individuals who were restrained were monitored by health care professionals continued to be a challenge for the facility.
- Analysis of behavioral incidents at the facility still focused on the individual's failure to comply with facility rules and programming, rather than on the facility's failure to provide adequate supports and training opportunities.

Abuse, Neglect, and Incident Management

- Of 739 allegations investigated by DFPS between 12/1/13 and 5/31/14, there were 12 confirmed cases of physical abuse, one confirmed case of verbal/emotional abuse, and eight confirmed cases of neglect. The facility reported that 70 other serious incidents were investigated by the facility during this period.
- There were 2190 injuries reported between 12/1/13 and 5/31/14 that included 13 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and were made available to IDTs for planning.
- Investigations continued to be thorough and were completed expediently. While the incident management and QA departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation of action steps following incidents.
- The facility was tracking the initial implementation of recommendations, however, the incident management department still needs to develop a system for tracking the outcome of recommendations. Action steps need to be written in measurable terms so that the efficacy of supports and interventions to prevent similar incidents can be evaluated.
- The monitoring team found the facility to be in substantial compliance with 20 of 22 provisions of section D.

Quality Assurance

- The QA program at SGSSLC continued to improve, such that a solid QA infrastructure existed at the facility. This was due to the work of the facility's QA director, Mike Fletcher, and the SAC, Misty Mendez. The QA program at SGSSLC remained vibrant and flexible. QA activities were a regular part of facility operations.
- Of the 22 inventories, 22 (100%) included data that could be used to identify trends as required in the wording of section E1; 22 (100%) included a wide range of data; 22 (100%) included what appeared to be key indicators; and 22 (100%) described the data being collected. The recently initiated process of reviewing each provision item of the Settlement Agreement to ensure that adequate indicators are identified and data are being collected was an excellent next step to ensure that the data list inventory (and thereby the QA matrix) were complete.
- 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.
- 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. Of the 31 components of the QA plan narrative (7) and QA plan matrix (24), the facility implemented 31 (100%).
- A facility QA report was created for six of the last six months (100%). Of the 5 sampled sections of the Settlement Agreement (F, J, P, Q, T) that were presented quarterly (April 2014, July 2014), 1 of 10 (10%) presentations (section T, August 2014) contained all of the components listed in section E2, (e.g., analysis of data).
- The CAPs program was again re-booted and, therefore, was not yet at substantial compliance. There were 4 open CAPs. Two (50%) appeared to appropriately address the specific problem for which they were created. 4 of the 4 (100%) had measurable criteria.

Integrated Protections, Services, Treatment, and Support

- The facility had made some progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Annual ISP meetings observed were lengthy and did not result in a plan that would ensure meaningful programming and supports. There was little discussion at meetings regarding how the individual spent a majority of his or her day or how the team would ensure that they were involved in meaningful activities.
- The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual.
- The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy.

Integrated Clinical Services

- The facility developed the Integrated Clinical Services Governing Body to establish guidelines and provide oversight of integrated clinical services and ensure consistent and coordinated healthcare to optimize outcomes for individuals served. The ICSGB developed a series of tools designed with the intent of measuring integration.
- The monitoring team heard numerous accounts of the ICSGB activities throughout the week of the compliance review. Many, such as review of clinical policies and procedures by the facility's clinical leaders, would appear to have a positive impact on the operations of the facility. However, it became apparent during the week of the compliance review that issues related to clinical integration that should have been brought to the ICSGB were not.
- The facility implemented a new IPN template for documentation of consults. This template was implemented for only a relatively short period at the time of the compliance review. The facility conducted audits, but the audits did not fully address the requirements of the Settlement Agreement and state policy.

Minimum Common Elements of Clinical Care

- There was very little progress seen and that was not unexpected given the series of transitions that occurred over the past 10 months. 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. In July 2014, a new medical director assumed the lead for this provision.
- The facility continued to monitor the timeliness of assessments, but no efforts were seen in evaluating the quality of assessments. While audits were conducted for provision H2, the medical director and medical compliance nurse acknowledged that no work had been done in the other areas.

At-Risk Individuals

- Since the last review, the facility had implemented a number of procedures to address risks including:
    - A PIT was completed to address the timeliness and quality of assessments. Standardized assessment templates were developed for each department.
    - A compliance RN was hired to provide oversight to ensure that departments were capturing risk elements.
    - The facility began focusing on the monthly review of IHCP outcomes.
- The monitoring team observed the risk identification process at ISP meetings. Each discipline presented relevant information included in the IRRF during the risk determination process. IDTs were engaging in a much more integrated discussion regarding risk ratings and the development of action steps to address risks.
- Teams were not 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.

Psychiatric Care and Services

- SGSSLC was found to be in substantial compliance with one provision (J1). 80% of the facility population, or 169 individuals, were receiving services via psychiatry clinic.
- There were improvements in the timeliness of quarterly psychiatric medication reviews. This was apparently related to the development of a psychiatric clinic that was structured and scheduled. A laudable accomplishment for the facility psychiatry clinic staff.
- The monitoring team observed three psychiatric clinics. It included representatives from multiple disciplines. Psychiatrist attendance at ISP meetings improved in the latter months with 100% attendance noted in May 2014.
- Only 54% 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.
- SGSSLC had instituted a monthly polypharmacy meeting, however, while the clinical pharmacist now chaired this meeting, there was not a facility level review of specific regimens. In addition, the psychiatric providers had not begun authoring clinical polypharmacy justifications for review.

Psychological Care and Services

- The facility maintained substantial compliance on seven items (K2, K3, K5, K7, K8, K9, and K11). Additional improvements since the last review included the addition of two board certified behavior analysts, and establishment of minimal frequencies of data timeliness, interobserver agreement (IOA), and treatment integrity. There was improvement in consistent data-based treatment decisions, and in the demonstration that some activity occurred when an individual was not making anticipated progress.
- SGSSLC should focus on ensuring that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. The facility also needs to ensure that replacement/alternative behaviors are recorded and reinforced when they occur outside of formal training sessions (e.g., skill acquisition plans) for all individuals with PBSPs.

Medical Care

- Generally, individuals received basic medical care. There was documentation that annual assessments were completed along with routine annual labs and screenings. Cancer screenings needed improvement. The documentation for those individuals excluded was not adequate.
- There were many issues related to the medical care provided to individuals with more complicated medical issues. Laboratory monitoring for drug use needed improvement. EKGs were noted to be delinquent and some abnormal EKGs were not ever read by a cardiologist.

- Physician documentation of follow-up assessments for acute medical conditions remained poor. Most records lacked documentation of resolution of acute medical issues.
- Pneumonia management remained challenging. The Pneumonia Review Committee met monthly, but this process was not as effective as it needed to be.
- Mortality reviews continued to lack an objective physician review. The medical department conducted two medical QA meetings, but no framework for a medical quality program had been established nor was there a formal medical quality committee. The meetings conducted lacked the appropriate participants and content.
- A new medical director was appointed in July 2014 to replace the prior director who resigned. There was also a new compliance nurse. As would be expected, changes in these key positions made progress in several areas of the Settlement Agreement difficult.

Nursing Care

- The monitoring team found substantial compliance with section M6. A new CNE was appointed since the last onsite review. There were changes in other nursing leadership positions, too.
- The Nursing Department began conducting real-time monitoring in April 2014. Nurse Educator had made changes in the structure of didactic, and bedside competencies.
- Nursing assessments and the development or lack of development of sufficient plans of care in response to the individual's needs, appeared to be hampered by the significant turnover of nursing positions.
- The Hospital Liaison, in collaboration with the Medical Director, continued to facilitate positive partnerships with the health care community, including hospice and the hospital. Current hospital information was consistently provided via visits and remote access to "live" records.
- The facility had an active and responsive Skin Integrity Committee that was collaborative in the development of policies and in educational preventive strategies to minimize pressure ulcers.
- Infection control continued its positive practices of hand hygiene campaigns, and revision of policies. Infection control implemented and followed nationally recognize standardized established Surveillance Definitions of Infections (McGeer) in June 2014.

Pharmacy Services and Safe Medication Practices

- The pharmacy department made limited progress in two areas of this provision. The overall lack of progress did not appear to be due to a lack of effort. In fact, there was evidence that a great deal of work had been done, however, the SGSSLC pharmacy department had significant deficits as a result of years of poor practices and a lack of attention to many aspects of the Settlement Agreement.
- Progress was seen in the documentation of communication between prescribers and pharmacists. Nonetheless, the single interventions failed to document resolution of identified problems for a good number of documented

interventions. However, serious concerns about physician order writing remained. Medications were written when allergies were documented and orders were written for wrong dosages. Thus, the value of the Intelligent Alerts was not clear.

- Only 27% of individuals had a current QDRR. This was lower than the 30% seen during the last compliance review. Moreover, there was a decline in the quality of the content of the evaluations.
- The MOSES and DISCUS evaluations were completed by nursing, but problems persisted with the prescriber review. ADRs were under-reported. The facility continued to report medication variances. The overall number of variances was decreasing. Medical variances were increasing due to better reporting, but there was no evidence to support that medical had taken appropriate corrective actions and addressed the providers who continued to have troubling prescribing practices.
- While a series of changes were made with regards to pharmacy practices, those changes did not translate into positive outcomes for the department. In many instances, major changes were made in processes, but the changes were not codified in policy and procedure.

Physical and Nutritional Management

- Gains were made across all sections due to the efforts of a consistent and steady leadership. There was a full complement of PNMT members. They continued to refine their processes and documentation.
- There were definite improvements noted in the dining rooms. The environments, overall, appeared to be calmer, quieter, and more organized. For the most part, individual dining plans were followed. Mealtime Coordinators were present.
- Positioning was also improved. The system of staff training was excellent (O.5), but was not adequately implemented for pulled staff, which impacted performance and competency (O.4). Pulled staff did not know the individuals risks, had not read their plans and did not implement plans as written, in some cases.

Physical and Occupational Therapy

- OT/PT assessments continued to improve and substantial compliance with P.1 was maintained. The essential elements section should be carefully reviewed so that content of some elements can be further refined.
- Further integration of OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA.
- The therapists, as well as all IDT members, must participate in the pre-ISP process to present an overview of the effectiveness of existing supports and to generate specific questions that must be answered through assessment in collaboration with other IDT members, permitting them to come back to the table at the ISP with specific information that permits the t

- It was disappointing that the Life Skills program had not follow the functional direction that was originally identified. There was limited variety of meaningful activities and no apparent carry over into the context of the daily routine.

Dental Services

- The dental clinic continued to make progress in several areas: (1) compliance with timely completion of annual assessments increased to greater than 90%, (2) oral hygiene ratings continued to improve, and (3) radiograph compliance continued to increase.
- Notwithstanding these improvements,
- SGSSLC did not have any arrangements to provide services for individuals who needed general dentistry procedures utilizing anesthesia/sedation, but who were determined to not be suitable for treatment with TIVA on campus.
- The frequency of dental assessments was based on the oral health of the individual. Individuals with poor oral hygiene were seen more often and were enrolled in the weekly suction toothbrushing program.
- Behavioral rehearsal plans were developed for individuals with a history of refusal, but the programs were not effectively implemented.
- During the week of the compliance review, the dental clinic was not able to provide routine care. The full time RDH and dental assistant positions were both vacant and the part-time hygienist was on leave.

Communication

- While the clinicians continued to be successful in the development of communication supports, the continued delay in completion of communication assessments relative to the ISP must be improved. The assessments completed attained a high level of excellence and consistency across clinicians.
- There were a fair number of communication systems in place, though integration of communication supports was not consistently integrated into the ISPs.
- Consistency of documentation of direct supports and review of indirect supports was needed.
- Effectiveness monitoring should reflect a review of all communication supports and SAPs at least on a quarterly basis, but instead appeared to focus primarily on the PNMP.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were several improvements since the last review. These included improvement in the quality of skill acquisition programs, the addition of SAM/HIP to the new SAP format, and a new monitoring tool to improve SAP documentation. There was also a improvement in the percentage of community trips that include a SAP training opportunity.
- Over the next six months, the facility should improve SAPs so that instructions following an incorrect response are specific and tailored to individual, data are accurately recorded, SAP objectives and SAP data sheets are consistent, task analyses are consistently complete. And training instructions are consistently clear.

Most Integrated Setting Practices

- The facility made progress in many areas of section T, however, a high rate of returns and behavior problems in the community continued to occur.
- The number of individuals placed was at an annual rate of about 13%; 14 individuals were placed since the last onsite review. Sixteen individuals were on the active referral list.
- During annual ISP meetings, the verbal presentation by each IDT member of his or her determination and opinion about community living and referral helped set the stage for a more robust living options discussion than would have otherwise likely occurred.
- There were problems with the availability of providers competent to support individuals with challenging psychiatric and behavior problems in many geographic areas of the state. In some geographic areas, there were very few providers at all, and those that were available were not competent to support the types of individuals who were on the referral list. As a result, IDTs (and LARs) made poor choices and individuals suffered (e.g., psychiatric hospitalization, return to the facility).
- CLDPs were initiated within 14 calendar days of referral and included documentation to show that they were updated throughout the transition planning process. IDT members actively participated in the transition planning process.
- Most CLDPs did not contain all of the supports needed by the individuals.
- There were 4 re-admissions. There were now 22 returns since monitoring began in 2010. At least three other individuals continued to display serious problem behaviors that made it likely they would also return to the facility.
- The monitoring team's review identified a number of variables that should be explored further, such as the occurrence of behavior problems in the first week of placement, housemate problems, cigarette and tobacco issues, lack of spending money, absence of crisis intervention plans, and many problems with psychiatric services and medication management/changes in the community.
- Post move monitoring occurred as required, however, the occurrences of behavior problems within the first week of moving (i.e., identified at the 7-day reviews) were not acted upon.

Guardianship and Consent

- The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions and develop training to address any barriers to making decisions when possible.
- Guardianship had been obtained for 10 individuals.
- The HRO continued to explore community resources for guardianship, such as meeting with local attorneys to discuss barriers to pursuing guardianship.

Recordkeeping Practices

- SGSSLC maintained performance in recordkeeping practices, and maintained substantial compliance with provisions V1 and V3. Given leadership changes in the last six months, the monitoring team was pleased that the facility was able to maintain the recordkeeping practices observed at the last onsite review.
- Eleven of 11 (100%) individuals' 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. Individual notebooks continued to be used for all individuals and as per state policies.
- Quality assurance procedures (audits) continued in the same manner as during the last review. Five (or more) were conducted in five of the previous six months. The URC summarized, analyzed, and reported on her data. She actively participated in all QA program activities at SGSSLC.
- The facility was in substantial compliance with four of the six items (67%) in V4.
- Provision V2 information had not been updated since the last review.

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>:

- DADS Policy: Use of Restraints #001.2
- SGSSLC Self-Assessment
- SGSSLC Provision Action Information Log
- SGSSLC Section C Presentation Book
- Restraint Trend Analysis Reports for the past two quarters
- Section C QA Reports for the past two quarters
- Sample of IMRT Minutes from the past six months
- Restraint Reduction Committee minutes for the past six months
- List of all restraint monitors and date training was completed
- List of all restraint by individual in the past six months
- List of all chemical restraints used for the past six months
- List of all medical restraints used for the past six months
- List of all restraints used for crisis intervention for the past six months
- List of all mechanical restraints for the past six months
- List of all individual that were restrained off the grounds of the facility
- List of all injuries that occurred during restraint
- SGSSLC "Do Not Restrain" justification
- List of individuals with crisis intervention plans
- List of individuals with desensitization plans
- Sample #C.1: 18 records of physical or chemical restraint used in a crisis intervention for eight 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>#209</td><td>Physical</td><td>5/27/14 @ 6:23 am</td></tr>
<tr><td>#209</td><td>Physical</td><td>4/25/14 @ 9:50 pm</td></tr>
<tr><td>#209</td><td>Physical</td><td>4/24/14 @ 9:15 am</td></tr>
<tr><td>#329</td><td>Chemical</td><td>5/28/13 @ 3:57 pm</td></tr>
<tr><td>#329</td><td>Physical</td><td>5/8/14 @ 9:13 am</td></tr>
<tr><td>#329</td><td>Physical</td><td>5/8/14 @ 8:58 am</td></tr>
<tr><td>#329</td><td>Physical</td><td>5/7/14 @ 6:50 pm</td></tr>
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#156	Chemical	5/30/14 @ 1:35 am
#156	Physical	5/26/14 @ 11:50 pm
#156	Physical	5/26/14 @ 11:00 pm
#156	Physical	5/26/14 @ 10:45 pm
#37	Physical	5/27/14 @ 1:22 pm
#37	Physical	5/29/14 @ 3:25 pm
#215	Physical	5/26/14 @ 4:44 pm
#235	Physical	5/29/14 @ 1:45 pm
#145	Chemical	5/31/14 @ 10:00 am
#145	Chemical	5/21/14 @ 6:36 pm
#201	Physical	5/2/14 @ 10:33 am

- Sample #C.2:
  The following 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,
    - training on use of restraints, and
    - training on abuse/neglect/exploitation, and
  - the signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

- 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, 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. Documentation for four other individuals was submitted for this sample, however, it was determined that sedation was used for treatment not considered routinely completely without sedation.

Individual	Restraint type
#59	5/14/14
#59	5/7/14
#201	5/13/14
#201	5/5/14
#216	5/28/14 (x2)

- Sample #C.4 (a subsample of #C.1) chosen from document II.5a . The total number of chemical restraints for crisis intervention was 110, involving 26 individuals. Records requested included the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For

the following:

Individual	Date
#329	5/28/14
#156	5/30/14
#235	5/29/14
#145	5/21/14
#145	5/31/14

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

Individual	Date
#201	5/2/14

- Sample #C.6: Positive Behavior Support Plans (PBSPs), Crisis Intervention Plans, and relevant ISPA meeting minutes for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:

- 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

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
- Jalown McCleery, Incident Management Coordinator
- Vanessa Barrientez, QIDP Coordinator
- Roy Smith, Human Rights Officer

Observations Conducted:
- Observations at residences and day programs
- Incident Management Review Team Meeting 8/19/14 and 8/21/14
- ISP preparation meeting for Individual #118
- Annual IDT Meeting for Individual #130 and Individual #57
- Human Rights Committee Meeting
- Executive Safety Committee Meeting

	• 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 from 12/1/13 through 5/31/14 (419), 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, measurable actions steps were developed to address those items. The facility assigned a self-rating of substantial compliance to C1, C2, C3, C6, and C7. The monitoring team found substantial compliance with C1, C2, C3, C7, and C8.
	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 454 restraints used for crisis intervention involving 65 individuals between 2/14/13 and 7/31/14. The number of restraint incidents had increased since the last onsite review when it was reported that there had been 306 restraints during the review period. In part, this increase was attributed to a reduction in medication for many individuals at the facility. Individual #329 accounted for 111 of the 454 (24%) restraints used for crisis intervention. Eleven individuals at the facility had 10 or more restraints during the past six months and another 45 individuals had three or less restraints. Concerns regarding the high number of chemical restraint administered for crisis intervention over the past six months (110) are addressed in further detail in section J of this report. A log of all dental/medical restraints provided by the facility included 46 instances of dental/medical restraint for routine medical care typically provided without sedation from 2/1/14 through 6/31/14. This did not include mechanical restraints used to promote healing. The facility reported that two individuals at the facility wore protective mechanical restraints (PMRs) for SIB. The facility was reviewing those restraints and had developed protective mechanical restraint plans. 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.

	The facility continued to document and review restraints consistent with requirements of the Settlement Agreement. Ensuring that individuals restrained were monitored by health care professionals continued to be a challenge for the facility. As noted in the previous report, it was still 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. Analysis of behavioral incidents at the facility still focused on the individual's failure to comply with facility rules and programming, rather than on the facility's failure to provide adequate supports and training opportunities. Action taken by the facility since the last review included: • Nursing Unit Managers had begun reviewing restraints to look for timeliness of the nursing assessment. • Monthly meetings were being held with dental staff to review treatment strategies related to pretreatment sedation and refusals to attend appointments. • Documentation completed by restraint monitors had been revised to capture additional information regarding the circumstances of restraint. • The Use of Restraint Policy had been updated to comply with the new state policy regarding restraint. 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. • Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines. • Ensure that appropriate consents are procured prior to medical/dental pretreatment sedation.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or	According to a list of all restraints implemented at the facility (Document II.5),	Substantial Compliance

Type of Restraint	August 2013-January 2014	February 2014-July 2014
Personal restraints (physical holds) during a behavioral crisis	234	344
Chemical restraints during a behavioral crisis	72	110
Mechanical restraints during a behavioral crisis	0	0
TOTAL restraints used in behavioral crisis	306	454

#	Provision	Assessment of Status	Compliance
	considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	(see nested table and text below)	

TOTAL individuals restrained in behavioral crisis	60	65
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	19	25
Medical/dental pretreatment restraints	56	46
TOTAL individuals restrained for medical/dental treatment	28	27
Protective mechanical restraints	2 individuals	2 individuals

Prone Restraint

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

b. Based on review of other documentation (list of all restraints between 2/1/14 and 7/20/14) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 2/1/14 and 7/30/14. Sample #C.1 was a sample of 18 restraints for eight individuals, representing 4% of restraint records over the last six-month period and 12% of the individuals involved in restraints. The sample included 13 physical restraints and five chemical restraint. Sample #C.1 included the four 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 18 of the 18 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others.

#	Provision	Assessment of Status	Compliance
		• g. For the 18 restraint records involving restraint for crisis intervention, a review of the descriptions of the events leading to behavior that resulted in restraint found that 18 (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 18 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. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 18 restraints, involving eight individuals, 18 (100%) were approved restraints. k. In 16 of 18 of these records (89%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Individual #145 did not have a current ISP, therefore, it was not possible to determine if an adequate plan was in place to address the behavior leading to restraint. l. The facility reported that there were two individuals subjected to restraints classified as protective mechanical restraints (PMRs). The behavioral health services department had developed Protective Mechanical Restraint Plans (PMRPs) for those restraints used to address SIB. PMRPs included a schedule of release, monitoring guidelines, and strategies for decreasing the use of the restraint. Sample C.7, a sample of documentation for two protective mechanical restraints (PMR), was reviewed. Of these, two (100%) followed state policy regarding the use, management, and documentation of PMR. The facility was in substantial compliance with the requirements of C1.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 13 physical restraint records involving the five individuals in Sample #C.1 were reviewed. Five 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 #209, Individual #329, Individual #156, Individual #37, and Individual #215), eight of 12 (75%) 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 four that were not released according to criteria escaped	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		from the restraint. b. For the individual who did not have Crisis Intervention Plans (Individual #201), one of one (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.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. A sample of 10 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: • 10 of the 10 (100%) had current training in RES0105 Restraint Prevention and Rules. • Six of the six (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training • 10 of the 10 (100%) had completed PMAB training within the past 12 months. • Six of the six (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. d. In 18 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. (see C.1.h)	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	a. Based on a review of 18 restraint records (Sample #C.1), in 18 (100%) there was evidence that documented that restraint was used as a crisis intervention. 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, all (100%) were used for crisis intervention (not programmatic restraint). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention, except for protective mechanical restraints for SIB. d. In 18 of 18 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. e. In 18 of 18 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the facility to document restraint considerations/restrictions. f. In 16 of 18 restraint records reviewed in Sample #C.1 (89%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. Individual #145 did not have a current ISP, therefore, it was not possible to determine if an adequate plan was in place to address the behavior leading to restraint. 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 of six (0%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent. • h. Four of six (67%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. • i. Four of six (67%) 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 show that the HRC has approved all medical/dental restraints prior to implementation.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C5</td><td>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.</td><td>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. Restraint Monitor training included training specific to monitoring of a restraint incident. According to a list provided by the facility, however, all restraint monitors had been deemed competent to monitor restraints.

c. Based on review of document request II.19, for staff that performed the duties of a restraint monitor for restraints in the sample, 18 (100%) successfully completed the training currently provided by the facility to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint.

Based on a review of restraint records (Sample #C.1), a face-to-face assessment was conducted:
d. In 18 out of 18 incidents of restraint (100%) by an adequately trained staff member. Competency based training had not yet been provided for restraint monitors.
e. In 17 out of 18 instances (94%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The exception was for Individual #156 dated 5/30/14.
f. In 18 instances (100%), the documentation showed that an assessment was completed of the application of the restraint.
g. In 18 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint.
A sample was not reviewed of PMR restraint records for which physicians had ordered alternative monitoring schedules was reviewed. (None reported)
h. In (n/a) the extraordinary circumstances necessitating the alternative monitoring were documented; and
i. In (n/a), the alternative monitoring schedules were followed.
Based on a review of 18 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 11 (61%) of the instance of restraint. Exceptions were:
Individual #209 on 5/27/14
Individual #209 on 4/25/13
Individual #329 on 5/7/14
Individual #156 on 5/26/14 (x3)
Individual #37 on 5/27/14</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• k. Monitored and documented vital signs in 18 (100%). • l. Monitored and documented mental status in 18 (100%). Based on documentation provided by the facility, three restraint incidents had occurred off the grounds of the facility in the last six months. A sample of one restraint incident was reviewed (sample #C.5). • m. Conducted monitoring within 30 minutes of the individual's return to the facility in one out of one (100%). • n. Monitored and documented vital signs in one (100%). • o. Monitored and documented mental status in one (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, • p. In six out of six (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 four out of six of the medical restraints (67%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Exceptions were: • Individual #59 on 5/14/14 and 5/7/14 – monitoring did not occur 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: 1. A licensed healthcare professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint. It is also recommended that the facility provide additional competency based training to all restraint monitors on the requirements of monitoring and reviewing restraints.	
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	A sample (Sample #C.1) of 18 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 18 (100%), continuous one-to-one supervision was provided; • b. In 18 (100%), the date and time restraint was begun; • c. In 18 (100%), the location of the restraint;	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	• d. In 18 (100%) of the crisis intervention restraints in the sample, 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 18 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8.
		• f. In 18 (100%), the specific reasons for the use of the restraint;
		• g. In 18 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint;
		• h. In 18 (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:
		    ○ i. In 18 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest physical restraint in the sample was 14 minutes.
		    ○ j. In n/a (%) of those restraints that lasted more than 15 minutes (there were none), the specific behaviors of the individual that required continuing restraint;
		    ○ k. In n/a (%), the care provided by staff during restraint lasting more than 30 minutes (there were none), 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 18 (100%), the level of supervision provided during the restraint episode;
		• m. In 13 of 13 physical restraints (100%), the date and time the individual was released from restraint; and
		• n. In 17 (94%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. The exception was for Individual #145 on 5/31/14
		
		o. In a sample of 18 records (Sample #C.1), restraint debriefing forms had been completed for 18 (100%).
		
		p. A sample of individuals subject to pretreatment sedation for medical treatment was reviewed (Sample #C.3), and in four of six instances (67%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. Exceptions were:
		• Individual #59 on 5/14/14 and 5/7/14 – monitoring did not occur with the frequency ordered by the physician.
		
		Sample #C.4 was a subsample of the five chemical restraints included in Sample #C.1.	

#	Provision	Assessment of Status	Compliance
		q. In five (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the facility was not in substantial compliance. Monitoring of pretreatment sedation restraints was not documented consistent with state policy requirements.	
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 21 individuals were placed in restraint more than three times in a rolling 30-day period. This was an increase compared to the last review when 15 individuals were placed in restraint more than three times in a rolling 30-day period. Six of these individuals (i.e., Individual #329, Individual #48, Individual #277, Individual #209, Individual #246, and Individual #100) were reviewed (29%) 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 six individuals. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item continued to be 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 six (100%) individual's adaptive skills and biological, medical, and psychosocial factors, and actions to address those factors. For example, Individual #329's ISPA reflected a discussion that she was reporting knee pain that likely contributed to her dangerous behaviors that provoked restraint. Additionally, the ISPA indicated that she was referred to a physician to attempt to reduce her pain. In order to maintain substantial compliance with this provision item, the minutes from at least 85% of the individual ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	This item continued to be rated to be in substantial compliance because the minutes from all six (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 #277'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 continued to be rated as being in substantial compliance because the minutes from all six (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 #246's ISPA meeting minutes indicated that the treatment team hypothesized that not being able to speak to her mother by phone was an antecedent to physical aggression, which sometimes resulted in restraint. In order to address this potential antecedent to restraint, the treatment team met with Individual #246's mother and developed a schedule of times that Individual #246's mother would be available to talk her daughter by phone. 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 continued to be rated in substantial compliance because the minutes from all six (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 #100's ISPA meeting minutes discussed that the team hypothesized that he often engaged in self-injurious behavior because he was not immediately provided the staff attention or desired item he was seeking. The ISPA minutes also indicated that his treatment team developed a skill acquisition program designed to teach Individual #100 to learn to wait	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		for desired items/events. 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;	There have been improvements in this item since the last review. Therefore it is now rated as substantial compliance. All six individuals reviewed (100%) had a PBSP to address the behaviors provoking restraint. The following was found: • All six 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 six (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 six of the PBSPs reviewed (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint, and • All six of the PBSPs reviewed (100%) contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results. All six individuals reviewed (100%) had a crisis intervention plan. The following was found: • For all six crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • For all six crisis intervention plans reviewed (100%), the maximum duration of restraint authorized was specified, • For all six crisis intervention plans reviewed (100%), the designated approved restraint situation was specified, and • For all six the crisis intervention plans reviewed (100%), the criteria for terminating the use of the restraint were specified. In order to maintain 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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	There have been improvements in this item since the last review. Therefore, it is now rated as substantial compliance. For all six individuals reviewed (100%) 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 #246's 4/16/14 ISPA indicated that her last treatment integrity assessment indicated that her PBSP was not implemented with a high level of integrity (i.e., 70%). The monitoring team was encouraged to find, however, that the staff was retrained and a subsequent treatment integrity assessment (dated 5/3/14) indicated that Individual #246's PBSP was implemented with a high level of treatment integrity (i.e., 94%). In order to maintain 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 the PBSPs were implemented with a high level (80% or above) of treatment integrity.	Substantial Compliance
	(g) as necessary, assess and revise the PBSP.	This item continued to be rated in substantial compliance. All six 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 behavioral health specialist, unit directors, and IMRT. A sample of documentation related to 18 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 17 (96%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exceptions was: ○ A restraint for Individual #37 on 5/27/14 was not reviewed until 6/9/14. • b. In 17 (96%), the review by the IMRT occurred within three business days of	Substantial Compliance

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		the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exceptions was (none): o A restraint for Individual #37 on 5/27/14 was not reviewed until 6/9/14. • c. In 18 (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 18 (100%), the review conducted by the restraint monitor and/or psychologist 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 facility documented recommendations from their review for 18 (100%)of the restraints in sample #C.1. • f. Of the ____ referred to the team, in _____ (n/a) appropriate changes were made to the individuals' ISPs and/or PBSPs. (none were referred) A review of ISPAs for the individuals in the sample indicated that IDTs routinely met following restraint episodes. Recommendations generally included a generic statement recommending that staff encourage the individual to use replacement behaviors. For two, a recommendation was made for a consultation with the psychiatrist. In one case, the individual was not seen by the psychiatrist until 19 days after the recommendation was made. Based on this review, the facility was in substantial compliance with review requirements. A review process was in place, however, the monitoring team recommends that any recommendations made during the restraint review process should be documented and tracked for follow-up.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o 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: Quality Assurance Process revised 1/30/14 o SGSSLC Policy: Threat of Harm to Self or Others dated 12/14/07 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 2/1/14 o All injury report for the past six months for any individual sustaining a serious injury o List of all ANE allegations since 12/1/13 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 abuse/neglect/exploitation, or failed to report it in a timely manner, including the date of the incident that was not reported or reported timely, the type of incident, and a description of any personnel action taken o List of staff who have alleged that they have been retaliated against for in good faith reporting an allegation o The current list of individuals for whom Adult Protective Services conducts "streamlined investigations" o A sample of Incident Management Recommendation 30-60-90 Day Follow-Up Log for three investigations. o Quality Improvement Council meeting minutes for the past six months o Executive Safety Committee meeting minutes for the past six months o Spreadsheet showing background checks for all staff o List of applicants not hired based upon background checks o List of employees terminated based upon background checks. o ISPs, IRRF, PBSP, ISPAs for Individual #50, Individual #156, Individual #134, Individual #201, Individual #362, Individual #381, Individual #200, Individual #365, and Individual #273. o Injury reports for the past six months for Individual #201 and #50

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

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#43134130	Physical Abuse	Unconfirmed	5/14/14 6:29 am	5/14/14 11:06 am	5/21/14
#43132985	Emotional/Verbal Abuse (3)	Unconfirmed (3)	5/13/14 12:37 pm	5/15/14 2:33 pm	5/19/14
#43130024	Emotional/Verbal Abuse	Unconfirmed	5/10/14 6:50 am	5/10/14 1:44 am	5/20/14
#43112763	Physical Abuse	Unconfirmed	4/26/14 8:14 pm	4/27/14 2:48 pm	5/19/14
#43117284	Physical Abuse	Unconfirmed	4/30/14 2:07 am	5/2/14 3:09 pm	5/7/14
#43101178	Physical Abuse (6)	Unconfirmed (6)	4/17/14 7:32 am	4/17/14 10:00 am	4/26/14
#43087326	Physical Abuse	Confirmed	4/6/14 3:18 pm	4/6/14 5:11 pm	4/11/14
#43072010	Neglect (2)	Confirmed (2)	3/25/14 10:44 am	3/27/14 9:50 am	4/14/14
#43068810	Physical Abuse (2)	Confirmed (1) Unconfirmed (1)	3/21/14 3:22 pm	3/21/14 5:38 pm	4/14/14
#43130091	Neglect	Clinical Referral	5/10/14 10:08 am	5/10/14 2:00 pm	5/10/14
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
#6663	Serious Injury Peer-to-Peer Aggression	5/14/14 1:00 pm	5/14/14 2:28 pm	5/9/14	
#2305	Serious Injury	5/2/14 9:45 am	5/5/14 11:00 am	5/6/14	
#6549	Unauthorized Departure/Encounter with Law Enforcement	4/5/14 Unknown	4/5/14 9:02 pm	4/9/14	
#6423	Serious Injury	2/13/14 3:30 pm	2/13/14 4:05 pm	2/18/14	

#6405	Non-serious injury Undetermined Cause	2/6/14 Unknown	2/6/14 2:55 pm	2/19/14	

Interviews and Meetings Held:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Jalown McCleery, Incident Management Coordinator
- Melinda Gentry, ADOP
- Vanessa Barrientez, QIDP Coordinator
- Roy Smith, Human Rights Officer
- Vicki Hinojos, Residential Director
- Dana Robertson, Provision Coordinator

Observations Conducted:
- Observations at residences and day programs
- ISP preparation meeting for Individual #118
- Annual IDT Meeting for Individual #130, Individual #50, and Individual #57
- Incident Management Review Team Meeting 8/19/14 and 8/21/14
- Human Rights Committee Meeting
- Executive Safety Committee Meeting
- 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.

The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 20 of 22 provisions. The monitoring team did not confirm compliance with the requirements of D3i and D4.

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 739 allegations at the facility between 12/1/13 and 5/31/14, including 366 allegations of physical abuse, 235 allegations of verbal/emotional abuse, 65 allegation of sexual abuse, 73 allegations of neglect, and no allegations of exploitation. Of the 739 allegations, there were 12 confirmed cases of physical abuse, one confirmed case of verbal/emotional abuse, and eight confirmed cases of neglect. The facility reported that 70 other serious incidents were investigated by the facility during this period. According to documentation presented in the July 2014 Trend Analysis Report and May 2014 QA report, there were a total of 2190 injuries reported between 12/1/13 and 5/31/14. These 2190 injuries included 13 serious injuries resulting in fractures or sutures. This indicated an overall increase from the 1930 injuries reported the previous six-month period. Injury trends were being generated by individual and were made available to IDTs for planning. The facility continued to have a high number of serious incidents and injuries. Investigations continued to be thorough and were completed expediently. While the incident management and quality assurance departments were placing a greater focus on identifying trends of incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation of action steps following incidents. The facility was tracking the initial implementation of recommendations, however, the incident management department still needs to develop a system for tracking the outcome of recommendations. Action steps need to be written in measurable terms so that the efficacy of supports and interventions to prevent similar incidents can be evaluated. The parties agreed that there would be reduced monitoring for 16 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 20 of 22 provisions of section D that were reviewed. Provision items found not to be in compliance were: • 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 measurable action plans to address trends of injuries and incidents and then tracking implementation of those plans.

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

	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with	The state policy 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 739 allegations of abuse, neglect, or exploitation investigated by DFPS at the facility between 12/1/13 and 5/31/14. From these 739 allegations, there were:
		• 366 allegations of physical abuse including,
		    ○ 12 confirmed
		    ○ 322 unconfirmed
			Substantial Compliance

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	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.	○ 15 unfounded ○ 17 inconclusive ○ 0 referred back for further investigation • 235 allegations of verbal/emotional abuse including, ○ 1 confirmed ○ 202 unconfirmed ○ 8 unfounded ○ 24 inconclusive • 65 allegations of sexual abuse including ○ 0 confirmed ○ 56 unconfirmed ○ 8 unfounded ○ 24 inconclusive • 73 allegations of neglect including, ○ 8 confirmed ○ 52 unconfirmed ○ 0 unfounded ○ 13 inconclusive • 0 allegations of exploitation According to a list provided by the facility, there were 70 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 9 serious injuries/determined cause, • 3 serious injuries from peer-to-peer aggression, • 1 serious injury/undetermined cause • 2 non-serious injury/unknown cause • 27 sexual incidents, • 7 choking incident, • 1 suicide threats, • 4 encounters with law enforcement, • 7 unauthorized departures, and • 4 deaths • 9 other unspecified From all investigations since 2/1/14 reported by the facility, 15 investigations were selected for review. The 15 comprised two samples of investigations:	

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		• 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 (10 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (5 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. Metric 2.a.4: Based on responses to questions about reporting, three of three (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. All staff were required to wear a badge with reporting requirements listed on the back of the badge. Metric 2.a.5: Based on responses to questions about reporting, three of three (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 10 investigation reports included in Sample #D.1: • Metric 2.a.6: 19 (100%) 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. • Metric 2.a.7: 10 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ○ 10 of 10 (100%) indicated the facility director or designee was notified of the incident within one hour.	

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		○ 10 of 10 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. ○ 10 of 10 (100%) documented that the state office was notified as required. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (n/a) included recommendations for corrective actions. Based on a review of five investigation reports included in Sample #D.2: • Metric 2.a.9: Four (80%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. ○ UIR #6641 was the investigation of a serious injury that occurred on 5/2/14. The physician documented the fracture following an x-ray on 5/2/14. It was not reported as a serious injury until 5/5/14. • Metric 2.a.10: Five (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders (100%) included recommendations for corrective actions. ○ Late reporting of a serious injury in UIR #6641 was addressed in recommendations by the facility. It was recommended that the RN involved should be retrained on reporting procedures. Documentation showing the completion of training was not in the case file. 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. Metric 2.a.13: Based on a review of 15 investigation reports included in Samples #D.1 and #D.2, 15 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. The facility was in substantial compliance with the requirements of D2a.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. The facility had a policy in place for assuring that alleged perpetrators were removed	Substantial Compliance

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	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.	from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. The monitoring team was provided with a log of employees who had been reassigned between 12/1/13 and 5/31/14. The log included the applicable investigation case number, and the date the employee was reassigned, date returned to work, and any action taken. Based on a review of investigation reports included in Sample D.1, in eight out of eight cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. In eight out of eight cases (100%), where there was a known alleged perpetrator, there was no evidence that the employee was returned to his or her previous position prior to the completion of the investigation or was returned prior to the completed investigation with increased monitoring when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the eight investigation files in Sample D.1, 10 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and an emotional assessment. The facility was in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 10 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 10 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • There was evidence that six of the six (100%) employees with current training	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		who had been employed over one year had completed the ABU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 10 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • There was evidence that six of the six (100%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. Based on this review, the facility was in substantial compliance with the requirement for annual 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 complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. 24 (100%) of 24 employees in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were five cases where staff failed to report abuse or neglect as required. The employees involved in each case received retraining on unusual incident reporting responsibility. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. A review was conducted of the materials to be used to educate individuals, legally	Substantial Compliance

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	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.	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 seven ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #134, Individual #201, Individual #362, Individual #156, Individual #381, Individual #200, Individual #365, and Individual #273. • Seven (88%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The ISP for Individual #201 did not include documentation that A/N/E information was shared with the individual or his family. The ISP included a review of all incidents and allegations along with a summary of that review. At the annual ISP meetings attended by the monitoring team, the IDT reviewed trends of injuries and incidents when developing supports. The facility remained 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 complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with her name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. The facility remained in substantial compliance with this provision item.	Substantial Compliance

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	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 10 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 10 (100%), when appropriate. OIG investigated five cases in the sample and criminal activity was not substantiated in any of the cases. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. Based on a review of ten investigations completed by DFPS (Sample #D.1), no staff indicated that they feared retaliation for reporting incidents. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures 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. Ninety files were chosen to be audited during the past six months. 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, Shift Logs, Client Injury Data Reports, and switchboard logs for documentation of any injuries the individual might have incurred during the month	Substantial Compliance

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		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. • Audit summaries included good documentation of findings including graphs, charts, and comprehensive narratives describing findings. • Auditors included recommendations for corrective action when warranted. For example, the February 2014 audit of home 509A noted that CIRs were not generated for 15% of all injuries identified. The audit report included recommendations to retrain staff on the home regarding injury reporting and documentation. Metric 2.i.4: In ___ of ___ (n/a) cases in sample #D.2, 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) 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 investigator investigated all serious injuries. Findings were reviewed by the facility at daily IMRT meetings. The facility maintained substantial compliance.	
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,	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	investigations and working with people with developmental disabilities. SGSSLC had 10 employees designated to complete investigations. This included the IMC, Facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, 10 (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, and • Comprehensive Investigator Training. Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that staff did not cooperate with any outside agency conducting investigations. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. Based on a review of the investigations completed by DFPS, the following was found: • Of the 10 investigations completed by DFPS (Sample #D.1), OIG investigated five of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility remained in substantial compliance with this provision.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>(d) Provide for the safeguarding of evidence.</td><td>The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews.

The SGSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it.

Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2):
• There was no indication that evidence was not safeguarded during any of the investigations.

Video surveillance was in place throughout SGSSLC, and investigators were regularly using video footage as part of their investigation.

The facility remained in substantial compliance with this item.</td><td>Substantial Compliance</td></tr>
<tr><td></td><td>(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.</td><td><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.
    ○ Contact with the alleged victim occurred within 24 hours in 8 of 10 (80%) investigations. Exceptions were DFPS cases #43117284 and #43072010.
    ○ 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, seven of 10 (70%) were completed within 10 calendar days of the incident. Extensions were filed for all three investigations. The investigations not completed within 10 days:
    ○ Case #43112763, Case #43072010, and Case #43068810
• All 10 (100%) resulted in a written report that included a summary of the investigation findings.
• In seven of 10 (70%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. One of those cases resulted in a referral back to the facility for further investigation.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		<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 five of five cases (100%). • Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Five of five (100%) included appropriate recommendations for follow-up action to address the incident. The facility was in substantial compliance with the requirement of D3e.	

	(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	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews.
		
		Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements.
		
		Metric 3.f.2: The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations in #D.1:
		• Metric 3.f.3: In 10 out of 10 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		• The report utilized a standardized format that set forth explicitly and separately:
		  ○ Metric 3.f.4: In 10 (100%), each unusual/serious incident or allegations of wrongdoing;
		  ○ Metric 3.f.5: In 10 (100%), the name(s) of all witnesses;
		  ○ Metric 3.f.6: In 10 (100%), the name(s) of all alleged victims and perpetrators;
		  ○ Metric 3.f.7: In 10 (100%), the names of all persons interviewed during the investigation;
		  ○ Metric 3.f.8: In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		  ○ Metric 3.f.9: In 10 (100%), all documents reviewed during the investigation;
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
	perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	○ Metric 3.f.10: In 10 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ○ Metric 3.f.11: In 10 (100%), the investigator's findings; and ○ Metric 3.f.12: In 10 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 3.f.13: In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: ○ Metric 3.f.14: In five (100%), each unusual/serious incident or allegations of wrongdoing; ○ Metric 3.f.15: In five (100%), the name(s) of all witnesses; ○ Metric 3.f.16: In five (100%), the name(s) of all alleged victims and perpetrators; ○ Metric 3.f.17: In five (100%), the names of all persons interviewed during the investigation; ○ Metric 3.f.18: In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ○ Metric 3.f.19: In five (100%), all documents reviewed during the investigation; ○ Metric 3.f.20: In four (80%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ▪ UIR #6663 did not include a review of similar incidents for the victim (e.g., other serious injuries, incidents of peer-to-peer aggression). ○ Metric 3.f.21: In five (100%), the investigator's findings; and ○ Metric 3.f.22: In five (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this provision.	

#	Provision	Assessment of Status	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 and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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.
		
		<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) noted a problem with one investigations in the sample regarding a wrong date.
		• 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.
		• Metric 2.g.6: The facility returned one cases in the sample to DFPS for correction. For one (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry.
		
		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,
		• 10 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion.
		• Seven (70%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation.
		    o DFPS completed case #43130024 on 5/20/14. The facility director and IMC signed off on the review on 5/28/14.
		    o DFPS completed case #43087326 on 4/11/14. The facility director and IMC signed off on the review on 4/24/14.
		    o DFPS completed case #43072010 on 4/14/14. The facility director and IMC signed off on the review on 4/22/14.
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In four out of five investigation files reviewed (80%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ○ The investigation documentation for UIR #6663 failed to note that the staff did not notify nursing staff when the injury was discovered. Staff reported that he discovered the injury at 1:00 pm. The nurse completing the CIR at 1:32 pm noted that she "went upstairs to draw blood from the individual. He was sitting on the couch bleeding from his right eye, side of his nose, and back of his head". She did an assessment of the injury at that time. Recommendations were not made regarding failure of the staff to seek immediate medical care. The facility was in substantial compliance with this provision. The IMC should ensure prompt review of completed investigations.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 15 out of 15 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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. The incident management department had a 30/60/90 day tracking form to follow-up on recommendations and ensure that protections remained in place. 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 five cases: • Three DFPS cases: #43068810, #43072010, and #43087326; and • Three facility investigations: UIR #6641, UIR #6663, and UIR #6423 Metric 3.i.3: For three out of three (100%) of the DFPS investigations (DFPS cases #43068810, #43072010, and #43087326) reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 four out of four 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 four 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. • For UIR #14-6641, the investigator recommended that the staff follow Individual #201's PBSP when he is displaying challenging behaviors following an incident that led to a serious injury on 5/5/14. He was also referred for psychiatric evaluation. His injury was determined to be self-caused. The UIR indicated that he had a total of 50 injuries over the previous year, 27 of which were self-caused. The IDT met following the incident and noted that Individual #201 was involved in 24 incidents of peer-to-peer aggression in the two months prior to this incident. The QIDP further noted that this was a significant increase in aggression to the point that his peers were "showing fear of him when he comes into an area" and "staff are scared to sign on to him." o Staff were retrained on his PBSP and he was seen by the psychiatrist following the incident. Although it did not appear that his PBSP was effective, the last revision of the plan was 9/4/13. The IDT met on 5/13/14 and 5/20/14 following additional injuries. The recommendation from both meetings was to continue to follow his PBSP. The IDT met again on 5/27/14 to discuss 39 more incidents of peer-to-peer aggression following the incident on 5/5/14. The IDT again, recommended that staff continue to follow his PBSP and noted that no revisions were necessary. It was documented that the team consulted with his psychiatrist on 5/7/14 to discuss the increased aggression. The psychiatrist changed his medications. There was no further discussion by the IDT regarding follow-up with the psychiatrist. • UIR #6423 was the investigation of a serious head injury for Individual #50. The UIR included a recommendation to train staff on supports and interventions developed by the IDT. The investigation file documented staff training, however, it was not evident that supports were consistently implemented and reviewed for efficacy. The April 2014 and May 2014 QA reports identified Individual #50 as being at continued risk for injury. Many of the same strategies and supports were noted to be "in progress" with no comments regarding the efficacy of supports.	

#	Provision	Assessment of Status	Compliance
		• For DFPS case #43068810, DFPS made a recommendation regarding conflict between the guardian and other team members and lack of documentation of injuries. A follow-up email indicated that the unit director was working with the home manager and QIDP to improve communication between the IDT and staff. It was also noted that the unit director had reminded the QIDP to keep in good contact with the guardian about incidents. There was no specific documentation on how either of those recommendations were implemented. • For UIR #6663, the investigation file included documentation that Individual #93's IDT met and consulted with the psychiatrist following a serious injury resulting from peer-to-peer aggression. There was no documentation, however, that the IDT was monitoring efficacy of interventions. 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.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly	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

#	Provision	Assessment of Status	Compliance
	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 Executive Safety Committee 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. A summary of that data was incorporated into the ISP. 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, a measurable 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.	

#	Provision	Assessment of Status	Compliance
		Metric 4.10: The trend reports/minutes did not review, as appropriate, the effectiveness of previous corrective actions. See examples in metric 4.12 and 4.13. 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. 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. For example, • The April 2014 and May 2014 trend reports in regards to injuries included recommendations for 10 individuals that were identified as being at risk for more injuries. The recommended action was the same for each individual. It was recommended for each of the individuals that the IDT should review injuries for preventative actions to reduce or eliminate similar incidents. In each case, the IDT was listed as the responsible person and the same date (two months from the date of the recommendation) was assigned as the due date for all individuals. • ISPAs were attached to the trend report to show that IDTs met to discuss trends, however as noted below, it was not evident that the IDTs were developing, implementing, and/or monitoring appropriate action steps. 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. For example, ○ Individual #201's team developed action plans to address his trend of injuries and incidents at his annual ISP meeting on 3/18/14. Action steps included: 1) PBSP should be reviewed and more realistic objectives should be developed. 2) He should be assessed to determine programming needs regarding employment. 3) A speech and language	

#	Provision	Assessment of Status	Compliance
		assessment will be completed. 4) The RN will discuss having an MRI with the PCP. 5) The team will meet to discuss OT/PT recommendations. The IDT met numerous times to review incidents and injuries following his annual ISP meeting. None of these recommendations were reviewed for implementation or efficacy. o Individual #50 sustained a serious head injury on 2/13/14. A critical incident meeting was held and recommended actions were developed to prevent similar incidents. The April 2014 and May 2014 QA report included a recommendation for the IDT to meet and implement a plan to reduce his injuries and incidents. An ISPA dated 6/12/14 submitted as evidence of follow-up to recommendations included a statement that many of the same recommendations from the 2/13/14 incident were "in the process." 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. • As detailed in metric 3.i.5 and metric 4.12, Individual #201's IDT met numerous times to review his trend of injuries and incidents of peer-to-peer aggression. Documentation did not indicate that the team reviewed supports for efficacy or revised supports when not effective. The IDT continued to recommend that staff follow his PBSP when targeted behaviors increased. His ISP included additional actions steps to assess medical, vocational, sensory, and communication issues that might impact his behaviors. ISPAs did not include a review of recommended assessments or follow-up to any resulting recommendations. • Individual #50 was identified in both the April 2014 and May 2014 QA report as one of the individuals at risk for additional injuries. The April 2014 report recommended that the IDT meet to address his injuries. The May 2014 report noted that his total number of injuries had decreased, so improvement was evident, however, evidence of action taken by the team to address his risk was an ISPA dated 6/12/14. Thus, it was not clear that the team met, implemented, or reviewed the efficacy of recommendations prior the May 2014 report. As noted in metric 4.12, some of the action steps were developed to address a serious head injury on 2/13/14. It was difficult to track implementation of those actions and not clear if supports were revised when he continued to experience a high number of injuries. Additionally, recommendations were made by the IDT to address Individual #50's trend of aggression towards others. ISPA dated 12/18/14, 4/1/14, and 5/13/14 noted that acts of aggression occurred around mealtime and medication administration. All ISPAs included general recommendations from his PBSP to address aggression. It was not evident that specific supports were implemented and tracked for efficacy in regards to meal	

#	Provision	Assessment of Status	Compliance
		or medication times. The ISPAs were attached as evidence of implementation to the incident management trend report, however, there was no evidence of implementation, monitoring, and/or review of efficacy for specific recommendations 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.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The parties agreed the monitoring team would complete a reduced review of this provision because the facility was in substantial compliance for more than three consecutive reviews. By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.	Substantial Compliance

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		According to information provided to the monitoring team, for FY14, criminal background checks were submitted for 1461 applicants. There were 46 applicants who failed the background check in the hiring process and therefore was not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self-report all criminal offenses. The facility remained in substantial compliance with this provision item.	

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: ○ DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names ○ SGSSLC facility-specific policies: • Quality Assurance Process, #2.1.23, 4/14/11, updated 1/30/14, CAP attachments updated 6/25/14 • QA plan (narrative), #2.1.23.a, 11/30/12, updated 7/24/14 • Policy/procedure approval and review committee, 1/4/11, 11/29/12, not updated • FSPI, #2.1.24, updated 4/24/14 ○ SGSSLC organizational chart, June 2014 ○ SGSSLC policy lists, 6/25/14 ○ List of typical meetings that occurred at SGSSLC (not provided) ○ SGSSLC Self-Assessment, 8/20/14 (new) ○ SGSSLC Action Plans, 7/21/14 ○ SGSSLC Provision Action Information, 6/9/14 ○ SGSSLC Quality Assurance Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 8/18/14 ○ SGSSLC DADS regulatory review reports, 2/14/14-7/2/14 ○ SGSSLC QA plan narrative, 7/24/14 ○ SGSSLC data listing/inventory, hard copy, 8/19/14 • Data listing with handwritten comments from QIC Board review in March 2014 ○ SGSSLC QA plan matrix, 8/18/14 ○ Adequate indicators review schedule, updated 8/18/14 ○ List of all QA department staff and their responsibilities, January 2014 ○ SGSSLC QA department meeting notes, March 2014-July 2014 (7 meetings) ○ Set of blank tools used by QA department staff ○ Standard trend analysis reports for four areas, for two quarters ○ QAD-SAC-1:1 face to face meetings minutes: • Administrative IDT monthly agenda and face to face schedule • Sure is easy as pie training slides • 15-item suggestions/FYI content for department heads • New scoring tool for face to face meeting • Cover sheets for each meeting, February 2014 to July 2014 ▪ Attachments for the July 2014 meetings ○ SGSSLC QA Reports, monthly, February 2014 to July 2014 (6) ○ QAQI Council minutes, March 2014 to August 2014 (6 months) • Handouts and agenda for meeting during onsite review, 8/21/14

	○ Performance Improvement Team minutes, 3 teams, active treatment, implementation, and assessments ○ SGSSLC Corrective Action Plan documents • Blank CAP forms • CAPs data summaries • 4 active CAPs • Closed CAPs log <u>Interviews and Meetings Held</u>: ○ Michael Fletcher, Director of Quality Assurance ○ Misty Mendez, Settlement Agreement Coordinator ○ Roy Smith, Human Rights Officer, Zula White, Human Rights Office Assistant, Janet Smith, Assistant Independent Ombudsman, Jalown McCleery, Incident Management Coordinator ○ Charles Njemanze, Facility Director <u>Observations Conducted</u>: ○ Face to face section meetings, section G, 8/19/14 ○ QI Council Admin IDT meeting, 8/21/14 ○ Self-advocacy meeting, 8/19/14 ○ Clinical services meeting, each morning
	Facility Self-Assessment The QA director fully revised the self-assessment such that it now lined up with the items and metrics in the monitoring team's report. This was done about two months prior to this onsite review. The self-assessment was also a document to which the QA director added new data each month (i.e., it was a six-month document). Thus, this was now a good self-assessment.
	Summary of Monitor's Assessment: The QA program at SGSSLC continued to improve, such that a solid QA infrastructure existed at the facility. This was due to the leadership, direction, and continual self-review of the facility's QA program by the QA director, Mike Fletcher, and the SAC, Misty Mendez. The QA program at SGSSLC remained vibrant and flexible. QA activities were a regular part of facility operations. The facility director, ADOP, and ADOA supported the QA program by attending and participating in QA activities, requiring participation by all departments and their staff, and reviewing data, outcomes, and quality assurance reports. Of the 22 data list inventories, 22 (100%) included data that could be used to identify trends as required in the wording of section E1; 22 (100%) included a wide range of data; 22 (100%) included what appeared to be key indicators; and 22 (100%) described the data being collected. The recently initiated process of

	reviewing each provision item of the Settlement Agreement to ensure that adequate indicators are identified and data are being collected was an excellent next step to ensure that the data list inventory (and thereby the QA matrix) was complete. 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. The facility created a QI Board to, among other things, regularly review the data inventories. The QA director and SAC created a 12-month schedule that laid out every provision item from the Settlement Agreement, and assigned it to a specific week in the calendar. The QA plan narrative was current, complete, and adequate. It was updated in July 2014 and reflected the many aspects of the SGSSLC QA program. 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. Of the 31 components of the QA plan narrative (7) and QA plan matrix (24), the facility implemented 31 (100%). Continued progress was seen at SGSSLC regarding the gathering, organization, and analysis of data. Five headings were added to the section leaders' data reports (and QA reports) to prompt: summation of data, identification and description of trends, explanation/analysis of the data, actions to take to make improvements if needed, and predictions of what the effects may be. The QA director and SAC continued to hold the monthly face to face meetings. Departmental QA meetings continued to occur, now by every department. In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QI Council) was created for six of the last six months (100%). Of the 5 sampled sections of the Settlement Agreement (F, J, P, Q, T) that were presented quarterly (April 2014, July 2014), 1 of 10 (10%) presentations (section T, August 2014) contained all of the components listed in section E2, including the analysis of data. The CAPs program was again re-booted and, therefore, was not yet at substantial compliance. There were 4 open CAPs. Two (50%) appeared to appropriately address the specific problem for which they were created. 4 of the 4 (100%) had measurable criteria. This was good to see. There was, however, no indication of how data as described in the criteria were to be collected, summarized/graphed, and reviewed.

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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.	As has been the case for each monitoring review, the QA program at SGSSLC continued to improve, such that a solid QA infrastructure existed at the facility. This was due to the leadership, direction, and continual self-review of the facility's QA program that the QA director, Mike Fletcher, and the SAC, Misty Mendez, regularly conducted. Thus, the QA program at SGSSLC remained vibrant and flexible. QA activities were a regular part of facility operations. Many of the activities had been operating for a number of years. The facility director, ADOP, and ADOA supported the QA program by attending and participating in QA activities, requiring participation by all departments and their staff, and reviewing data, outcomes, and quality assurance reports. Without this administrative support, it is likely that the QA program would not have continued to improve in the way that it has over the past few years. <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, updated 5/22/13. The monitoring team's comments on the state policy are in previous monitoring reports and are not repeated here. b. There were facility policies that adequately supported the state policy for quality assurance. The QA plan narrative served as one of the facility specific policies. It contained detail about the facility specific QA activities. <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 continued to improve, contain more information, and address the requirements of the Settlement Agreement. The data list inventory is a key foundational component of a QA program because it lists, in one place, all of the data collected at the facility. From this inventory, senior management and QA staff can ensure that key indicators are chosen for review. The data list inventory was 69 pages long, contained 22 topic areas (one for each section of the Settlement Agreement, plus section S and I were 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 22 inventories, 22 (100%) included data that could be used to identify trends as required in the wording of section E1; 22 (100%) included a wide range of data; 22 (100%) included what appeared to be key indicators; and 22 (100%) described the data being collected. The recently initiated process of reviewing each provision item of the Settlement Agreement to ensure that adequate indicators are identified and data are	Noncompliance

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		being collected was an excellent next step to ensure that the data list inventory (and, thereby, the QA matrix) was complete. 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. All items were notated to be a process or an outcome indicator. The purpose of this notation is to help ensure that the facility is selecting both types of indicators. Some items, however, were not correctly labeled. Each data listing (a) did not yet include all relevant data items, however, (b) each data item was being collected by the section leader, (c) each was available for presentation if requested, and (d) data were being used as per the wording of this Settlement Agreement provision. The facility engaged in a number of activities to improve the content, validity, and comprehensiveness of the data list inventories: • The creation of a QI Board, comprised of about six senior managers, including the facility director and ADOP. The board met quarterly beginning in March 2014. At that first meeting, they reviewed the entire inventory in a thorough manner (three two-hour meetings over three consecutive days). The QI Board also used the inventory to determine what items to recommend be brought to QI Council (i.e., be in the QA matrix). This type of detailed review, with participation of facility leadership, was good to see. The QI Board planned to review the data inventory and QA matrix every six months. • Data inventories were reviewed with section leaders every month at their QAD-SAC face to face meetings. • The QA director and SAC created a 12-month schedule that laid out every provision item from the Settlement Agreement, and assigned it to a specific week in the calendar. This indicated that during the face to face meeting to be held that week, the QA director, SAC, and section leader would discuss that provision item in detail to determine if the proper and sufficient number of indicators were being used to assess that provision. This was another new, and good, addition to the QA program. • A short narrative description of each data item was written in that item's box in the inventory. • The staff person responsible for the collection and management of the data was included for every item. • The inventory indicated if the item was to be reviewed at QI Council, only at the department's own QA meeting, or if the data were collected but not reviewed at	

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		either meeting. At this point, given the maturity of the QA program at SGSSLC, the monitoring team suggests that state office discipline coordinators be asked for their comments on the data inventories for their respective section(s). d. The data list inventory was current. 22 of the 22 lists (100%) were updated within the past six months. Each inventory item had its own date of update or review. Quality Assurance Plan Narrative e. The QA plan narrative was current, complete, and adequate. It was updated in July 2014 and reflected the many aspects of the SGSSLC QA program. QA Plan Matrix 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. It was frequently updated by the QA department. The monitoring team reviewed the 8/18/14 QA matrix. The SGSSLC QA plan matrix was 17 pages long. It was well organized and the items lined up with the data listing inventory. The QA matrix was drawn from the single database used for the data inventory. QA matrix items were checked (QIC review column) and those were then selected and printed as the QA matrix. The QA director and SAC continued to assess the correspondence of what was in the QA matrix compared to what the section leader presented in the QA report. They did this during the monthly face to face meeting with each section leader. 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 20 of the 20 (100%). However, as noted above, as the QA inventory is completed via the review of each provision item of the Settlement Agreement, the QA matrix will be modified. g. Of the 20, both process and outcome indicators were identified for 18 of the 20 (90%) in the QA matrix (sections H and U only contained items labeled process). • Every item was labeled as a process or outcome indicator.	

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		h. Of the 20, in 20 (100%), the indicators provided data that could be used to identify the information specified in E1: "trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports." • For many items, the description included how data were being collected, broken down by these types of variables. i. The QA matrix included self-monitoring tools/self-monitoring procedures for 7 of the 20 sections (35%). The QA director and SAC reported that the need for a tool called a self-monitoring tool was discussed with each section leader, but was determined to not be needed because of the number and range of data items that were being collected. Further, the QA department discussed this at their periodic departmental staff meeting on 6/24/14 and the QI Board reviewed all items to be included in QA matrix in March 2014. The monitoring team agreed with this. j. All data that QA staff members collected were listed in the matrix. k. All of the items in the QA matrix did appear in the QA data list inventory. QA Plan Implementation 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: F, J, P, Q and T: face to face meeting cover sheets for three months (May 2014 to July 2014), data and graphs submitted during the face to face meeting for July 2014, and the QA report for each of these five sections for six months (February 2014 to July 2014). l. Of the 50 items in the QA plan matrix (for the sampled sections), 47 (94%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). • The above metric was calculated by combining the facility provided data for June 2014 (100%) with the monitoring team's data for July 2014 (88%). • The facility continued to collect monthly data on the correspondence between each section's QA matrix and the data actually reported during face to face meetings, at QI Council, and in the QA report. The overall percentages, reported by the facility, were 97%, 89%, and 92% for May 2014, June 2014, and July 2014, respectively. m. Of the 50 items in the QA plan matrix, 47 (94%) were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). n. Of the 31 components of the QA plan narrative (7) and QA plan matrix (24), the	

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		facility implemented 31 (100%). o. Documentation and observation did indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. Self-Monitoring Tools Given the discussion regarding the need for self-monitoring tools at SGSSLC, the monitoring team did not evaluate these four metrics: p. Content/validity q. Adequate instructions r. Implementation s. QA review	
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. The QA director and SAC were working with section leaders on increasing their analysis activities (as compared to solely describing the data with no analysis). They had taken some specific actions to this end: • The SAC created a two-hour training session on graphic presentations of data and on five components of analyzing one's own data. She presented this training to all of the section leaders. • Five headings were added to the section leaders' data reports (and QA reports) to prompt: summation of data, identification and description of trends, explanation/analysis of the data, actions to take to make improvements if needed, and predictions of what the effects may be. • The QA director and SAC continued to hold the monthly face to face meetings. During these meetings, they continued to score the section leader on a variety of QA-related activities, such as updating of the data inventory and whether the items in the QA matrix lined up with what was in their data reports. Since the last review, they added scoring of how well the section leader did on the five components of analyzing their data, as well as whether data were being collected in sufficient particularity as worded in E1. • Departmental QA meetings continued to occur, now by every department. • The SAC and her staff continued to keep 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.	Noncompliance

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		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. a. Data from the QA plan matrix for 20 of the 20 (100%) sections of the Settlement Agreement were summarized and graphed showing trends over time. Not all had yet analyzed data 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. The QA director reported that many section leaders had been analyzing data across these various areas, but found little useful information when doing so, or had made adjustments to their processes in order to make improvements. The QA director reported that he and the SAC were now working with section leaders to do more meaningful analyses of their current data, trends, and graphs; and to include information about these areas in that section of the narrative in the QA report. Monthly QAD-SAC meeting with discipline departments The QA director and SAC continued to develop and improve upon these meetings. They were called face to face meetings. All sections participated. If a section met certain criteria, their face to face meeting was moved to quarterly, but data and other QA-related documents continued to be required to be submitted each month. Meetings were held on the Monday or Tuesday of the same week in which the section leader would be presenting to QI Council later that same week (the third and fourth weeks of each month). The monitoring team selected a sample for review for five sections: F, J, P, Q and T. b. Since the last onsite review, a meeting occurred at least twice for 5 of the 5 (100%) sampled sections of the Settlement Agreement. • 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. c. Since the last onsite review, during 15 of the 15 (100%) meetings (May 2014 to July 2014), data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during 15 of the 15 (100%) meetings (May 2014 to July	

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		2014), data were reviewed and analyzed. For the purposes of this metric, the monitoring team rates this as acceptable if there was review and discussion of data.
		
		e. Since the last onsite review, during 15 of the 15 (100%) meetings (May 2014 to July 2014), action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed.
		
		<u>QA Report</u>
		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 QI 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.
		
		h. Of the 5 sampled sections of the Settlement Agreement (F, J, P, Q, T) that were presented quarterly (April 2014, July 2014), 1 of 10 (10%) presentations (section T, August 2014) contained all of the components listed below.
		• Self-monitoring data
		  ○ reported for a rolling 12 months or more
		  ○ broken down by program areas, living units, work shifts, etc., as appropriate
		  - As discussed in section E1, self-monitoring tool data were not considered for the rating of this metric.
		• Other key indicators/important data for the section
		  ○ reported for a rolling 12 months or more
		  ○ broken down by program areas, living units, work shifts, etc., as appropriate
		• Narrative analysis
		
		<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 March 2014 to August 2014 (6 months, 19 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. Overall, this	

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		meeting was running very well at SGSSLC. i. There was 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 19 (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 19 (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. Corrective Actions The CAPs program was again re-booted. A new system was very recently put in place regarding the criterion for a CAP, how to initiate a CAP, reporting on a CAP, and assessing its progress. The monitoring team reviewed a number of CAP-related documents (above in the Documents Reviewed list). There were 4 open CAPs. They were related to 3 Settlement Agreement provisions (C, F, G). The monitoring team reviewed 4 of the 4 open CAPs in detail. The CAPs program was not being used across the facility. This was based upon interview with the QA director and was evidenced by CAP usage in only three areas. In addition, the closed CAPs log was 99 pages long and the monitoring team could not discern relevant information related to recently closed CAPs in order to include a set of closed CAPs in metrics o. through u. below. o. An adequate written description existed that indicated how CAPs were generated. p. When considering the sample of 4 CAPs, 4 (100%) CAPs were chosen following the written description, policy, or procedure. q. Of the 4 CAPs reviewed by the monitoring team, 2 (50%) appeared to appropriately	

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		address the specific problem for which they were created. • 4 of the 4 (100%) had measurable criteria. This was good to see. There was, however, no indication of how data as described in the criteria were to be collected, summarized/graphed, and reviewed. • The F CAP appeared to be for ISP attendance and ISP filing within 30 days. The actions only addressed ISP attendance. • Two of the CAPs were very similar, regarding assessment timeliness and quality of content. There was overlap in the two CAPs' objectives and other sections of the form. These should be separated into two distinct CAPs. Based on these 4 CAPs: r. 4 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. The number ranged from 5 to 11. s. 4 (100%) included the anticipated outcome of each action step. t. 4 of the 4 CAPs (100%) included the job title <u>and</u> name of the person(s) responsible. u. 4 of the 4 (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 4 open/new CAPs, which represented 100% of the total: a. 4 (100%) included documentation about how the CAP was disseminated b. 4 (100%) included documentation of when each CAP was disseminated, and c. 4 (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.	a. Based on a sample of 4 open CAPs and 0 closed CAPs, 2 (50%) were implemented fully and 3 (75%) were implemented in a timely manner. • One CAP was initiated in January 2014, but no actions occurred until April 2014. • Two CAPs did not fully address the objectives of the CAP. b. There was an adequate system for tracking the status of CAPs. Of the 4 open CAPs being tracked by the facility, 0 (0%) indicated the status of the CAP. c. The facility QA director did maintain summary information/data regarding CAPs and	Noncompliance

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		(open or closed), but not regarding the status of action steps. The information that was available was updated within the month prior to the onsite review. d. The QA director or section leader did present this information to QI Council at least quarterly.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	a. For 0 out of 4 CAPs (0%), documentation showed review of their effectiveness (i.e., outcomes), and for 0 out of 4 CAPs (0%), documentation showed review of their timely completion. b. Of the n.a. CAPs that appeared to need modification, n.a. (--%) were modified. c. Based on a sample of 0 completed CAPs and 4 in process CAPs, 4 (100%) were discussed at QAQI Council. d. For n.a. out of n/a (--%) modified CAPs, evidence was present to show timely implementation. e. For n.a. out of n/a (--%) modified CAPs, evidence was present to show full implementation. For most corrective action plans, there had not been enough time following implementation to determine if action was effective.	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: Individual Support Plan Process 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 and date ISP was filed. o Draft ISPs and Assessments for Individual #130, Individual #50, and Individual #57 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): Individual #201, Individual #273, Individual #134, Individual #381, Individual #362, Individual #365, and Individual #200. <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 Jalown McCleery, Incident Management Coordinator o Melinda Gentry, ADOP o Roy Smith, Human Rights Officer o Vicki Hinojos, Residential Director o Dana Robertson, Provision Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o ISP preparation meeting for Individual #118 o Annual IDT Meeting for Individual #130, Individual #50, and Individual #57 o Incident Management Review Team Meeting 8/19/14 and 8/21/14 o Human Rights Committee Meeting o Executive Safety Committee Meeting o Restraint Reduction Committee Meeting

	Facility Self-Assessment: The self-assessment had been updated on 7/24/14 with recent activities and assessment outcomes. For each provision, the facility had identified: (1) activities engaged in to conduct the self-assessment, (2) the results of the self-assessment, and (3) a self-rating. The QIDP Coordinator was responsible for the section F self-assessment. The current self-assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and provided a self-rating for each provision item. SGSSLC used the statewide section F monitoring tool to assess compliance with section F. Additionally, 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 in substantial compliance with F1b, F1e, F2a4, F2a6, F2b, and F2g. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. While the monitoring team did note progress for each provision area that the facility found in substantial compliance, the facility was not yet in substantial compliance. • For F1b, attendance remained high for most disciplines, however, the facility needs to focus on ensuring that individuals, the LAR, family, psychiatry, and DSPs attend the ISP meeting. • For F1e, ISPs included minimal formal training to be implemented in the community. General outcomes were written to attend activities at community sites without describing what training would occur while there. The facility needs to continue to focus on training in the least restrictive setting. • For F2a4, action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Few action steps were written in terms of measurable action that the individual would perform to complete the objective. • For F2b, the monitoring team found that many 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. • For F2g, progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation, however, it was not evident that QA measures were accurately identifying problems noted with the development of adequate ISPs
	Summary of Monitor's Assessment The facility had made some progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. 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. There was little discussion at meetings regarding how the individual spent a majority of his or her day or how the team would ensure that they were involved in meaningful activities. The IDTs did not develop outcomes that would build on what the

	individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual. The facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy. 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 four ISP meetings and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		Meeting documentation, as available. A sample was requested of the most recently developed ISPs from each residence on campus, and eight were submitted for review. Six of the eight were developed in the six months prior to the monitoring team's visit. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. A QIDP Coordinator oversaw the QIDP Department. The facility had 15 QIDPs. Three had been designated as ISP facilitators. These facilitators were responsible for facilitating the annual IDT meetings. QIDPs were trained on facilitation skills using the Q Construction curriculum. They were assessed by the QIDP Coordinator and/or QIDP Educator for competency in facilitation skills. Thirteen of the 15 QIDPs had been deemed competent in meeting facilitation skills using the Q Construction Assessment tool. 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. • Implementation and monitoring of supports was inconsistent. Team members were unable to determine that status of outcomes implemented the previous year or found that supports were not consistently implemented so the efficacy of supports could not be determined. • 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 that the QIDPs did not consistently ensure the	

#	Provision	Assessment of Status	Compliance
		team completed assessments or monitored and revised treatments, services, and supports as needed. At all ISP meetings observed, it was noted that outcomes developed the previous year had not been implemented. There was no evidence that the QIDP was monitoring services and taking action when supports were not in place or action steps developed by the team had not been implemented. There was not an adequate monthly review process in place. As a result, it was unclear whether progress had been made on outcomes or if current supports were effective. In some cases, data were presented regarding outcomes implemented the previous year, however, team members were not sure what the data represented or specifically what progress had been made by the individual. Consequently, IDTs made very few changes in supports and services for the upcoming year. 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 supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	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 to identify assessments to be completed prior to the annual ISP meeting. The QIDP Coordinator was tracking attendance by relevant IDT members monthly. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for February 2014 to June 2014. Attendance remained high for most disciplines, however, the facility needs to focus on ensuring that individuals, the LAR, family and DSPs attend the ISP meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance

Team member	Feb	March	April	May	June
Individual	95%	77%	78%	88%	82%
LAR	70%	67%	71%	50%	86%
Family/Advocate	25%	100%	71%	60%	25%
DSP	74%	85%	74%	100%	76%
QIDP	95%	100%	100%	100%	100%
Psychologist/BA	95%	100%	100%	100%	88%
RN	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%
Physical Therapist	100%	100%	100%	100%	100%
Speech Therapist	100%	100%	100%	100%	100%
Dietician	83%	100%	100%	100%	100%
PCP	40%	100%	100%	100%	60%
Psychiatrist	73%	100%	75%	100%	75%
Dental Services	100%	100%	100%	100%	100%
Vocational Services	86%	88%	100%	100%	100%
Program Developer	100%	100%	100%	100%	100%
Home Manager	100%	100%	100%	100%	100%
LA	100%	100%	100%	100%	100%

A sample of six ISP attendance sheets was reviewed by the monitoring team for participation at annual IDT meetings. Findings were similar to findings of the facility audit. The sample was Individual #273, Individual #134, Individual #381, Individual #362, Individual #365, and Individual #200. Individual #365's and Individual #200's ISPs were developed by an appropriately constituted IDT. Regarding those that were not:

- Individual #134 did not attend his annual ISP meeting.
- The LAR did not attend the meeting for Individual #273 and Individual #381.
- The DSP, dietician, and psychiatrist did not attend Individual #362's annual ISP meeting.

In zero of six 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.

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

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>regularly attend ISP meetings for individual's participating in psychiatry clinic.

At the annual IDT meetings observed by the monitoring team, all team members were present and actively engaged in integrated discussion. This was positive to see.

Although significant progress had been made, the facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. When team members cannot attend the meeting, the ISP should note efforts to get input from those team members prior to the annual meeting.</td><td></td></tr>
<tr><td>F1c</td><td>Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.</td><td>DADS Policy #004.1 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.

Annual ISP preparation meetings were held approximately 90 days prior to the annual ISP meetings. At the ISP preparation meeting, the IDT was to identify the assessments that were required for the annual ISP meeting. The state policy required that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting for review by all IDT members. The assessments were to be used by the QIDP to develop an ISP Guide prior to the ISP annual meeting. 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 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 February 2014 through May 2014 indicated that the submission of assessments prior to the annual IDT meeting still needs to be a focus area for the facility. The chart below shows the overall assessment submission rates for that time period. The consistently low submission rate of behavioral health, functional skills, psychiatric, and communication assessments were attributed to vacancies in departments responsible for submission of those assessments.

<table><tr><td>February (19 ISPs)</td><td>March (21 ISPs)</td><td>April (23 ISPs)</td><td>May (16 ISPs)</td></tr><tr><td>68%</td><td>70%</td><td>74%</td><td>71%</td></tr></table>
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 pre-ISP determination of assessments needed prior to the annual IDT meeting list was compared to assessments submitted.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		• Individual #134's behavioral assessment was not submitted for IDT members to review 10 days prior to his ISP meeting. His psychiatric and dental assessments were submitted after his annual meeting. • Individual #200 did not have an updated psychiatric evaluation. His behavioral assessment was not submitted at least 10 days prior to his annual IDT meeting. • Individual #362's behavioral and dental assessment were not submitted 10 days prior to her annual IDT meeting. She did not have a current vocational assessment. • Individual #273 and Individual #365 did not have a current behavioral assessment. • Individual #381 did not have a current psychiatric assessment. In six of six (100%), 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. In zero of six (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 to 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> The timeliness and quality of functional assessments, full psychological assessments, and annual psychological updates was excellent. Vocational assessments were also timely, however, functional skill assessments (FSAs) and preference and strengths inventories (PSIs) were not timely. <u>OT/PT/Communication</u> 100% of the assessments reviewed for OT, PT, and speech identified the individual's preferences and strengths, however, there were many individuals who did not have a current communication assessment. <u>Nursing</u> The Comprehensive Nursing Assessments did consistently include, from the pre-ISP, the individual's strengths, preferences, or needs. Even so, individual preferences did not	

#	Provision	Assessment of Status	Compliance
		include how the individual may incorporate using his or her identified strengths as to participating in his or her own health care. For example, Individual #251, at high risk for infections, constipation, weight, did not incorporate his identified strengths and goals regarding how he could participate in his own health to minimize risks. Nursing Assessments did not consistently provide recommendations that would effectively guide the IDT to support the individual. For example, Individual #214's determined risk areas included cardiac and circulatory, but the record had an omission for addressing the individual's tobacco use, or for any recommendation to discuss a cessation program. 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.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	A review of recent ISPs indicated that when adequate assessments were completed prior to the ISP meeting, IDTs were doing a much better job of incorporating recommendations from assessments into the ISP. For example, Individual #365's outcomes were developed from needs and preferences identified in his vocational, functional skills, behavioral, and dental assessments. The team considered both his preferences and his priority needs. As described in F1c, comprehensive assessments required to develop an appropriate ISP were not always completed prior to the annual meeting. When developed after the annual meeting, it was not clear how those assessment recommendations were incorporated into supports. For example, • Individual #273 did not have outcomes to be implemented during the day program. Her ISP dated 2/12/14 indicated that the OT would complete an additional assessment by 3/14/14 to determine activities for session enrollment. There was no evidence that the assessment was completed, or if completed, that recommendations were used to develop outcomes. • Individual #201's ISP indicated that a speech and vocational assessment would be completed. There was no evidence that supports were updated based on recommendations from those assessments. • Individual #381's ISP indicated that a psychiatric assessment would be completed within 30 days and recommendations would be reviewed by the team. There was no documentation of a team meeting to discuss recommendations from the assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		At the ISP meeting for Individual #130, during discussion, the IDT recognized that some assessments were not adequate for planning. The team agreed to reconvene after the habilitation therapy department completed additional communication and sensory assessments. In this case, the development of supports was placed on hold until further assessments could be completed. Assessment needs should have been discussed at the pre-ISP meeting, so that team members could come to the ISP meeting with information needed to develop supports. At the ISP for Individual #50, the team discussed working with him on sign language. It was not clear that an adequate assessment had been completed to determine how much sign language he knew and whether or not he communicated more effectively using sign language or verbal communication. The team stopped short of developing measurable outcomes for communication. 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 four (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. It was not clear in the meetings how the IDT established priorities for training. Outcomes were based on activities that the individuals already had an opportunity to participate in without consideration of potential opportunities for growth. The facility had established an assessment PIT to address problems with assessment submission and quality. Assessment forms had been revised to ensure some standardization with regards to required components. The adequacy of integration of recommendations into the ISP for specific disciplines is discussed in detail in other sections of this report and some comments are below. Recommendations from assessments were consistently used to develop PBSPs for individuals. For example, functional assessments were consistently used to develop PBSPs to address behavioral issues. On the other hand, only 68% of SAPs were based on clear needs identified in assessments. Recommendations from nursing assessments were not always used to develop appropriate protections, services, and/or supports for the individual. For example, Individual #28 was identified for being allergic to bee/wasp stings. The Nursing	

#	Provision	Assessment of Status	Compliance
		Assessment did not include a recommendation that addressed her needed supports to assure any bee or wasp stings were reported promptly, in order that she receive her prescribed injectable EPI Pen medication. The habilitation therapy assessments often provided suggestions for a SAP, though it was not always clear that they participated in the development, training, or review of these. As indicated, the clinicians made recommendations for direct therapy in some cases. Measurable and functional objectives were typically outlined for speech, OT and/or PT services. Otherwise, most of the recommendations were related to the primary indirect support, the PNMP. Recommendations typically focused on the development of the PNMP to address health and risk concerns, with less attention to the development of functional skill acquisition. When assessments were completed after the annual IDT meeting, it was not always evident that the IDT met to review the assessment and incorporate recommendations into the ISP. 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).	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. A sample of seven ISPs was reviewed to determine if training was offered in the least restrictive setting. The sample was Individual #201, Individual #273, Individual #134, Individual #381, Individual #362, Individual #365, and Individual #200. Zero of seven (0%) of the individuals in the sample were offered a range of opportunities to participate in meaningful activities in the community. Zero of seven (0%) of the individuals in the sample had adequate access to the use of community services and community supports (e.g., hair salons, gyms, banks, churches, pharmacies). Zero of seven (0%) of the ISPs in the sample included functional training opportunities that included measurable outcomes to develop new skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISPs included minimal formal training to be implemented in the community. General outcomes were written to attend activities at community sites without describing what training would occur while there. For example, • Individual #365 had a community based outcome that stated "will be taken into town to shop for books, games, and movies when he has the money." While the outcome was based on his preferences, it did not describe training that would occur while in the community or what skills he might build. • Individual #201 did not have any functional action steps to be implemented in the community. He had an action step that stated "will be offered the opportunity to participate in leisure activities in the community." Again, this was not measurable and did not describe how he might build skills in the community. • Individual #200's money management action steps indicated that the community was a possible training site, however, the related SAP required him to complete all steps at home. The outcome was to save money and implementation was based on teaching him to place money in a jar in his room. At IDT meetings observed, the IDT engaged in good discussion regarding community living options. The IDTs developed outcomes for further exposure to living options through attendance at provider fairs, coffee house discussions, and visits to community group homes, however, the IDT did not consider other outcomes that would encourage community integration for further exposure to new things in the community. There was no focus on providing supported employment or volunteer opportunities in the community for individuals at the facility. 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;	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. The Preferences and Strengths Inventory (PSI) was used to identify preferences and strengths. A PSI had been completed for each individual in the sample. Outcomes were most often based on the preferences that were readily available to the individual at the facility. Preferences that were not readily available were often not addressed and barriers to addressing them were not noted. For example, • Individual #273 indicated in her PSI that she wanted to live and work in the community, with her own room and patio. This was not listed in her preferences. Her preference list included foods and activities that were available to her at the facility (e.g., lipstick, hot sauce, board games). Barriers to her living and working in the community were not adequately addressed in her ISP. Lists of preferences in the ISPs in the sample 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. 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 attempted to develop plans to include the individual's preferences. 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. In a review of seven 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 none were focused on gaining specific skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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;	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 many 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. A majority of the action steps in the ISPs reviewed addressed what staff would do, not what the individual would do to achieve an outcome. None (0%) of the plans in the sample included a full array of measurable outcomes. For example,
		• Individual #134 had an action step in his ISP that stated "adaptive equipment will be available for his use."
		• Individual #273 had an action step to address her desire to work that stated "workshop for 8:30 to 10:30 MF." It was not clear what skill would be learned or what would be measured. Her ISP did not specify what supports would be needed.
		• Individual #362 had a three outcomes that stated what supports the facility would provide rather than what skills she would achieve through training. Most of the related action steps were also directions for what staff would do, not what the individual would do. Her outcomes included:
		  ○ Provide structured behavior support in addressing interactions with others.
		  ○ Continue to provide leisure activities of preference.
		  ○ Provide meaningful employment to the individual Monday through Friday.
		
		Additional training had been provided to IDTs in May 2014 on writing measurable outcomes. ISPs in the sample were developed prior to the additional training, thus, the monitoring team was unable to evaluate the impact of training on the inclusion of measurable outcomes in the ISP.
		
		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.
		
		It was not always evident that appropriate supports were developed when IDT members
			Noncompliance

#	Provision	Assessment of Status	Compliance
		identified needs or barriers to achieving outcomes. Individualized measurable treatment strategies based on identified needs were developed, in some cases. Examples include functional assessments and PBSPs. Assessments, however, were not consistently used, however, to develop SAPs (see S2 for further detail). In regards to nursing assessments, appropriate supports were developed when IDT members identified needs or barriers to achieving outcomes in most cases. For example, Individual #72, was documented as not accepting his medications (medication refusal). The IDT team met, and the physician made treatment decisions regarding his medication regimen based on discussion of the individual's medication. Strategies employed were individualized to the individual, including to continue to prompt the individual to take his medication and continue to administer the medications in specific preferred mediums In some cases, individualized measurable goals/objectives/treatment strategies based on identified need were not developed in regards to nursing recommendations. For example, Individual #98's Nursing Assessment recommendations did not include preventive measures for incorporating infection control practices related to her frequent UTIs, such as the implementation of education and monitoring of her hygiene, and application of standard precautions. 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. As noted in F1e, ISPs did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. The facility was not in compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. The development of action plans that integrated all services and supports was still an area with which the facility struggled. Action plans to address outcomes in both the IHCP and SAPs typically included reference to ancillary plans (i.e., PNMP, communication plans, PBSP), however, strategies from those plans were not integrated into supports with strategies specific to achieving the outcome. For example, Individual #381's IHCP	Noncompliance

#	Provision	Assessment of Status	Compliance
		included the following outcomes to address her risks: continue diet, continue bi-annual labs, continue medication, continue to follow behavioral support plan, and continue psychiatric consults. Section J required ongoing collaboration with other disciplines (i.e., behavioral health, neurology, nursing, medical, dental, and pharmacy) for delivery of suitable and timely psychiatric services through the IDT process. Examples of need for collaboration included the pretreatment sedation process, neuropsychiatric coordination of care, review of findings of MOSES/DISCUS, review of QDRRs, and review of Reiss scales. 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 separate plans. When developing the ISP for an individual, the team should consider all recommendations from each discipline, along with the individual's preferences, and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. It was noted at ISP meetings observed that IDTs were having a more integrated discussion among disciplines when considering supports and services. 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.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Method for implementation As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Few action steps were written in terms of measurable action that the individual would perform to complete the objective. 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. Each action step should be measurable action the individual will perform, include the frequency, method of documentation and reporting requirements, and designate the assigned person for implementing and reviewing progress. IHCP action steps were generally brief statements of action to address the risk or references to additional plans (i.e., PNMP, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Time frame for completion A sample of ISPs was reviewed to verify that action steps included a time frame for completion. Action steps included projected completion dates for all ISPs in the sample. In most cases, 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. Staff responsible Outcomes 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.	
	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 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. As noted in F2a3, recommendations of each discipline were not effectively integrated into the outcomes, action plans, and teaching strategies. Teaching and support strategies were not sufficient to ensure consistent implementation of outcomes. 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. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. Data to be collected 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. Few action steps included clear direction for documenting implementation and progress. The facility continued to use very broad terms for when (daily, monthly, annually) and how to document progress (i.e., observation note, monthly review) Frequency of data collection For the sample reviewed, 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. 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. Person responsible for collecting and reviewing data As noted in F2a4, outcomes in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the	As noted in F1, adequate assessments were often not completed prior to the annual meetings. When assessments were recommended by the team, it was not evident that 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	ISP.		
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A small sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. Data reviewed for ISP submission, however, indicated that only 63% of the ISPs developed within the past year were filed in the active record within 30 days of development. As noted in other sections of this report, the monitoring team found that outcomes were rarely 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
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.	QIDPs were assigned overall responsibility for monitoring services and supports in the ISP. The facility had a monthly review process in place to review all supports. A review of QIDP monthly reviews indicated that none of the reviews (0%) in the sample adequately reflected the status of all outcomes and services included in the ISP. For example, • The QIDP monthly reviews for Individual #365 did not include any specific comments regarding implementation of outcomes. For all outcomes, the QIDP wrote a word or two that indicated progress, no progress, or no concerns. It was not possible to determine if outcomes were consistently implemented, what progress had been made or what defined progress for each outcome. For example, for his outcome to obtain an EKG, the QIDP noted "no concerns." There was no indication that the EKG had been obtained or if obtained, recommendations and findings had been discussed by the team. His May 2014 data sheet for implementation of his cooking goal noted refusals to participate in each trial. The QIDP noted "progress" on his cooking goal in her monthly review. • For Individual #381, QIDP monthly reviews did include data that described the status of some outcomes. For example, the QIDP noted the individual's weight and the amount of weight lost over the month reviewed in her review of an outcome to lose weight. For her behavioral outcome to address unauthorized departures, the QIDP gave a brief description of an incident of unauthorized	Noncompliance

#	Provision	Assessment of Status	Compliance
		departure from the facility. On training outcomes, however, she only noted "progress" or "no problems noted" without including specific data. For her outcomes to do her laundry and prepare a meal, the QIDP noted "no problems noted" each month for February 2014 through April 2014. She did not have SAPs for either outcome. Staff were keeping data for an action step for identifying safety signs/symbols. That action step was not found in her ISP and the QIDP was not reviewing the data. There were no SAPs developed for many of the action steps in her ISP and no evidence that the action steps were implemented or that the QIDP was reviewing progress. • For Individual #200, there were SAPs for outcomes not found in his ISP for which staff were tracking data on implementation (e.g., money management and identifying medications). There were no SAPs found for his current outcomes. The QIDP monthly review did not note problems with implementation of his plan. A sample of QIDP monthly reviews were reviewed to determine if the IDT convened as needed when there was a change in the individual's status or support needs, evidence that the ISP was not being implemented, or a lack of progress towards outcomes that might require revision of the ISP. The monitoring team found that the monthly review process was not adequate for ensuring that ISPs were modified, when appropriate. For example, • Individual #200's monthly review for April 2014 listed 11 instances of peer-to-peer aggression during the month. The QIDP's recommendation was to continue to follow prompts in the PBSP. There was no indication that his IDT met to review supports. Supports were not revised and additional supports were not put into place to ensure that a serious incident or injury did not occur from continued peer-to-peer aggression. The QIDP noted that this was an increase in both aggression and victimization. The team failed to address the increase. He had an outcome for cell phone use. The QIDP noted that he did not have a cell phone. No action was taken to ensure that the outcome was implemented. Similarly, he had an outcome to work in the greenhouse. The QIDP noted that no openings were available at the greenhouse. There was no indication that the team revised the outcome or addressed barriers to his working in the greenhouse. • Individual #362 had an action step for the home manager to submit a cash request to obtain a weekly newspaper. The action step was implemented 2/14/14 and stated that it would be completed in 14 days. The QIDP noted in April 2014 "not done yet." There was no indication that the QIDP followed up with the home manager to discuss any barriers to implementation.	

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		The monitoring team found little evidence that individual team members were following up on their responsibility to monitor services and supports and document specific progress or regression. Additionally, supports were not always modified when the individual experienced a change of status, regression occurred, and/or outcomes were not achieved. The facility was collecting data on the completion of monthly reviews by the QIDP. The following table shows data included in the section F QA report for May 2014. <table><tr><td rowspan="2">% of Monthly Reviews Completed</td><td>February</td><td>March</td><td>April</td></tr><tr><td>73%</td><td>47%</td><td>51%</td></tr></table> The monitoring of services and supports was improving. For example, monthly PBSP progress notes were completed and indicated that action occurred when the individual outcomes were not achieved. Comprehensive/Quarterly Nursing assessments for problems identified did not consistently provide statements of their progress or lack of progress. Individual #393's document indicated the individual received pain medication. The assessment did not include statements as to whether or not the severity and type were responsive to the pain medication. Supports were not consistently monitored or modified. For example, Individual #203 experienced passing of an object that "appeared to be the PEG tube bumper." There was no indication in the record that monitoring observations of the tube were occurring in addition to the designated eight-hour shifts associated with providing eternal feedings or water. Nursing services and supports were not consistently monitored and specific progress or regression was documented. For example, Individual #21 was assessed and treated for her urinary tract infections, along with a new event of a new infectious organism. This also required the implementation of contact isolation precautions due to the nature of the spread of transmission of the type of organism. An Acute Care Plan for infections was in place, including staff training. The current Annual ISP and IHCP was not present in the record. A current IRRF dated 3/5/14 was provided in the record request, of which the Infection Risk continued to be determined as low, even though the individual's Annual Comprehensive Nursing assessment documented frequent urinary tract infections. Direct therapy was reviewed after each session with data and IPNs recorded (some clinicians used alternate methods and these did not appear to be filed with the IPNs in	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>the individual records. Monitoring for compliance and effectiveness of the PNMP and communication supports was routinely conducted for the samples reviewed. There was evidence that when supports were deemed to be ineffective, modifications were recommended and implemented.

There was evidence of modifications to therapy treatment plans when progress was not consistent, though in some cases, it appeared that therapy was just discontinued without sufficient rationale and documentation. PNMPs were routinely modified to reflect changes in status or need.

The monitoring team found that the current IDT process is not adequate for implementing, assessing, and monitoring of services for individuals. To move forward towards compliance,
1. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues or consider revising supports.
Plans should be updated and modified as individuals gain skills or experience regression in any area.</td><td></td></tr>
<tr><td>F2e</td><td>No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive</td><td>In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document.

The facility was gathering data on the completion of competency based training with DSPs to ensure training was completed within 14 days of the development of the ISP. Data from 12/1/13 through 5/31/14 indicated that DSPs were not being trained on implementation of the ISP within adequate timelines.

<table><tr><td>Dec 2014</td><td>Jan 2014</td><td>Feb 2014</td><td>March 2014</td><td>April 2014</td><td>May 2014</td></tr><tr><td>6%</td><td>4%</td><td>5%</td><td>14%</td><td>22%</td><td>38%</td></tr></table>
During the week of the monitoring visit, four annual IDT meetings were observed. At the meetings observed,
• Meetings were lengthy, yet very few revisions were made to current supports. IDTs were unable to determine the status of current supports due to a lack of implementation and consistent monitoring of services. Consequently, 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.
• Outcomes and action steps were not necessarily developed based on priorities</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	updated competency- based training when the plans are revised	established for the individual. • Teams were still struggling with using strengths and preferences to provide new training opportunities with a focus on developing new skills. • IDTs were still struggling with developing measurable objectives to track progress or regression. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at SGSSLC. All new employees were required to complete Supporting Vision, the statewide training on the ISP process. 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 Facility Superintendent grants a written extension.	A small sample of plans (15) was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available in all records reviewed. This was good to see, 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. The facility self–assessment indicated that 214 out of 217 (99%) annual ISP meetings were held within 365 days of the previous annual ISP meeting. A list of ISP dates with the date the ISP was due and the date the ISP was filed (document V.10). 137 of 217 (63%) 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 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 it was noted that outcomes were not implemented or lack of progress was noted. 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.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two	The facility was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement.	Noncompliance

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	years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality assurance activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings. Progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation.	

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:** <u>Documents Reviewed</u>: o DADS <u>draft</u> policy #005: Minimum and Integrated Clinical Services o SGSSLC Policy/Procedure: Integrated Clinical Services Governing Body, 7/24/14 o Off Campus Consultation Process, 7/26/12 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC Policy/Procedure: Integrated Clinical Services and Minimum Common Elements of Clinical Care, 9/13/12 o SGSSSLC Section G Self-Assessment o SGSSLC Section G Action Plan o SGSSLC Provision Action Information o SGSSLC Section 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 <u>Interviews and Meetings Held</u>: o David Jolivet, MD, Medical Director o Valerie Murphy, RN, Medical Compliance Nurse o Dena Johnston, Habilitation Services Director o Misty Mendez, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. <u>Observations Conducted</u>: 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 o Integrated Clinic Services Governing Body Meeting o QA Director – SAC Face to Face Meeting, Section G

	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. The self-assessment reviewed three items: (1) ISP attendance by clinicians, (2) data from the Integrated Audit Tools which measured integration of clinical committee recommendations into the ISPs, and (3) review of clinical committee meeting minutes for documentation supporting integration. 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. Consults were also audited to determine if ISPAs were appropriately completed. The facility's process for measuring integration of clinical services is relatively new and will likely evolve over time. Future self-assessments should reflect revisions made in the process. The facility's lead should take note of the comments related to assessing section G2 and make the appropriate adjustments to the self-assessment. The facility found itself in noncompliance with provision G1 and substantial compliance with provision G2. The monitoring team found noncompliance with both provision items.
	Summary of Monitor's Assessment: The facility director served as the lead for this provision. The facility developed the Integrated Clinical Services Governing Body to establish guidelines and provide oversight of integrated clinical services and ensure consistent and coordinated healthcare to optimize outcomes for individuals served. The ICSGB developed a series of tools designed with the intent of measuring integration. Audits of meeting minutes, ISP data, and other information were completed to determine if integration occurred. The monitoring team attended the Integrated Clinical Services Governing Body meeting as well as the face-to-face section G meeting to learn of about the facility's section G activities. The ICSGB was established in April 2014 and met on a weekly basis to engage in a variety of activities designed to promote integration of clinical services. The monitoring team heard numerous accounts of the ICSGB activities throughout the week of the compliance review. Many, such as review of clinical policies and procedures by the facility's clinical leaders, would appear to have a positive impact on the operations of the facility. However, it became apparent during the week of the compliance review that issues related to clinical integration that should have been brought to the ICSGB were not. The facility implemented a new IPN template for documentation of consults. This template was implemented for only a relatively short period at the time of the compliance review. The facility conducted audits, but the audits did not fully address the requirements of the Settlement Agreement and state policy. These requirements have been clearly outlined in the recommendations of several monitoring team reports. The lack of a robust audit tool and the use of a skewed sample resulted in data that suggested compliance with this provision item. However, the monitoring team found compelling evidence in the

	active records that only one provider was documenting the required information.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Integrated Clinical Services Governing Body was established. The ICSGB was comprised of the facility director/ADOP, clinical department directors and/or leads as well as the medical compliance nurse. The ICSGB was charged with: • Collecting data to ensure that clinical services were integrated • Analyzing and trending data • Providing training, education, and support to the IDTs and clinical committees • Providing oversight to the clinical committees The committee met weekly starting 4/29/14 to address matters related to clinical integration. Audit tools were developed and each member was assigned responsibilities for completing the audits. An Integrated Clinical Services Tool was developed to monitor several elements. Committee meeting minutes were audited to assess attendance, sharing of relevant data, generation of recommendations, follow-up of recommendations, and the effectiveness of recommendations. ISP documents were reviewed to determine if assessments completed by the clinical disciplines were integrated into the ISP. Overall, this process represented the facility's best efforts in developing systems to improve integration. Throughout the week of the compliance review, the monitoring team heard many reports about how the ICSGB contributed to integration. It appeared that if the committee functioned as designed, it would have a significant impact on the manner in which the facility delivered integrated services. Therefore, it was somewhat disconcerting to learn that several clinical issues that were the direct result of a lack of integration had not been addressed by the committee during the four months and many meetings that had occurred. Problems with the facility's MOSES and DISCUS evaluations and the lack of appropriate collaboration between dental and behavioral health services would appear to be the very types of issues that the ICSGB could and should have addressed. These clinical issues impacted the health care services provided to the individuals. While this committee appeared to have the potential to result in meaningful changes relative to the delivery of integrated clinical services, the fact that major issues were not reviewed is reflective of the need to continue to refine the process. Through interviews, observations of activities, review of records and data, the monitoring team saw evidence of integration of clinical services. Details on integration activities can be found in the varies sections of this report. The following are a few examples where integration was observed:	Noncompliance

#	Provision	Assessment of Status	Compliance

		• Daily Provider Meetings
		• Clinical Committees:
		  ○ Infection Control Committee
		  ○ Pharmacy and Therapeutics Committee
		  ○ Pneumonia Review Committee
		  ○ Skin Integrity Committee
		  ○ PNMT
		  ○ PBSP Committee
		• OTs, PTs, and SLPs (related to mealtimes and swallowing) completed Comprehensive Assessments and Assessment of Current Status collaboratively on at least an annual basis. They also completed assessments in the interim for acute concerns or a change in status. There was some evidence of collaboration with behavioral health services to address individuals with communication needs, but improvement was needed.
		• Psychiatry demonstrated clinical integration in the various meetings observed. As noted in section J, while information about various topics, such as polypharmacy and seizure disorder 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. Integration of psychiatry was more pronounced in the psychiatric quarterly evaluations because the clinical disciplines provided pertinent information for the integrated document.
		• Behavioral health services demonstrated functional integrated services with psychiatry.
		
		Several areas offered great opportunities for improvement:
		• ISP Attendance - Attendance at annual ISPs improved for most clinical disciplines. Improvement was needed in medical participation.
		• As previously noted, there were continued problems with the integration of behavioral health services and dental clinic. Individuals were referred to behavioral health services and plans were written, but the plans were not well executed.
		• There was no effective integration of neurology and psychiatry. The neurologist often commented that he was unaware of the importance of certain AEDs or whether they were being used for a psychiatric indication. This is discussed in further detail in section L1.
		• Since June 2013, only 12% 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. This was a decrease from the 18% that were documented as complete during the last compliance review.
		• The pretreatment sedation review forms that were completed did not include	

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		• the documentation of a consensus decision with regard to the use of a particular medication. • The Medication Variance Committee meeting included discussion from nursing and pharmacy. Greater participation and input were needed from the medical department. <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 lead should address the concerns outlined in the comments above. 2. 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 medical department tracked off-site consultations. A total of 45 consults in the record sample that were completed after February 2014 were reviewed: • 37 of 45 (82%) consultations were summarized by the medical providers in the IPN within five working days • 15 of 45 (33%) IPN entries included all required elements (summary of findings, agree/disagree, and decision to refer to the IDT). The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within <u>five working days.</u> A number of formats was used for IPN documentation of consultations. In the weeks prior to the compliance review, a new IPN template was implemented. Very few consults were seen in this format. Even when this format was used, not all providers used it appropriately. For example, for Individual #117, the new template was used on 8/15/14. The date of the consult was not provided. The summary was two words, which were illegible. There was no response to agree/disagree or IDT referral. This was the typical documentation seen for this provider. The facility found itself in substantial compliance with this provision item. The validity of the self-assessment process was problematic: • While the newly implemented consultation note template included the question regarding IDT referral, the audit tool did not address the requirement. • The audits conducted by the facility included a sample of consults that were predominately in the caseload of one physician. As noted in section L, the	Noncompliance

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		documentation of the two primary care providers differed markedly. The facility's sample was weighted towards the provider with better documentation. • The facility placed emphasis on Question #45 from the internal/external medical audits. As detailed in the last monitoring team report, 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 additional requirements cited in state policy regarding the need to summarize the findings, state agreement/ disagreement, and determine the need for IDT referral. The monitoring team has observed that other SSLCs utilized a state audit tool related to section G2. This tool covered all required elements. The medical director and medical compliance nurse were not aware of this tool. The Settlement Agreement Coordinator stated that use of the tool was not mandatory. The facility should consider use of the state tool or develop a valid audit tool. The documentation requirements have been outlined repeatedly in the recommendations of previous monitoring team reports. This provision remains in noncompliance due to the lack of the required IPN documentation. Compliance Rating and Recommendations The monitoring team disagrees with the facility's self-rating of compliance. 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. 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:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o SGSSLC Policy/Procedure: Integrated Clinical Services and Minimum Common Elements of Clinical Care, 9/13/12 o SGSSSLC Section H Self-Assessment o SGSSLC Section H Action Plan o SGSSLC Provision Action Information o SGSSLC Sections H 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 ICSGB Minutes o Administrative IDT meeting minutes o Review of records listed in other sections of this report Interviews and Meetings Held: o David Jolivet, MD, Medical Director o Valerie Murphy, RN, Medical Compliance Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily Medical Provider Meetings o Integrated Clinic Services Governing Body Meeting
	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 as well as the comments and recommendations found in the monitoring team report for the February 2014 compliance review. 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: Over the past year, multiple changes occurred in 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. In July 2014, a new medical director assumed the lead for this provision. There was very little progress seen and that was not unexpected given the series of transitions that occurred over the past 10 months. The facility continued to monitor the timeliness of assessments, but no efforts were seen in evaluating the quality of assessments. While audits were conducted for provision H2, the medical director and medical compliance nurse acknowledged that no work had been done in the other areas. In fact, the self-assessment noted that monitoring was suspended or did not occur for provision items H3 –H6.

#	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 - 2014 Compliance With Timely Submission (%)						
	Dec	Jan	Feb	Mar	Apr	May
OT/PT	100	85	100	100	100	100
Speech Annual	77	55	64	11	18	0

#	Provision	Assessment of Status	Compliance

Audio Annual	100	64	80	92	100	88
Nutrition Evaluation	81	83	78	80	100	100
Nursing Comprehensive	100	87	68	78	86	88
Medical Annual	69	96	79	100	100	100
Psychiatry Comprehensive	15	24	25	33	36	29
Psychology APES	69	52	79	72	70	88
Dental Annual	88	82	79	94	81	88
QDRR	33	6	35	63	100	100

The data applied to ISP submission dates and did not necessarily reflect the requirements that some disciplines had to complete assessments within 365 days of the previous assessment. Therefore, the facility began auditing a sample of medical, dental, and psychiatry assessments to determine if the assessments met this requirement. Those data are presented in the table below.

Compliance With Timely Submission (%) Based on Previous Assessment 2013 - 2014						
	Dec	Jan	Feb	Mar	Apr	May
Medical	100	100	100	100	100	100
Dental	100	0	50	100	100	100
Psychiatry	0	0	0	0	0	50

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 -2014						
	Jun	Jul	Aug	Sep	Oct	Nov
PNMT RN	100	100	50	100	100	100
Provider Post Hospital	80	100	100	100	100	100
RN Post Hospital	60	50	75	73	75	50
Psychiatry (restraint)	89	89	45	41	94	87
Pharmacy (restraint)	89	89	45	41	94	87
Psychiatry-Pharmacy	89	89	82	94	100	100
Psychology ESM	60	60	100	80	80	100
Nursing Serious Injury	100	100	100	67	100	100

The audits captured several important assessments that were done in response to hospitalizations, the use of chemical restraints, and serious injury. There was no audit to capture physician's response to acute illness that did not require hospitalization.
All of the facility's efforts were focused on timelines. There was no evaluation of the quality of the assessments as required by state policy.

#	Provision	Assessment of Status	Compliance
		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: • Annual Medical Assessments were found in all of the records included in the record sample. For a sample of 15 AMAs, 14 of 15 (93%) were completed within 365 days of the prior AMA. The PCPs began completing Quarterly Medical Assessments in October 2013. Medical assessments are discussed in section L1. • Annual Dental Examinations were completed in a relatively timely manner. The compliance rate for completion of annual assessments was 92%. Dental assessments are discussed in section Q2. • Only 27.7% of individuals had current QDRRs. Completion of QDRRs is discussed in further detail in section N2. • For the two most recent Admission/Annual/Quarterly Nursing Assessments, 9 of 10 (90%) were completed in a timely manner. For the majority of records, there was some improvement in assessments. However, the majority of the assessments did not adequately document response to treatment interventions. • At SGSSLC, 169 of the 209 individuals received psychopharmacologic intervention at the time of the review. The facility continued to struggle with the completion of the evaluations in Appendix B format. A list of individuals with completed comprehensive psychiatric evaluations (CPE) per Appendix B guidelines included 78 individuals. As there were 169 individuals participating in psychiatry clinic, 54% of individuals still required CPEs. Interviews indicated that the delays in completing CPEs were due primarily to the lack of psychiatric staffing and frequent turnover in the psychiatry department. • Functional assessments were completed and timely for 93% of individuals with PBSPs. Additionally, 100% of individuals at SGSSLC had an annual psychological update. On the other hand, only 11% of individuals had a timely full psychological assessment. <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.	

#	Provision	Assessment of Status	Compliance
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 of 30 records (5 records each month) for medical diagnoses. The medical conditions audited were diabetes mellitus, pneumonia, UTI, constipation, osteoporosis, and seizures. Thirty records were also reviewed to determine if the combined case formulation resulted in the appropriate treatment plan. 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. • 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 assessments and diagnoses.	The facility did not do any additional work in this area. Assessment for this area consisted of presentation of data for Round 7, Round 8, and Round 9 of the internal/external medical audits. Round 9 is discussed in section L of this report. Round 7 and Round 8 were discussed in previous reports. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. Comments and recommendations for moving in the direction of substantial compliance are detailed in the monitoring team report for the February 2014 compliance review.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The self-assessment documented that "Monitoring for this action step has been temporarily discontinued." Thus, no current data were provided. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. Comments and recommendations for moving in the direction of substantial compliance are detailed in the monitoring team report for the February 2014 compliance review.	Noncompliance

#	Provision	Assessment of Status	Compliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The self-assessment documented that "Monitoring for this action step has been temporarily discontinued." Thus, no current data were provided. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. Comments and recommendations for moving in the direction of substantial compliance are detailed in the monitoring team report for the February 2014 compliance review.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	Per the self-assessment, monitoring was not implemented and no tools were developed. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. Comments and recommendations for moving in the direction of substantial compliance are detailed in the monitoring team report for the February 2014 compliance review.	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 presented data from the Integrated Clinical Services Audit Tool. This tool was developed to determine if the clinical committees demonstrated good clinical integration. The facility averaged the scores for the six data elements. Data were presented for March 2014 through May 2014. The average score for each month was <50%. The facility, therefore, determined that the there was a lack of data to support and validate integrated clinical services, policies, and procedures. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. State office should provide further guidance to the facility in the form of a finalized section H policy.	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:** <u>Documents Reviewed</u>: ○ DADS Policy #006.1: At Risk Individuals dated 12/29/10 ○ DADS SSLC Risk Guidelines dated 4/17/12 ○ List of individuals seen in the ER in the past year ○ List of individuals seen in the infirmary in the past year ○ List of individuals hospitalized in the past year ○ List of individuals with serious injuries in the past year ○ List of individual at risk for aspiration ○ List of individuals with pneumonia incidents in the past 12 months ○ List of individuals at risk for respiratory issues ○ List of individuals with contractures ○ List of individuals with GERD ○ List of individuals at risk for choking ○ Individuals with a diagnosis of dysphagia ○ List of individuals at risk for falls ○ List of individuals at risk for weight issues ○ List of individuals at risk for skin breakdown ○ List of individuals at risk for constipation ○ List of individuals with a pica diagnosis ○ List of individuals at risk for seizures ○ List of individuals at risk for osteoporosis ○ List of individuals at risk for dehydration ○ List of individuals who are non-ambulatory ○ List of individual who need mealtime assistance ○ List of individuals at risk for dental issues ○ List of individuals who received enteral feeding ○ List of individuals with chronic and acute pain ○ List of individuals with challenging behaviors ○ List of individuals with metabolic syndrome ○ List of individuals who were missing and/or absent without leave ○ List of individuals required to have one-to-one staffing levels ○ List of 10 individuals with the most injuries since the last review ○ List of 10 individuals causing the most injuries to peers for the past six months ○ Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings ○ A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed. ○ Draft ISPs and Assessments for Individual #130, Individual #50, and Individual #57

	○ ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): Individual #201, Individual #273, Individual #134, Individual #381, Individual #362, Individual #365, and Individual #200. Interviews and Meetings Held: ○ Informal interviews with various individuals, direct support professionals, program supervisors in homes and day programs; ○ Vicki Hinojos, Residential Director ○ Vanessa Barrientez, QIDP Coordinator ○ Melinda Gentry, ADOP ○ Dana Robertson, Provision Coordinator ○ Jalown McCleery, Incident Management Coordinator ○ Roy Smith, Human Rights Officer Observations Conducted: ○ Observations at residences and day programs ○ ISP preparation meeting for Individual #118 ○ Annual IDT Meeting for Individual #130, Individual #50, and Individual #57 ○ Incident Management Review Team Meeting 8/19/14 and 8/21/14 ○ Human Rights Committee Meeting ○ Executive Safety Committee Meeting ○ Restraint Reduction Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment updated 7/24/14. 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. For example, to assess compliance with I1, the facility: 1. Reviewed facility policies regarding the risk assessment process. 2. Reviewed training records to ensure staff had received competency based training. 3. Reviewed the ISP assessment database to determine if assessments were submitted 10 days prior to annual IDT meetings. 4. Reviewed 20 ISPs over a six month period to determine if risks were identified and supports developed to address risks. 5. Reviewed the ISP attendance database to determine if relevant team members were present for the risk discussion. 6. Reviewed eight ISPs per month to evaluate the quality of the risk discussion.

7. Reviewed data to determine if the IRRF and IHCP documentation was completed within policy timeframes.
8. Reviewed 82 ISPs to ensure all included current risk ratings and required IHCP elements.
9. Reviewed data to determine if staff related training occurred within 14 days of IHCP development.
10. Interviewed 10 to 20 DSPs per month regarding knowledge of risks and supports.
11. Reviewed five records per month of individuals rated as high or medium risk to determine if assigned staff were reviewing supports for effectiveness.
12. Reviewed ISPAs for individuals admitted to the hospital to ensure that a review of risks occurred within five days.
13. Reviewed a sample of ISPAs for individuals who had a change of status to determine if appropriate assessments and re-evaluation of risk ratings were completed.

The facility had an adequate self-assessment process in place. Additional work towards compliance with section I was focused on findings from the self-assessment.

The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed with the facility's ratings for section I.

Summary of Monitor's Assessment:

The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. Since the last review, the facility had implemented a number of procedures to address risks including:

- A PIT was completed to address the timeliness and quality of assessments. Standardized assessment templates were developed for each department.
- A facility wide schedule was implemented to increase attendance at ISP and IDT meetings.
- A compliance RN was hired to provide oversight to ensure that departments were capturing risk elements.
- The facility began focusing on the monthly review of IHCP outcomes.

The monitoring team observed the risk identification process at ISP meetings. Each discipline presented relevant information included in the IRRF during the risk determination process. IDTs were engaging in a much more integrated discussion regarding risk ratings and the development of action steps to address risks

The facility continued to monitor the submission of assessments prior to annual ISP meetings. Data indicated that there had been some improvement in assessment submission, however, a review of current ISPs and supporting assessment showed that all ISPs in the sample were developed without up-to-date assessment information. Without current assessments available to the IDT for review, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings.

As noted in section F, the facility did not have an adequate system in place to monitor supports. Teams were not consistently documenting the completion of assessments and resulting recommendations and

	supports were not monitored to ensure consistent implementation. 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. Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that ISPs were often not filed and available for implementation within 30 days of development. The QIDP Coordinator indicated that this was a focus area for the QIDP department. To move forward with section I: 1. 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. 2. 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. 3. 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 state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop an integrated health care plan (IHCP) to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee when appropriate. IHCPs were designed to provide a comprehensive plan to be completed annually and updated as needed. The monitoring team observed the risk identification process at ISP meetings. Each discipline presented relevant information included in the IRRF during the risk determination process. IDTs were engaging in a much more integrated discussion regarding risk ratings and the development of action steps to address risks 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. Data submitted by the facility indicated compliance with this mandate had improved significantly. The table below shows the percentage of assessments submitted 10 days prior to the risk discussion for February 2014 through May 2014. The consistently low submission rate of behavioral health, functional skills, psychiatric, and communication assessments were attributed to vacancies in departments responsible for submission of those assessments.	Noncompliance

#	Provision	Assessment of Status	Compliance
		<table><tr><td>February (19 ISPs)</td><td>March (21 ISPs)</td><td>April (23 ISPs)</td><td>May (16 ISPs)</td></tr><tr><td>68%</td><td>70%</td><td>74%</td><td>71%</td></tr></table> A review of a sample of ISPs developed in the last six months supported the facility's own finding that not all assessments were being submitted prior to annual ISP meetings in some cases. The sample included Individual #134, Individual #200, Individual #362, Individual #273, Individual #365, and Individual #381. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. When further assessments were recommended by the IDT, it was not always clearly documented when the assessment was obtained or if the IDT discussed findings from the assessment and reconsidered risk ratings, supports, and services. A PIT was completed to address the timeliness and quality of assessments. Standardized assessment templates were developed for each department. The templates were designed to ensure that recommendations regarding risks and recommendations for supports were included in each assessment. This should improve the quality of the risk discussion. It will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.	
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 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 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 was reviewing ISPAs for individuals admitted to the hospital to determine if appropriate assessments and re-evaluation of risk ratings were completed within five days of discharge. The following table shows a summary of that review. <table><tr><td>Month</td><td>Feb 2014</td><td>Mar 2014</td><td>April 2014</td><td>May 2014</td></tr><tr><td>% reviewed within 5 days of discharge</td><td>32%</td><td>77%</td><td>63%</td><td>55%</td></tr></table>	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility was in the process of developing a list of indicators that might identify a change of status in addition to hospitalization. A fairly comprehensive database that could assist teams in identifying a change of status was available, but not consistently used by IDTs to signal the need for a review of services and supports. For example, Individual #200's QIDP included a list of 11 incidents of peer-to-peer aggression in April 2014 in his monthly review. There was no evidence that the IDT met to review his risk ratings or revise supports and services. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended following a change of status. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization and the lack of comprehensive monthly review of services, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. The monitoring team reviewed a sample of assessments from various disciplines to determine whether or not an adequate assessment process was in place to address identified risk. Overall, the facility had made progress in ensuring that assessments were adequate to identify risks. Findings by discipline are summarized below. <u>Nursing</u> Based on the records selected by the monitoring team for review, Eight of nine (88%) of the records contained an Admission/Annual Comprehensive Nursing Assessment/Nursing Physical Assessment, and the required accompanying documents. Eight of nine (88%) of the records included a completed Admission/Annual Nursing Assessments to assist the team in developing appropriate plans to address the individual's health care needs. See M2 for information regarding timeliness, and quality of the Nursing Admission/Annual assessments. <u>Psychiatry</u> The lack of psychiatric participation in the PBSP and ISP process negatively affected the decision-making process in regard to recommendations of less intrusive measures, diagnostics, and indications for utilization of psychotropic medication. <u>Medical</u> See sections L and N regarding the identification of medical risk factors. <u>OT/PT</u> Based on a review of 14 individual records, 13 individuals had been provided an adequate OT/PT assessment completed to address the individuals' at risk conditions,	

#	Provision	Assessment of Status	Compliance
		(93%) included an adequate OT/PT assessment to assist the team in developing an appropriate plan. Based on a review of 22 individuals records, 18 (82%) had been provided a current and appropriate communication assessment. Each of these had sufficiently addressed the individual's at risk conditions. Although progress was noted, the facility did not yet have an adequate system in place to ensure that all recommended assessments were completed and discussed in a timely manner.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, 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.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner, if indicated by the risk status. The facility was gathering data on the completion of competency based training with DSPs to ensure training was completed within 14 days of the development of the ISP. Data from 12/1/13 through 5/31/14 indicated that DSPs were not being trained on implementation of the IHCP within adequate timelines. The table below shows the percentage of training completed within 14 days for ISPs developed within each month. Dec 2014: 33% ; Jan 2014: 61% ; Feb 2014: 42% ; March 2014: 48% ; April 2014: 22% ; May 2014: 19% Additionally, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed. The facility was collecting data on the completion of monthly reviews by the QIDP. The following table shows data included in the section F QA report for May 2014. % of Monthly Reviews Completed: February 73% ; March 47% ; April 51% IDTs were not tracking the completion of assessments and documenting resulting recommendations. Documentation of plan implementation was not consistent. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For the QIDP monthly reviews, the QIDPs were not consistently documenting implementation of action steps or reviewing status of IHCP outcomes. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. 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	Noncompliance

Dec 2014	Jan 2014	Feb 2014	March 2014	April 2014	May 2014
33%	61%	42%	48%	22%	19%

% of Monthly Reviews Completed	February	March	April
	73%	47%	51%

#	Provision	Assessment of Status	Compliance
		ancillary plan in place or instructions were too general (e.g., monitor weights, follow diet, DSP instructions). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. For example, • Individual #273's IHCP had action steps to address her dental risk, risk for choking, and gastrointestinal issues that stated "hab therapy monitoring for individualized adaptive equipment, swallowing, or choking issues" and "DSP instruction sheet." She had action steps to address her cardiac risk that stated "nursing will get weight weekly and PRN" and "DSP instruction sheet." The attached DSP instruction sheets were similarly vague with statements that included, "encourage her to exercise as tolerated" and "encourage her to drink her fluids so she does not get dehydrated." To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: 1. Develop action plans with measurable criteria for assessing outcomes. 2. Document the implementation of action plans. 3. Document that clinical data are 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:** Documents Reviewed: o Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, 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 in-service 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 ○ List of new facility admissions for the previous six months and whether a Reiss screen was completed ○ Spreadsheet of all individuals (both new admissions and existing residents) who have had a Reiss screen completed in the previous 12 months ○ 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 ○ A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations ○ A list and copy of all forms used by the psychiatrists ○ All policies, protocols, procedures, and guidance that relate to the role of psychiatrists ○ A list of all psychiatrists including board status; with indication who has been designated as the facility's lead psychiatrist ○ CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. ○ Overview of psychiatrist's weekly schedule ○ Description of administrative support offered to the psychiatrists ○ Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility ○ A list of continuing medical education activities attended by medical and psychiatry staff ○ A list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff ○ For the past six months, minutes from the committee that addressed polypharmacy ○ Any quality assurance documentation regarding facility polypharmacy ○ Facility-wide data regarding polypharmacy, including intra-class polypharmacy ○ For the last 10 newly prescribed psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; Positive Behavior Support Plan (PBSP); HRC documentation ○ 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)

	○ List of all individuals age 18 or younger receiving psychotropic medication ○ 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 ○ Documentation of psychiatry attendance at ISP, ISPA, PBSP, or IDT meetings ○ A list of individuals requiring chemical restraint and/or protective supports in the last six months. <u>Documents Requested Onsite:</u> ○ Reiss Screen Policy ○ List of variables for all clinic patients observed and for all charts requested ○ Five examples of polypharmacy justification authored by psychiatry ○ List of individuals who had a Reiss Screen for change of status and the result of the screen. ○ Audit data regarding psychiatry providers compliance with QDRR recommendations ○ All data presented, doctor's notes and documentation for Dr. Cormack's clinic 8/28/14 regarding Individual #263 and Individual #10. ○ All data presented, doctor's notes and documentation for Dr. Cormack's clinic 8/19/14 regarding Individual #235 and Individual #298 ○ Copy of the CAP regarding providing information regarding neurology to the IDT. ○ Copy of the polypharmacy monitoring policy ○ Copies of minutes from ICSGB including draft policy ○ Copy of the pearls book ○ Five examples of IRRF submission ○ Tracking data regarding timelines of IRRF submissions for the last six months ○ Facility specific psychiatry policy regarding psychiatry clinic ○ New TIVA policy ○ Copy of Administrative IDT presentation 8/21/14 for sections J and N ○ All data presented, doctor's notes and documentation fro Dr. Manshardt's clinic on 8/21/14 regarding Individual #77. ○ These following documents for these individuals: Individual #76, Individual #48, Individual #329, Individual #38, Individual #246, Individual #251, Individual #227, Individual #209, Individual #370, 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) Observations Conducted: ○ Psychiatry clinic conducted by Dr. Cormack ○ Psychiatry clinics conducted by Dr. Manshardt ○ Polypharmacy Committee meeting ○ Pharmacy and Therapeutics Committee meeting ○ Integrated Clinical Services Governing Body meeting ○ Pretreatment Sedation Meeting

	○ Daily Provider meeting ○ Administrative IDT <u>Interviews and Meetings Held</u>: ○ Trina Cormack, M.D., Psychiatry Department Head with Jennifer Quisenberry, psychiatry assistant ○ Jennifer Quisenberry, psychiatry assistant ○ David Jolivet, M.D., Medical Director ○ Constance M. Whorton, R.N., M.S.N., C.N.S., C.P.H.Q., facility psychiatry nurse ○ Robb Weiss, Psy. D., Director of Behavioral Health Services, Chief Psychologist ○ Janis A. Rizzo, R.Ph., pharmacy director with Sara Dempsey, Pharm. D. ○ James Manshardt, M.D., facility psychiatrist
	Facility Self-Assessment: SGSSLC submitted documentation regarding section J for the self-assessment dated 7/24/14 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. 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. 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 substantial compliance for only one provision item (J1). The monitoring team agreed with the self-rating provided by the facility. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the psychiatry department (i.e., lead psychiatrist, facility psychiatrists, psychiatry assistant, and psychiatric nursing staff), 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 developing a scheduled psychiatry clinic inclusive of documentation requirements from other disciplines.

	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 been providing services at the facility for approximately six months. In addition, the facility had retained the services of a child and adolescent psychiatrist 12 hours per month. In an effort to ease the transition for locum tenens providers, the facility had developed a "pearls of wisdom" book to include information pertinent to the practice of psychiatry at the facility. At the time of this monitoring visit, 80% of the facility population, or 169 individuals were receiving services via psychiatry clinic. The monitoring team observed three 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 improvements with regard to timeliness of quarterly psychiatric medication reviews. This was apparently related to the development of a psychiatric clinic that was structured and scheduled. A laudable accomplishment for the facility psychiatry clinic staff. There was some integration between psychiatry, primary care, and behavioral health achieved by case reviews in various committee meetings (e.g., polypharmacy and medication review committee). Additionally, the psychiatric clinic included representatives from multiple disciplines. The facility data regarding psychiatric participation in the ISP meetings indicated that for the time period of December 2013 through May 2014, psychiatry attended 63% of ISP meetings. It was noted that attendance percentages were improved in the latter months with 100% attendance noted in March 2014 and May 2014. This was laudable given the scarce psychiatric resources at the facility. Data were confusing, however, because there were ISP meetings in months noting 100% psychiatry attendance 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. 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, 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.

	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, rather relying on adjustments to the medication regimen. 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 54% 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, while the clinical pharmacist now chaired this meeting, there was not a facility level review of specific regimens. In addition, the psychiatric providers had not begun authoring clinical polypharmacy justifications for review. The facility made progress in the area of informed consent, but remained in noncompliance with J14 due to

	the lack of 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.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications The psychiatrists who provided services at SGSSLC were either board eligible or board certified in general psychiatry by the American Board of Psychiatry and Neurology. The facility had retained the services of a new lead psychiatrist who began work approximately six months ago. 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 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 in addition to the facility lead psychiatrist to perform clinical duties. The current lead psychiatrist had been providing services in the facility for approximately six months. 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.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At SGSSLC, 169 of the census of 209 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. A list of individuals with completed comprehensive psychiatric evaluations (CPE) per Appendix B guidelines included a total of 78 individuals. As there were currently 169 individuals participating in psychiatry clinic, 54% of individuals still required CPE. Interviews indicated that the delays in completing CPEs were 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	Noncompliance

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		process regarding scheduling, psychiatric documentation and diagnostic concordance, the monitoring team had difficulty determining the current diagnoses and treatment plan due to the paucity of completed evaluations leading to discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., drug regimen review profile, physician's annual medical review, ISP, PBSP). Per the facility self-assessment, a review of five records per month, for a total of 30 records during this monitoring period, revealed that of all audited records, on average, 47% of the records contained documentation that individuals had been evaluated and diagnosed in a clinically justifiable manner. There were additional concerns noted in some clinic observations. For example, in some clinics, the team continued to focus on behaviors 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. 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. Clinical Justification Discussions with the facility staff revealed an awareness of the difference in quality regarding clinical documentation. A review of a sample of 15 records revealed varying content in their completeness. Given the paucity of completed CPE 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. Tracking Diagnoses and Updates The psychiatry department implemented a database to track diagnoses and capture diagnostic updates. For example, a spreadsheet of individuals prescribed psychotropic medication listing Axis I, II, and III diagnoses was provided with dates of clinical contact. The psychiatry department indicated that with the initiation of the new quarterly psychiatry clinic process, there were marked improvements in the timeliness of completion of quarterly clinics. In the months of January 2014, February 2014, and March 2014, on average, only 6% of quarterly clinics were completed. This improved greatly beginning in April 2014 where 95% of quarterly clinics were completed. In July 2014, 100% of quarterly clinics were completed.	

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		As discussed while onsite, if a quarterly examination was due, the psychiatrist could complete an Appendix B instead, being that it was 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 (CPE) and a history of delays in completion of quarterly clinical reviews 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 CPE reviews in lieu of a quarterly psychiatric clinic. 3. Focus on the completion of CPE 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 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	<u>Treatment Program/Psychiatric Diagnosis</u> 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 facility self-assessment, 95% of the individuals receiving psychotropic medications had a current PBSP. 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 the monitoring team's review of 15 records, all had diagnoses noted in the record. The facility self-assessment of 24 records of individuals prescribed psychotropic medication revealed that, on average, 47% of records included a psychiatric or neuropsychiatric diagnosis and, on average, 47% of records included a specific behavioral-pharmacological hypothesis.	Noncompliance

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	not be used as punishment.	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, and in the use of objective rating scales normed for this population. It will be imperative that psychiatry and behavioral health 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. Emergency use of psychotropic medications Data provided indicated that from 12/1/13 through 5/30/14 (six months) there were 97 episodes of chemical restraint. This was an increase of 22 chemical restraint episodes compared to the previous monitoring period when there were 75 chemical restraints. Review of the data revealed that some individuals were receiving multiple chemical restraints. For example, Individual #156 received chemical restraints on 11 occasions. On 3/24/14, he received a total of 30 mg of Zyprexa intramuscularly in three separate injections. At that time, he was also prescribed Tegretol, Seroquel, Lithium, Metoprolol, Thorazine, and Benadryl. Despite administration of chemical restraints, this individual was next seen in psychiatry clinic five weeks later, on 4/30/14. Documentation from this clinical encounter did not include a review of the previously administered chemical restraints. 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). 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 an individual 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. For example, as discussed while onsite, Zyprexa IM was used at the facility. Medical and nursing staff must be aware of medication interactions or contraindications specific to certain medications in order to ensure safety. Documentation regarding 10 post-chemical restraint clinical reviews was requested. Four examples were provided. Of these, three examples included no psychiatric documentation and all examples included notations that there was no IDT documentation.	

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		Of the 97 chemical restraint episodes outlined via the document request, 25 incidents involved the use of two medications and eight 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. Per the previous monitoring visit, the psychiatry department had discontinued the use of "PRN" medication orders. These are orders that are available for nursing to use "as needed." <u>Monitoring Team's Compliance Rating</u> Given the above, this provision will remain in noncompliance in agreement with the facility self-assessment. To move toward 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 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. o Discontinue the use of "PRN" psychiatric medications.	
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	<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 multidisciplinary team input to address this provision that called for coordination of services, including as appropriate, psychiatric, pharmacy, and medical services. For example, behavioral health staff was to address if the	Noncompliance

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	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.	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 December 2013 and May 2014, there were 43 pretreatment sedations scheduled. Previously, the facility self-assessment reviewed the number of "Pretreatment Sedation Notification Forms" completed. This was not included in the current self-assessment. Per interviews with facility staff, the consultation forms were being completed by the various disciplines, however, there were meetings with regard to development of a consensus recommendation. The report of consistent use of the "Pretreatment Sedation Notification Form" did not correlate with information received via the document request. Ten examples of completed forms were requested, but only six were available. • 49 individuals received medical or dental sedations. This was a 27% decrease from the previous monitoring visit. 43 of these individuals received only pretreatment sedation. Six of these individuals received TIVA. For those individuals who received pretreatment sedation, it was noted that the pre-sedation consultation was only completed in six instances. When comparing the examples of pretreatment consultation with the list of individuals receiving pretreatment sedation, only two examples were included in the list. The remaining four were not included. <u>Extent of Pretreatment Sedation</u> Facility data regarding the extent of pretreatment sedation were confusing and apparently incomplete. 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 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	

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		documentation. • Between December 2013 and May 2014, 49 pretreatment sedations were scheduled. There were, however, only six (12%) "Pretreatment Sedation Notification Forms" completed. This must be addressed because most 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 six individuals regarding the nursing follow-up and monitoring following administration of pretreatment sedation revealed that, per protocols, nursing did document review of the vital signs and assessment following TIVA and other pretreatment sedation administration in five of the six examples (also see section Q1). <u>Other Strategies (i.e., Behavioral Rehearsal Plan, Desensitization Plan)</u> Another goal of this provision is the development of treatments or other strategies (e.g., behavioral rehearsal plans) to minimize or eliminate the need for pretreatment sedation. Sixty individuals had been assessed with regard to the need for behavioral rehearsal, incentives, or other treatment strategies to reduce the need for pretreatment sedation. Staff interview revealed that currently, there were no desensitization plans in effect. There were, however, a total of 16 skill acquisition plans targeting dental behavioral rehearsal. Facility staff interviews revealed plans to form a work group to address dental and medical desensitization. The work group planned their inaugural meeting the week following this monitoring visit. <u>Monitoring Team's Compliance Rating</u> 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:	

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		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.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	Psychiatry Staffing Approximately 80% of the census received psychopharmacological intervention at SGSSLC as of 8/18/14, which was a 1.5% percent decrease since last review. Of these, five individuals were 18 years of age or younger. This was a decrease over the previous monitoring period where there were eight individuals younger than 18 years of age. The psychiatry department had a full time lead board certified general psychiatrist who had been working at the facility approximately six months. In addition, the facility had maintained the services of a board certified child and adolescent psychiatrist, who provided services 12 hours per month. A second full time board eligible general psychiatrist who had been hired prior to the previous monitoring visit left the facility in April 2014. The facility had relied on locum tenens providers to provide services. All locum tenens providers were either board certified or board eligible in general psychiatry. 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 had recently been adjusted. Administrative Support The psychiatry clinic staff included a psychiatric assistant, psychiatric nurse, and medical office manager. One issue was that administrative support staff were shared with other departments and were not able to give 100% effort to psychiatry clinic. For example, the psychiatry assistant was assigned to psychiatry 60% of the time. Psychiatry staff were aware that the medical office manager, who began work in the department 8/1/14, had other duties. At the time of this review, this staff member's percentage of effort assigned to	Noncompliance

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		psychiatry remained unclear. <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 consider the use of mid-level providers in order to expand resources and provide services.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations Completed</u> A list of individuals with completed comprehensive psychiatric evaluations (CPE) per Appendix B guidelines included a total of 78 individuals. As there were currently 169 individuals participating in psychiatry clinic, 54% of individuals still required CPE. Appendix B style evaluations were reviewed for 10 individuals. The CPEs were complete in that they followed the recommended outline and included pertinent information. All of the examples included a five-axis diagnosis and documented a detailed discussion regarding the justification of diagnostics. All Appendix B evaluations reviewed included case conceptualizations and history that reviewed information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation, and in some examples included recommendations such as "learning coping skills and anger management." <u>Monitoring Team's Compliance Rating</u> Although the completed evaluations were generally of adequate quality, the small percentage of those completed resulted in this provision remaining in noncompliance, in agreement with the facility self-assessment. Per interviews with the psychiatry clinic staff, there were plans to schedule comprehensive psychiatric evaluations each month. The psychiatrists' duties would require the completion of approximately eight evaluations per month in order to meet substantial compliance with this provision item within 11 months.	Noncompliance

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J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	Reiss Screen Upon Admission The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SGSSLC, only for those who did not have a current psychiatric assessment. The Reiss screen should also be administered to those individuals with a change in psychiatric and/or behavioral status. The 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. Per policy, behavioral health staff were responsible for administration of Reiss screens. The psychiatry and behavioral health departments must share this vital 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. The monitoring team was informed there were 13 new facility admissions from December 2013 through May 2013. Of these, it was noted that eight were administered the Reiss Screen within 30 days of admission. The remaining five individuals did not receive a Reiss Screen, rather a CPE was completed at admission. Of the eight individuals screened, it was noted that all had score elevations. While all were reportedly reviewed in psychiatry clinic, only two were documented as receiving a CPE. If a Reiss screen was elevated and the individual did not require intervention by a psychiatrist, the psychiatrist should document this information for easy access by the IDT and others (i.e., comprehensive functional assessment, ISP document). The above data were in conflict with data provided via the facility self-assessment which noted a total of 16 new admissions, with 13 positive Reiss Screens, and a total of eight CPE's completed. Data regarding the timeliness of completion of the CPE was not provided. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) The facility self-assessment indicated that for the months of December 2013 through May 2014, there was an average of 43 individuals who were not receiving psychiatric services and would be required to have a baseline Reiss screen administered. The data revealed that, of these, none required screening. This was interpreted to mean all had previously received a Reiss Screen. 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 and the document request.	Noncompliance

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		Reiss Screen for Change in Status 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. Three individuals required a Reiss screen for change in status and the facility completed these screens. All were referred to psychiatry. Two individuals were prescribed psychotropic medications as a result of the referral. 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). Monitoring Team's Compliance Rating 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 other interventions through combined assessment and case formulation.	Policy and Procedure Per the "Psychiatry Services Procedure Manual" dated 5/23/13, "each state center will develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation…annual and quarterly reviews will be conducted with participation of the IDT and the individual (if the individual is able to participate)." The policy then defined the roles of IDT members including nursing, psychology, QIDP, DSP, dietary, habilitation therapy, and workshop representatives outlining a system to integrate pharmacological treatment with behavioral and other interventions. The facility had a facility specific policy and procedure regarding "Psychiatric Scheduling and Note Processing" revised 12/15/11. In addition, the psychiatry clinic staff had devoted a great deal of effort into organizing standard scheduled psychiatry clinic inclusive of forms prepopulated by IDT members based on their roles and responsibilities. At the time of this visit, this process had not been codified into policy and procedure. Psychiatry clinics were comprehensive, including staff from various disciplines, to ensure appropriate discussion and treatment planning for individuals. This was observed during the current monitoring	Noncompliance

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		reviews The comprehensive clinic process had been fully implemented at the facility. Interdisciplinary Collaboration Efforts The monitoring team observed three psychiatric clinics. Per interviews with psychiatry and behavioral health staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. While there was some participation in the discussion and collaboration between the disciplines (psychiatry, behavioral health, nursing, QIDP, direct care staff, and the individual), two of the clinics observed were more of a medical model and less reflective of a flat team process required at the facility. There were improvements in the quality of data provided by behavioral health. In general, data were graphed and up to date. It was noted that data graphs had improved and frequently included timelines or event markers. It will be necessary that behavioral health staff make efforts to provide an analysis for data results. Behavioral health staff must improve the description and analysis of the data and their assessment of what the presented data means, so that all members present have a good understanding. While data were documented in the record, both psychiatry and behavioral health staff predominantly discussed maladaptive behavior, such as aggression and self-injurious behavior, but did not focus on the psychiatric symptoms that resulted in the assigned psychiatric diagnosis. Medication decisions made during clinic observations conducted during this onsite review were based on approximately 30 minute observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the scheduled psychiatry clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic and discussed the individual's progress with them. In two psychiatry clinic observations, discussions regarding the plan for changes or alterations to the pharmacological regimen were held by the IDT following the individual's departure. A review of the behavioral health and psychiatric documentation for 15 individual records did not routinely reveal case formulations that tied the information regarding a particular individual's case together. This was due to the paucity of comprehensive psychiatric evaluations completed per Appendix B. Therefore, there were inconsistencies with regard to the implementation of a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. Case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the	

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		individual's current level of functioning. There was discussion during the psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis (BPRS). The use of additional objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and behavioral health in determining the presence of symptoms and in monitoring symptom response to targeted interventions. Integration of Treatment Efforts Between Behavioral Health and Psychiatry The biggest challenges with regard to integration remained as outlined: • The presentation of behavioral data was not helpful in determination of the efficacy of the psychopharmacological regimen. • The deficiency in the completion of the collaborative case formulations for each individual enrolled in psychiatry clinic per Appendix B. • The need for the identification and implementation of non-pharmacological interventions specific to the individual's needs. Coordination of Behavioral and Pharmacological Treatments There was cause for concern with regard to some examples of rapid, multiple medication regimen alterations in the absence of data review to determine the effect of a specific medication change on the individual's symptoms or behaviors. The generally accepted professional standard of care is to change medication dosages slowly, one medication at a time, while simultaneously reviewing the data regarding identified target symptoms. In this manner, the psychiatrist can make data driven decisions with regard to medications, and the team can determine the need to increase or alter behavioral supports to address symptoms. This type of treatment coordination was not evident in the psychiatric clinics observed, or in the clinical documentation reviewed. Additionally, documents reviewed revealed a paucity of nonpharmacological interventions outside of the individual's PBSP. For example, Individual #48 had multiple medication regimen changes over the course of several months: • 3/12/14 Individual #48 returned from Big Springs hospital. Medication regimen included Fanapt, Ativan, and Depakote. On return to the facility, the Depakote dosage was increased, and Trileptal and Lexapro were added. • 4/16/14 Zyprexa 10 mg IM prescribed for agitation. • 4/17/14 Depakote dosage increased, Trileptal taper started. Orders to taper Trileptal over the course of 21 days. • 4/24/14 Morning dosage of Ativan discontinued. • 4/25/14 Ativan dosage changed, increased noon and bedtime dosage. • 5/4/14 Zyprexa 10 mg IM prescribed for aggressive behavior. • 5/6/15 Lexapro discontinued, Prolixin started.	

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		• 5/9/14 Prolixin Decanoate ordered. The multiple medication regimens over this brief period of time did not allow for a review of data to determine the individual's response to these regimen changes. <u>Monitoring Team's Compliance Rating</u> The monitoring team agreed with the facility self-assessment that this provision remained in noncompliance. The monitoring team identified a paucity of combined assessment and case formulations, a lack of identification of non-pharmacologic treatment interventions outside of the PBSP, and a lack of coordination in behavioral and pharmacological interventions.	
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 about polypharmacy justification." 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 <u>and</u> 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. The review of the sample of records for 15 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 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	Noncompliance

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		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. Psychiatry Participation in PBSP 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 since the last review. The facility data regarding psychiatric participation in the ISP meetings indicated that from December 2013 through May 2014, psychiatry attended 63% of ISP meetings. These attendance percentages improved in the latter months with 100% attendance noted in March 2014 and May 2014. This was laudable given the scarce psychiatric resources at the facility. Data were confusing, however, because there were ISP meetings in months noting 100% psychiatry attendance 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. Treatment via Behavioral, Pharmacology, or other Interventions It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed in the psychiatry clinic, during the already regularly scheduled clinics, with additional reviews as clinically indicated. The monitoring team noted that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis The monitoring team provided information in previous reports encouraging the psychiatrist to meet with the IDT before a proposed PBSP for individuals receiving psychiatric care is implemented.	

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		Per the facility self-assessment, four records were reviewed per month from December 2013 through May 2014. Records were reviewed to determine if interventions in place were the least intrusive; interventions in place were the most positive; and if the individual would be best served via behavioral interventions, pharmacological interventions, other interventions, or a combination. On average, data revealed compliance at 79%, 79%, and 70%, respectively. Furthermore, the self-assessment reviewed the behavioral health services tracking sheet to determine the total number of individuals prescribed psychotropic medications who had an active PBSP. Data revealed that 162 of 171 (94%) individuals prescribed medications had a current PBSP in place. <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 and, 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. In addition, the need to review risks of proposed treatment and benefits of proposed treatment were included in facility policy and procedure entitled "Informed Consent: Explanation, Education, and Due Process" dated 5/10/02 revised 8/17/07. 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 versus medication and nonpharmacological treatment or interventions with the IDT. In addition, there are also	Noncompliance

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		elements that have not yet been implemented." The facility self-assessment reported that three records were reviewed monthly for a total of 18 records reviewed between 12/1/13 and 5/31/14. For this six month period, an average of 58% of records reviewed included a discussion of the risks/benefits of a particular treatment in the CPE. Furthermore, the self-assessment indicated that, for the same period, four records were reviewed monthly for a total of 24 records to determine the presence of the risk/benefit discussion and information regarding alternative treatments or less restrictive measures in documentation regarding informed consent. Data revealed that an average of 63% of records reviewed included documentation regarding the risk/benefit discussion and 46% included documentation regarding alternative treatments or less restrictive measures. <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. Some of the informed consent explanation for the use of psychoactive medication forms had a section to outline the expected risks of medication versus illness. Others reviewed did not include this section. Some of 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. Others left this section blank. 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. That is, 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 #86 for Clonidine, in order to address hyperactivity, 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 hyperactivity and impulse control disorder." Furthermore, the quarterly psychoactive medication review included with this example did not include documentation	

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		regarding psychiatric observations and evidence of the efficacy of psychiatric medications, vital signs, MOSES/DISCUS results, or pertinent labs. At the 5/14/14 meeting, the physician's documentation revealed plans to discontinue Clonidine, however, it was not possible to discern the rationale for this medication change given the sparse documentation. In the consent process, the explanation of the medication, its class, dosage, and purpose should be specific for the individual. The facility had gathered important clinical information, but did not summarize the case material in an applicable manner for the care of the individual once the findings were discovered. The psychiatry department must also utilize the findings in the quarterly drug regimen reviews (QDRRs) to enhance clinical care of the individual. The monitoring team 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 recommends the facility: • 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. Team integration should be measured via consistency in the records across disciplines. Again, the risk-benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. The success of this process, however, will require a collaborative approach from the individual's treatment team, inclusive of the psychiatrist, primary care physician, psychologist, and nurse. It will also require that appropriate data regarding the individual's updated medical status and target symptom monitoring are provided, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in	

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		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 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	

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		consent in place.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Facility-Level Review System 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 December 2013 through May 2014, there was a monthly meeting. For the months of December 2013 through April 2014, these meetings did not include a review of polypharmacy justifications, but rather were a review of specific cases and data. In April 2014, a new process for polypharmacy committee was reviewed and beginning in May 2014, the polypharmacy committee began to review justifications of medication regimens that met criteria for polypharmacy. The facility had policy and procedure entitled "Monitoring the prescribing of psychotropic polypharmacy" dated 7/24/14. Per this policy, documentation of the justification for prescribing medication that meets the definition of psychotropic polypharmacy must be completed and included in the Integrated Progress Notes and addressed at least quarterly in the Psychotropic Medication Review. Per policy, attendees at the monthly facility level review at a minimum must include the clinical pharmacist, lead psychiatrist, a member of the individual's IDT, and compliance staff. The monitoring team attended the polypharmacy meeting that was conducted during the monitoring visit. This meeting was chaired by the clinical pharmacist, a change that occurred in April 2014. The clinical pharmacist, the lead psychiatrist, the psychiatric nurse, and the psychiatry assistant attended the meeting. The regimens of two individuals were reviewed, however, there was no written justification presented. Other staff required by facility policy and procedure were not in attendance. As discussed during the polypharmacy meeting, it was laudable that the staff were attempting to conduct polypharmacy reviews, however, the current meetings were not consistent with the requirements of this provision, which require a facility level review of the justification of polypharmacy regimens. 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. Per the document request regarding this provision, "no facility wide data pertaining to polypharmacy has yet occurred." Data presented at the Pharmacy and Therapeutics meeting attended during this monitoring visit revealed that as of August 2014, 172 individuals were prescribed psychotropic medications. Of these, 92 individuals were prescribed polypharmacy with 40 individuals prescribed intraclass polypharmacy. Furthermore, the data indicated that 37 individual medication regimens had been discussed in polypharmacy with 12 individual regimens reviewed. The distinction between those regimens discussed and those regimens reviewed was unclear.	Noncompliance

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		The manner in which data were presented resulted in the facility (and the monitoring team) being unable to review trends in 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 number of individuals who received three medications, four medications, five medications, and so on. Ninety-two of 172 individuals (53%) who were enrolled in psychiatry clinic received psychotropic polypharmacy. This was similar to the percentage reported for the previous monitoring period. This calculation does not include the number of individuals reportedly prescribed intraclass polypharmacy. During the monitoring review, facility staff were unable to state if the 40 individuals prescribed intraclass polypharmacy were included in the total number of 92 individuals prescribed polypharmacy. The facility needs 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 is 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 information that is collected in the psychiatry department and vice versa in regard to this provision. Review of Polypharmacy Data Regarding polypharmacy, as of August 2014, one individual received seven psychotropic medications, five individuals received six psychotropic medications, nine individuals received five psychotropic medications, 24 individuals received four, 52 individuals received three, 46 individuals received two medications, and 35 individuals received one medication. The names of the individuals were not 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. Review of Polypharmacy Justifications The intention of the facility-level review was to ensure that the uses of psychotropic	

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		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 is 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 regard 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 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. Monitoring Team's Compliance Rating The facility continued to struggle in addressing this provision item, and 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. Ensure a multidisciplinary, facility level review of polypharmacy regimens chaired by pharmacy staff to monitor at least monthly, polypharmacy trends, aggregate data, prescribing practices, and justification for psychotropic medication regimens prescribed.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Policy and Procedure 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. Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) Review of the MOSES/DISCUS tracking spreadsheet provided via nursing did not allow for a determination of the timeliness of completion for these assessments. Per the monthly QA report for August 2014, utilizing data obtained from the Avatar system, in June 2014, 51% of DISCUS assessments were completed (i.e., assessed by nursing and reviewed/signed by psychiatry). The percentage completed in July 2014 was only slightly improved at 58%.	Noncompliance

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		With regard to MOSES assessments, in June 2014, 56% were completed (i.e., assessed by nursing and reviewed/signed by psychiatry). The percentage completed in July 2014 was only slightly improved at 64%. 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. There were no data available with regard to the timely review of either assessment instrument by psychiatry. 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. 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. Per staff interview, as the facility had only one full time psychiatrist, and relied on locum tenens providers who were often only present at the facility for one month, the facility lead psychiatrist was responsible for review and signature of all MOSES and DISCUS assessments regardless of whether the individual assessed was assigned to her caseload. Review of MOSES and DISCUS assessments must be performed by the individual's treatment provider. Four individuals were prescribed Reglan (Metoclopramide). Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. One of these individuals, Individual #150 also had a diagnosis of TD. During this monitoring period: • Individual #287 received Reglan, but had no administration of the DISCUS documented. • Individual #150 received Reglan, had a diagnosis of TD and had DISCUS assessments in December 2014 and March 2014. • Individual #85 received Reglan, and had DISCUS assessments in December 2013 and March 2014.	

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		• Individual #217 received Reglan, and had DISCUS assessments in December 2013 and March 2014. <u>Training</u> Documentation provided by nursing included attendance signatures regarding staff attendance at the monthly nurse case manager meeting. Handouts and meeting minutes indicated that MOSES and DISCUS were discussed/reviewed during these monthly meetings. There were no data provided regarding pre-service training for newly hired nurse case managers. 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 are reviewed in section N. <u>Quality of Completion of Side Effect Rating Scales</u> The names of 17 individuals were provided to the monitoring team who had the diagnosis of some type of dyskinesia due to medication, such as tardive dyskinesia. All of these individuals had monitoring via the DISCUS within the previous five 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 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	

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		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). 3. Review challenges of the Avatar system due to frequent changes in psychiatric physicians due to the facility's reliance on locum tenens providers. Determine a remedy to these challenges that allows for the prescriber to review and score the assessments.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no	<u>Policy and Procedure</u> SGSSLC facility-specific policy and procedure "Psychiatric Services" dated 10/8/12 noted a comprehensive process cohesive with the content of the Settlement Agreement. In addition, the facility had developed a quarterly psychiatry clinic structure that allowed for regularly scheduled clinics, improvements in timeliness of reviews, and documentation from other disciplines (e.g., behavioral health, nursing). This clinic process had not yet been codified in policy and procedure. <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 15 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 15 individuals and reviewed data provided by the facility with regard to the most recent quarterly psychiatry clinic held for each individual participating in psychiatry clinic. While early in the monitoring period delays were evident, this had improved markedly with the initiation of the quarterly psychiatry clinic process. There were also some individuals that were, in fact, seen in clinic more frequently than quarterly via initial, interim, follow-up, and/or quarterly assessment. 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	Noncompliance

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	less often than quarterly.	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. Psychotropic medications must be indicated for symptoms associated with a specific DSM-IV diagnosis. There remained issues with regard to identification of target symptoms for treatment with psychotropic medications. For example, Individual #167 was prescribed the antipsychotic medication Risperdal for an indication of Autism. This would not be an appropriate indication for this medication, which is indicated for treatment of irritability associated with Autism. Furthermore, this individual had a history of a diagnosis of Schizophrenia and was noted to be experiencing psychotic symptomatology. In some records, the indication for Risperdal was indicated as psychosis, in others autism. This is further evidence of the need for diagnostic concordance across disciplines. <u>Psychiatry Participation in ISP Meetings</u> The facility data regarding psychiatric participation in the ISP meetings indicated that from December 2013 through May 2014, psychiatry attended 63% of ISP meetings. Attendance percentages were improved in the latter months with 100% attendance noted in March 2014 and May 2014. This was laudable given the scarce psychiatric resources at the facility. Data were confusing, however, because there were ISP meetings in months noting 100% psychiatry attendance 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. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT in psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization, and management. This provision required that every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, must ensure that the treatment plan for the psychotropic medication addressed the cited requirements of this provision based on the individual's current status and/or changing needs, no less often than quarterly. <u>Psychiatry Clinic</u> The monitoring team attended three 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	

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		individual and discussing the individual's treatment. Pertinent medical information, weights, laboratory data, and MOSES and DISCUS results were reviewed. In all instances, the individual was present for the clinic. All treatment team disciplines were represented during each clinic. The data presented to the psychiatrist predominantly focused on behavioral presentation (e.g., agitation, SIB, aggression towards others) and did not consistently include relevant psychiatric target symptoms of the assigned diagnostics to determine medication efficacy. <u>Medication Management and Changes</u> The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response, the physician can determine the benefit, or lack thereof, of each medication adjustment. The problem remained that when the psychiatrist inquired if the individual was doing "better," the psychiatrist and the IDT had not outlined what would constitute if an individual had improved (e.g., reduction of psychotic symptoms for someone who had Schizophrenia). 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. <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 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.	
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	<u>Policy and Procedure</u> 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	Noncompliance

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	procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	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 monthly QA report for August 2014, there had been a marked improvement in the completion of the consent process. In March 2014, 24% of informed consent documentation was delinquent. Data revealed a marked improvement beginning in April 2014 where 99.8% of documentation was complete, May 2014 100% was complete, June 2014 99.8% was completed, and in July 2014 100% was completed. Although there were laudable improvements with regard to timeliness of completion of informed consent, issues remained with regard to documentation of the consent process. For example, the facility self-assessment indicated a review of four records per month for a total of 24 records to ensure that pertinent medication side effects were listed, that limitations for the use of the medication were listed, and that associated risks were documented. Data were presented from December 2013 through May 2014. There was a marked improvement in documentation noted beginning in March 2014, with scores of 100% in the first two categories reviewed. In the third category, identification of associated risk; scores were consistently at 50%, indicating a need for improvement in this area.	

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		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, and in most cases, it was noted that the nurse case manager had performed this task. 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. Furthermore, as noted in the facility self-assessment, many of the consent documents did not include documentation of the risk of the medication versus illness or a description of expected benefits. For example, Individual #393 was prescribed Topamax for mood stabilization. The consent document was incomplete and did not include information regarding risk/benefit. In addition, per the document, the nurse case manager performed the explanation of the informed consent. In another example, Individual #145 was prescribed Prazosin for nightmares. The risk of the medication versus illness and description of the expected benefits sections of the document were blank. The signature of the staff member explaining the informed consent process was illegible. Current facility practice was not consistent with generally accepted professional standards of care that require that the <u>prescribing practitioner</u> disclose to the individual (or guardian) 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. 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	

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		noncompliance, in agreement with the facility self-assessment. This was due to deficiencies in documentation, the need to 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, and the need for the prescribing practitioner disclose to the individual (or guardian) 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.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 5/1/13, "when medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of medications through the IDT process." Facility specific policy and procedure entitled, "Communication with Neurologist" dated 4/7/11 reviewed the process by which information obtained from off campus neurology consultation would be reviewed by psychiatry. The facility specific policy and procedure did not include a process for coordination between the providers outside of document review. There was, however, a corrective action plan in place regarding the need for psychiatry to provide information regarding neurology consultation to the IDT. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic The monitoring team received a numbered alphabetized list of 52 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Adequacy of Current Neurology Resources The record request for the schedule of the consulting neurologist indicated there were two clinics in February 2014, two clinics in March 2014, one clinic in April 2014, and three clinics in May 2014. There were two neurologists providing services to individuals residing in the facility. Neither of these providers was available for on campus consultation. Individuals traveled to their offices and ere seen off campus. Per interviews with facility staff, there as no collaboration or consultation with these providers outside of the review of progress notes. Review of data regarding the last clinical consultation for individuals requiring neuro-psychiatric consultation revealed that of 52 individuals, 14 individuals (27%) had not been seen in neurology clinic in the previous year. Data provided indicated that these 14 individuals did not have a treating neurologist and had no dates of neurology consultation. The remaining 38 individuals had an assigned neurologist and data indicated they had been seen in clinic within the year.	Noncompliance

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		The facility must ensure that all individuals requiring neurology consultation are scheduled for clinic in a timely manner. It was noted that the facility had created a spreadsheet for tracking neurology clinic that included the individual's name, medications prescribed, treating psychiatrist, date of the last neurology clinic, name of the treating neurologist. This could be expanded to include information regarding scheduling for the individual's upcoming annual consultation. All of the individuals were evaluated by outside providers for neurological care. These individuals require ongoing review through the IDT process, especially when there is a change in status, such as increased frequency of seizures, the addition of another AED, and/or removal of an agent, with resultant change in psychiatric presentation. The awareness by the IDT/psychiatrist was imperative in these scenarios in order to work with the neurologist and discourage prescription of a psychotropic medication known to further lower the individual's seizure threshold. The drug regimen and drug interactions require a thorough review, particularly for individuals with intractable epilepsy, and how these variables affect the mental status presentation. Per the facility self-assessment, in March 2014, the facility had begun a review of neurology recommendations related to "urgent issues." Data revealed that in March 2014 and May 2014, "no urgent reports" were received. In April 2014, two "urgent" reports were received and were reviewed/discussed by the psychiatrist with the IDT. Monitoring Team's Compliance Rating The neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder. Data revealed that 27% of individuals with a diagnosis of seizure disorder requiring neurology consultation had not been seen in clinic in the previous year. Staff interview revealed that there was currently no coordination of treatment occurring between neurology and psychiatry. As such, this provision will remain in noncompliance in agreement with the facility self-assessment.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: ○ Positive Behavior Support Plans (PBSPs) for: • Individual #277 (5/1/14), Individual #37 (3/28/14), Individual #365 (1/31/14), Individual #237 (5/29/14), Individual #295 (2/29/14), Individual #329 (5/9/14), Individual #38 (6/6/14), Individual #258 (5/23/14), Individual #68 (1/29/14), Individual #24 (3/19/14), Individual #246 (6/1/14), Individual #100 (1/25/14), Individual #48 (7/17/14) ○ Functional Assessments for: • Individual #277 (4/9/14), Individual #37 (2/5/14), Individual #365 (1/22/14), Individual #237 (5/14/14), Individual #295 (1/29/14), Individual #329 (1/8/14), Individual #38 (5/7/14), Individual #258 (5/7/14), Individual #68 (3/10/14), Individual #24 (2/12/14) ○ Six months of progress notes for: • Individual #277, Individual #37, Individual #365, Individual #237, Individual #295, Individual #329, Individual #38, Individual #258, Individual #68, Individual #24 ○ Annual Psychological updates for: • Individual #258 (5/7/14), Individual #277 (3/18/14), Individual #365 (2/18/14), Individual #295 (3/3/14), Individual #38 (4/22/14) ○ Full Psychological Assessment for: • Individual #378 ○ Sessions treatment plans and progress summaries for: • Individual #340, Individual #338, Individual #86, Individual #247, Individual #77 ○ Individual Support Plans (ISPs) for: • Individual #9, Individual #86, Individual #295, Individual #237, Individual #104, Individual #365, Individual #37, Individual #277, Individual #134, Individual #24 ○ Individual records for: • Individual #9, Individual #117, Individual #329, Individual #165, Individual #251, Individual #77 ○ Graph of data collection timeliness, IOA, and treatment integrity, December 2013 to April 2014 ○ Behavioral Support Monitoring tool, dated 6/17/14 ○ Behavior Support Monitoring data for: • Individual #9, Individual #145 ○ Section K presentation Book, undated ○ Section K self-assessment, 7/24/14 ○ Section K action plan, 7/21/14 ○ List of all individuals who have PBSPs and date of most recent revision, undated

	○ List of all individuals who have a functional assessment and date of the most recent revision ○ List of the most recent revision of all individuals annual psychological evaluation, undated ○ List of the most recent revision of all individuals full psychological evaluation, undated ○ Minutes of behavioral health services department meetings during the last six months <u>Interviews and Meetings Held</u>: ○ Robb Weiss, Psy.D., BCBA-D, director of behavioral services ○ Robb Weiss, Director of Behavioral Health Services; John Church, Assistant Director of Behavioral Health Services; Lynn Zaruba, BCBA, Clinical Supervisor; Sim Nyakunika, BCBA, Applied Behavior Analyst; Neal Perlman, Counselor; Dana Robertson, Section C Lead ○ John Church, Assistant Director of Behavioral Health Services; Lynn Zaruba, BCBA, Clinical Supervisor; Sim Nyakunika, BCBA, Applied Behavior Analyst; Neal Perlman, Counselor; Dana Robertson, Section C Lead ○ Dana Robertson, Section C Lead ○ John Church, Assistant Director of Behavioral Health Services ○ Lynn Zaruba, BCBA, Clinical Supervisor <u>Observations Conducted</u>: ○ Psychiatry Clinic Rounds • Psychiatrist: Dr. Manshardt • Individual presented: Individual #77 ○ Peer Review Committee • Individual presented: Individual #117 ○ Psychiatry Clinic Rounds • Psychiatrist: Dr. Cormack • Individuals presented: Individual #235, Individual #298 ○ Functional Assessment review meeting • Individual presented: Individual #28 ○ Pre ISP meeting for: • Individual #148 ○ Pre Treatment Sedation meeting ○ 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 self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be based directly on the monitoring team's report. SGSSLC's self-assessment included a review for each provision item, a list of the activities engaged in by the monitoring team, and the topics that the monitoring team commented upon both positively and negatively. This allowed the behavioral health

	services department and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of the behavioral services department in completing the self-assessment, and believes that the facility continued to proceed in the right direction. SGSSLC's self-assessment indicated compliance for items K2, K3, K5, K7, K8, K9, K11, and K12. 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 for item K12 are discussed below. Finally, the self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team continues to recommend that the facility staff establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: SGSSLC did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the seven items (K2, K3, K5, K7, K8, K9, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional areas. These improvements since the last review included: • Addition of two board certified behavior analysts (K1) • Establishment of minimal frequencies of data timeliness, interobserver agreement (IOA), and treatment integrity (K4/K10) • Evidence of consistent data-based treatment decisions (K4) • Consistent demonstration in the progress note that some activity (e.g., retraining of staff, modification of PBSP) had occurred when an individual was not making anticipated progress (K4) The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors (K4) • Develop a system to track the frequency and level of data timeliness, IOA, and treatment integrity for all individuals with a PBSP (K4) • Demonstrate that established minimum frequencies and levels of data collection timeliness, IOA, and treatment integrity are achieved (K4, K10) • Ensure that replacement/alternative behaviors are recorded and reinforced when they occur outside of formal training sessions (e.g., skill acquisition plans) for all individuals with PBSPs (K4)

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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.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all staff at SGSSLC who wrote Positive Behavior Support Plans (PBSPs) were board certified behavior analysts (BCBAs). At the time of the onsite review, three staff that wrote PBSPs were BCBAs. This represented an improvement over the last time this item was reviewed (i.e., August 2013) when one staff that wrote PBSPs was BCBA. Additionally, the director of behavioral health services and clinical director were BCBAs. Overall, eight of the 10 staff who wrote PBSPs (80%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. This is comparable to last time this item was reviewed, when 77% of the staff that wrote PBSPs, either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. The clinical supervisor provided supervision of staff enrolled in the BCBA program. SGSSLC and DADS are to be commended for their continued efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of behavioral health services had a Psy.D. and was licensed in several states, including Texas. Additionally, Dr. Weiss was a board certified behavior analyst, and a member of the Psychological Association of Greater West Texas, and had over 15 years of experience working with individuals with intellectual disabilities. Finally, under Dr. Weiss' leadership, several initiatives had begun toward the attainment of substantial compliance with provision K.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The facility continued to be in substantial compliance with this item. SGSSLC continued its weekly internal, and monthly external, peer review meetings. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Support Plan Committee), the internal peer review meetings provided an opportunity for behavioral health specialists to present new cases or those that were not progressing as expected. The peer review meeting observed by the monitoring team reviewed Individual #117's PBSP. The meeting included active participation from the majority of the department's staff and included (on speakerphone) a BCBA from Mexia SSLC, therefore, functioning as an external peer review. Finally, the peer review meeting appeared to result in a clearer understanding of the environmental variables affecting Individual #117's target	Substantial Compliance

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		behaviors. Review of minutes from internal peer review meetings indicated that the majority of behavioral health specialists in the department regularly attended peer review meetings. Additionally, meeting minutes indicated that internal peer review meetings occurred in 24 of the last 26 weeks (92%) from 12/1/13 to 5/31/14, and that once in each of the last six months, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted 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, SGSSLC was in the process of modifying their system for collecting PBSP data. As discussed in the last report, the scan cards had persistent mechanical problems and they contributed to the inflexibility of the system. Because of these issues, in May 2014, the facility discontinued the use of the scan cards to collect target and replacement behaviors. At the time of the onsite review, SGSSLC used antecedent and consequent behavior charts (ABC data) on a separate data sheet to record the occurrence of target behaviors. Replacement behaviors were recorded on skill acquisition program (SAP) sheets (see S1). This modification of the data system addressed the mechanical problems of the scan cards, but did not address the need for a more flexible system to accommodate individualized data collection needs. The ABC data system currently in use is typically used for behaviors that occur at a low frequency. The requirement of recording antecedents and consequences for a high frequency behavior that occurs multiple times a day could result in direct support professionals (DSPs) under-recording the target behavior. In an attempt to assess if the ABC charts were under-recording target behaviors, the monitoring team reviewed the individual notebooks of six individuals with PBSPs, and compared the occurrence of target behaviors recorded in the observation notes with the data found in the ABC charts. The monitoring team found, in two of the six examples reviewed (33%), that target behaviors were recorded in observation notes, but not in the ABC sheets. Theses discrepancies are outlined below: • Individual #251's observation note indicated physical aggressive on 8/15/14, but there was no ABC data sheet for that date.	Noncompliance

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		• Individual #77's observation note reported an incidence of verbal aggression on 8/14/14, but there was no ABC data sheet for that date These data suggest that ABC charts may be underestimating the occurrence of some target behaviors. For high frequency behaviors, a partial interval or frequency per interval system is typically used. The monitoring team suggests that the facility consider adding various interval and frequency recording systems for high frequency behaviors, and use the ABC data for low frequency and new behaviors. Additionally, the collection of replacement behavior on SAP sheets did not appear to be adequate. As reported in the last review, not all individuals' replacement behaviors were being collected at the time of the onsite review. None of the six individual records reviewed by the monitoring team during the onsite review had replacement data for the occurrence of replacement behaviors outside of the SAP training session. The SAP sheets included an area for the recording of replacement behaviors outside of training (referred to as maintenance data), however, none of the SAPs reviewed contained maintenance data. In order to be most useful, replacement behaviors need to occur during non-training times, and a data system needs to reflect the occurrence, or absence, of these important behaviors. Additionally, although all 10 of the progress notes reviewed contained replacement behavior graphs, several indicated very low frequencies of occurrence of replacement behaviors. The facility needs to ensure that the replacement/alternative behaviors are consistently collected outside of formal training times for all individuals with PBSPs. Interval recording systems, like the scan cards, typically require DSPs to record a predetermined code in each recording interval if target or replacement behaviors occurred, and another predetermined code if no target or replacement behaviors occurred. This procedure allows behavioral health specialists to determine if DSPs were recording data at the intervals specified (i.e., data collection timeliness). The monitoring team could not assess data collection timeliness at SGSSLC because the ABC data were only recorded after the target behaviors occurred. Prior to the discontinuation of the scan cards, the facility was conducting their own data collection timeliness. From 12/13 to 4/14, data collection timeliness across the facility averaged 86%, which was above their goal level of 80%. 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. Since the last review, SGSSLC had established that IOA	

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		would be collected monthly for individuals with a PBSP who were also rated as a high behavioral risk, and quarterly for individuals with a PBSP that have been rated as a low or moderate behavioral risk. The goal level for IOA was established as 80%. Available data provided to the monitoring team indicated that IOA from 12/14 to 4/14 averaged 92%. Although data collection timeliness and IOA across the facility were above the established levels, there was not documentation that all individuals with a PBSP achieved the frequency goal. It is recommended that minimal frequencies of data collection timeliness and IOA be tracked, so that SGSSLC can document that they occur at the established goal 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. The routine use of data to make treatment decisions was improved at SGSSLC. During the onsite review, all three of the individuals discussed in psychiatry clinics had current data contributing to data based decisions concerning the use of medications and treatment interventions. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for 10 individuals, four (Individual #277, Individual #237, Individual #295, and Individual #329), or 40%, indicated no obvious improvement in severe behavior. This is comparable to the last review when 33% of the individual's reviewed showed no obvious improvement in severe behavior. Finally, there were improvements in the progress notes. The monitoring team consistently found examples of action taken to address the lack of progress (e.g., Individual #295). In summary, it is recommended that the facility expand the flexibility of the data collection system, and ensure that replacement/alternative behaviors are consistently collected (including during non-training time) for all individuals with PBSPs. Additionally, SGSSLC should ensure that established data collection timeliness and IOA frequency and level goals are achieved.	
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	The facility continued to be in substantial compliance with this item. <u>Psychological Assessments</u> A spreadsheet of full psychological assessments indicated that 208 of the 209 (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	Substantial Compliance

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	for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	indicated that one full psychological assessment was completed in the last six months, and that full psychological assessment was reviewed to evaluate its' comprehensiveness. The full psychological assessment was found to be 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 175 of the 177 individuals with PBSPs (99%) had a functional assessment. This was comparable with the last review when 100% of all individuals with a PBSP had a functional assessment. One hundred and sixty-three of those 175 functional assessments (93%) were current (i.e., revised/reviewed within one year). This is also comparable to the last review when 96% of the functional assessments were current. The spreadsheet indicated that 76 functional assessments were completed in the last six months. Ten of these (13%) 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 and direct assessment procedures. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This was also comparable to the last report when 100% of all functional assessments included potential antecedents and consequences. One functional assessment (i.e., Individual #365), however, included both environmental consequences (i.e., enhanced attention from staff), and consequences that were included in the PBSP (i.e., administration will be notified). Only environmental consequences should be included in the functional assessment. All 10 of the functional assessments reviewed (100%) were judged to have a clear summary statement. This is identical to the last review when 100% of the functional assessments reviewed were found to have a clear summary statement. Overall, 10 of the 10 functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This is the same as the last review when 100% of the functional assessments reviewed were evaluated as acceptable.	

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K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The majority of SGSSLC's full psychological assessments were not current and, therefore, this provision item was rated as being in noncompliance. Thirty-five of the 209 individuals with full psychological assessments (17%) were conducted in the last five years. This represented a slight improvement from the last time this item was reviewed (i.e., August 2013) when 11% of the full psychological reviews were conducted within the last five years. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	The parties agreed the monitoring team would conduct reduced monitoring on this provision item because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. 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 89 annual psychological updates were completed in the last six months. Reduced monitoring consisted of the review of five (6%) of these annuals to assess their comprehensiveness. All five annual psychological updates reviewed (100%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status. This is consistent the last review when 100% of the annual assessments reviewed were rated as comprehensive. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that nine of nine individuals admitted to the facility in the last six months (100%) had psychological updates completed within 30 days of admission.	Substantial Compliance
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	The parties agreed the monitoring team would conduct reduced monitoring on this provision item because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. Multiple therapies, psycho-educational classes, and individual therapies were offered at SGSSLC. Reduced monitoring consisted of the review of five individual treatment plans	Substantial Compliance

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	in such a way that progress can be measured to determine the efficacy of treatment.	and progress summaries to assess compliance with this provision item. All treatment plans reviewed were found to be goal directed, with measurable objectives, specific treatment expectations, and appeared to be derived from evidence-based practices. They also contained an objective review of progress, and each treatment plan reviewed included a "fail criterion" and a plan for the generalization of acquired skills. Staff who provided therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or who supervised homework or milieu activities, received training and monitoring from qualified therapists. Finally, the facility developed a referral procedure that documented the need for services.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This provision continued to be rated in substantial compliance. A list of individuals with PBSPs indicated that 177 individuals at SGSSLC had PBSPs and 169 of these (95%) were current (i.e., reviewed/revised at least every 12 months). This was a slight decrease from to the last review when 100% of PBSPs were current. All PBSPs had the necessary consent and approvals. Additionally, a spreadsheet provided to the monitoring team indicated 173 of the 177 PBSPs (98%) were implemented within 14 days of receiving consent. This represented an improvement from the last review when 89% of PBSPs were implemented within 14 days. Eighty PBSPs were completed since the last review, and 13 (16%) of these were reviewed to evaluate compliance with this provision item. As found in the last review, all PBSPs reviewed (100%) included operational definitions of target and replacement behaviors. All 13 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 was consistent with the last review when 100% of the PBSPs reviewed were judged to be consistent with the stated function. Replacement or alternative 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. The monitoring team found that 13 of 13 (100%) replacement behaviors that could be functional were functional. This represented an improvement from last review when 88% of all replacement behaviors that could be functional were functional.	Substantial Compliance

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		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. 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. This required DSPs to record the training of the replacement behavior on the SAP data sheet (see S1), however replacement behaviors that occurred (or should occur) during non-training times were not consistently recorded (see K4). In order to be most useful, replacement behaviors should occur during non-training times. It is suggested that the facility review the utility of SAPs for replacement behaviors that are part of an individual's behavioral repertoire. Finally, all 13 PBSPs reviewed included the reinforcement of replacement/alternative behaviors. Overall, all 13 PBSPs reviewed (100%) represented examples of complete plans that contained all of the following. This represented an improvement from the last review when 88% of the PBSPs reviewed were judged to be acceptable. • rationale/purpose of the plan • 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 • use (or stated why not) SAPs to address the acquisition of replacement/alternative behaviors • baseline data for one or more target behavior • antecedent-based or preventative strategies • strategies to promote replacement or alternative behavior • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures • signed and dated	

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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%. Additionally, since the last review SGSSLC established a goal frequency of IOA data collection as monthly for individuals rated as at high risk for behavioral issues, and quarterly for individuals rated at low and moderate risk for behavioral issues. As discussed in K4, SGSSLC achieved their goal level of IOA, however, data were not available to demonstrate that they achieved their goal frequency. All of the DSPs who were 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. The goal level for treatment integrity at SGSSLC was established as 80%. Since the last review, SGSSLC established a goal frequency of treatment integrity data collection as monthly for individuals rated at high risk for behavioral issues, and quarterly for individuals rated at low and moderate risk for behavioral issues. Data provided to the monitoring team indicated that treatment integrity across the facility averaged 88% from 12/13 to 4/14 and, therefore, exceeded their level goal. There was not documentation, however, that the facility's frequency of treatment integrity goal was achieved. It is recommended that minimal frequencies of IOA and treatment integrity data collection be tracked, so that SGSSLC can document that they occur at the established goal 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 in substantial compliance. The monitoring team reviewed 13 PBSPs written in the last six months and concluded that they all 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 3.3 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 14 PBSPs written in the last six months and determined that they all were at or below the 8th grade reading level.	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.	SGSSLC's self-assessment indicated that this item was in substantial compliance. This item was rated as being in noncompliance, however, because SGSSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Staff trainings were regularly scheduled, resulting in many DSPs being trained each month. Behavioral health specialists and behavior analysts conducted the trainings prior to PBSP implementation and whenever plans changed. All DSPs asked about training during the monitoring team's review indicated that they had been trained. The monitoring team did not observe the training of PBSPs during this onsite review. In past reviews, however, the monitoring team found the training to be thorough, including a review of the PBSP by the behavior specialist, an opportunity for DSPs to ask questions, and written questions pertinent to the PBSP. The facility maintained inservice logs on all staff training conducted by the behavioral health staff. At the time of the onsite review the majority of float staff were inserviced by the residential staff. Additionally, the behavioral services department did not know the method residential staff 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 a manner similar to that conducted by the behavioral health department) 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.	This provision item specifies that the facility must maintain an average of one BCBA for every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SGSSLC had a census of 209 individuals and employed 10 behavioral health specialists responsible for writing PBSPs. Additionally, the facility employed four psychology assistants and one psychology technician. Three of the facility's staff that wrote PBSPs had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least seven staff that write behavior support plans with BCBAs.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: ○ Health Care Guidelines, May 2009 ○ DADS Policy #009.2: Medical Care, 5/15/13 ○ DADS Policy Preventive Health Care Guidelines, 8/30/11 ○ DADS Policy #006.2: At Risk Individuals, 12/29/10 ○ DADS Policy #09-001: Clinical Death Review, 3/09 ○ DADS Policy #09-002: Administrative Death Review, 3/09 ○ DADS Policy #044.2: Emergency Response, 9/7/11 ○ SGSSLC Medical Care Policy, 9/1/13 ○ Medical Policy and Procedures Manual ○ Pneumonia Review Committee Meeting Minutes, ○ Shannon Hospital Partners Meeting Minutes, ○ Clinical Daily Provider Meeting Minutes ○ Listing of Medical Staff ○ Medical Caseload Data ○ Medical Staff Curriculum Vitae ○ Mortality Review Documents ○ External/Internal Medical Audit Data ○ Clinic Tracking Logs ○ Listing, Neurology Clinics ○ Internal and External Medical Reviews ○ Listing, Individuals with seizure disorder ○ Listing, Individuals with history of status epilepticus since last compliance review ○ Listing, Individuals with diagnosis of refractory seizure disorder ○ Listing, Individuals with VNS ○ Listing, Individuals with pneumonia ○ Listing, Individuals with a diagnosis of osteopenia and osteoporosis ○ Listing, Individuals over age 50 with dates of last colonoscopy ○ Listing, Females over age 40 with dates of last mammogram ○ Listing, Females over age 21 with dates of last cervical cancer screening ○ Listing, Individuals with DNR Orders ○ Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD ○ Listing, Individuals hospitalized and sent to emergency department ○ AED Polypharmacy Data ○ 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 #66, Individual #346, Individual #379, Individual #288, Individual #31, Individual #117,Individual #354, Individual #227, Individual #199Individual #46 ○ Annual Medical Assessments the following individuals: • Individual #371, Individual #165, Individual #340 Individual #40, Individual #383, Individual #27, Individual #372, Individual #71, Individual #112, Individual #258, Individual #338, Individual #370, Individual #30, Individual #63, Individual #344 ○ Neurology Notes for the following individuals: • Individual #40, Individual #26, Individual #331, Individual #154, Individual #201, Individual #214, Individual #52, Individual #35, Individual #203 Individual #250 <u>Interviews and Meetings Held</u> ○ David Jolivet, MD, Medical Director ○ Brad Baker, MD, Primary Care Physician ○ Valerie Murphy, RN, Medical Compliance Nurse ○ Angela Garner, RN, QA Nurse ○ Lisa Owen, RN, Chief Nurse Executive <u>Observations Conducted</u>: ○ Daily Medical Provider Meetings ○ Pneumonia Review Meeting ○ Administrative IDT Meeting ○ Medication Variance Committee Meeting ○ 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 compliance nurse who now worked in another position at the facility. The monitoring team reviewed the self-assessment during interviews, however, the medical director and medical compliance nurse were not familiar with the data included in the self-assessment Section L1 covers the overall provision of medical care. As such, it should include a number of metrics capable of measuring the overall status of the provision. The L1 assessment covered five areas including timeliness of the AMAs, initial medical assessments and QMSs, review of Shannon meeting minutes, review of cancer screening compliance, and physician participation in ISPs and ISPAs. The monitoring team found that the facility's compliance data differed significantly from that determined by the monitoring team. This was due to the exclusion of numerous individuals, many of whom lacked documentation of the appropriate

	criteria for exclusion. 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: The medical department underwent changes in key staff since the February 2014 compliance review. A new medical director was appointed in July 2014 to replace the prior director who resigned. The new director was working at the facility for a year and was, therefore, familiar with the operations of the department. He had not been involved, to any great extent, with Settlement Agreement activities and was, therefore, not familiar with many aspects of the Settlement Agreement. There was also a new compliance nurse. At the time of the compliance review, she had been in the position for four months. As would be expected, changes in these key positions made progress in several areas of the Settlement Agreement difficult. At the time of the compliance review, there were two full time primary providers. The part time primary provider continued to work every other week. There remained one vacancy for a full time primary care provider. Physician participation in ISPs improved. Even so, they attended only 16% of ISPs. The facility was also tracking ISPA attendance. ISP and ISPA participation was expected to improve with full staffing of the medical department. The quality of IPN documentation differed markedly between the two full time providers. This may have been due to a lack of knowledge regarding the specific documentation requirements. The self-assessment documented that all current providers had not been trained on all policies, procedures, and guidelines. Generally, individuals received basic medical care. There was documentation that annual assessments were completed along with routine annual labs and screenings. Cancer screenings needed improvement. The documentation for those individuals excluded was not adequate. "See IPN," or "risk greater than benefit" continued to be submitted as the rationale for deferring screening. There were many issues related to the medical care provided to individuals with more complicated medical issues. Laboratory monitoring for drug use needed improvement. EKGs were noted to be delinquent and some abnormal EKGs were not ever read by a cardiologist. The use of standing orders appeared to decrease and the records reviewed documented improved notification of physicians by the nursing staff. Even so, physicians were not always conducting assessments

	of individuals when treatments were provided via standing orders and phone orders. Physician documentation of follow-up assessments for acute medical conditions remained poor. Most records lacked documentation of resolution of acute medical issues. Pneumonia management remained challenging. The Pneumonia Review Committee met monthly, but this process was not as effective as it needed to be. The external and internal medical reviews were completed as required. There continued to be problems with implementation of the corrective action plans based on data submitted. Mortality reviews continued to lack an objective physician review. The medical department conducted two medical QA meetings, but no framework for a medical quality program had been established nor was there a formal medical quality committee. The meetings conducted lacked the appropriate participants and content. The department continued to lack adequate policies and procedures. Many of the policies, procedures, and guidelines submitted had not been reviewed or revised in several years. Moreover, training related to the medical policies and procedures was not provided to all members of the medical staff.

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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, one full time primary care physician, and one part-time primary care physician. The current medical director had worked at the facility for more than a year and assumed the role of medical director on 7/18/14, filling the vacancy that resulted from the resignation of the previous director. The two full time PCPs had an average caseload of 94. The long-term locum tenens part time physician had a caseload of 18, however, he only worked every other week. There was a new medical compliance nurse who reported that she had been in the position for four months at the time of the onsite review. **Physician Participation In Team Process** <u>Daily Provider Meeting</u> The facility continued to conduct the daily provider meetings. Attendees included the medical staff, medical compliance nurse, nursing representatives, pharmacy director,	Noncompliance

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		clinical pharmacist, hospital liaison nurse, psychology, dental director, dietary representative, and residential services. The medical director facilitated the meetings, which were now conducted at the beginning of each day. The transition to an early morning meeting allowed staff to share information related to after hours and upcoming events at the very beginning of each day. 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 for the months of February 2014 to May 2014. The minutes documented numerous clinical discussions, however, the minutes submitted were often incomplete and frequently included handwritten notes and changes. The content was not always appropriate. There were minutes that documented personal medical issues of one member of the medical staff who was not present for the discussion. ISP Meetings The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data for the months of December 2013 through May 2014 were submitted and are summarized in the table below.	

ISP Attendance 2013 - 2014

	No. of ISPs	ISPs Attended	% ISPs Attended	No. of ISPAs	ISPAs Attended	% ISPAs Attended
Dec	19	1	5	184	1	.5
Jan	23	0	0	209	3	1.4
Feb	19	2	10	244	3	1.2
Mar	21	6	28	260	3	1.1
Apr	23	6	26	210	8	3.8
May	16	5	31	245	9	3.6

The medical staff attended 4% of ISPs from June 2013 to November 2013. Attendance for December 2013 through May 2014 was 16.6%. The average attendance for the last three reported months was 28%. This was a significant improvement. The medical staff also attended 27 of 1352 (1.9%) of ISPAs for the same reporting period. The number of ISPAs that physicians were requested to attend was not provided.

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

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		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 continue the efforts to attend meetings with particular emphasis on the meetings for which physician participation is requested. **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. The facility continued to lack an adequate process to integrate neurology and psychiatry. 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. Participants 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. SGSSLC facility staff had access to the Shannon portal for checking lab results. 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. EKGs were not routinely over-read by a cardiologist. The medical director reported that only abnormal EKGs were referred to cardiology. The facility should address this because all EKGs should have a final reading by a cardiologist. The monitoring team reviewed EKGs with abnormalities that were not noted by the PCP. In fact, the DPM minutes for 1/21/14 documented comments from the medical director related to an erroneous computer EKG interpretation. The individual was scheduled for a cardiac ablation. The individual expired in June 2014 and the cause of death was not provided. Following the onsite review, the facility reported that death was due to embolic stroke. Overall, there was evidence that most individuals received the basic medical services such as screenings, immunizations, and most elements of preventive care. The medical management of conditions became more problematic for those individuals with more complicated problems who required follow-up and assessment. For those individuals,	

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		gaps in care were identified in a number of areas: • Documentation of acute medical conditions was often incomplete. Physician documentation of problem resolution was infrequent. Similarly, the active records sometimes lacked or included inadequate documentation of pre-hospital transfers and post-hospital assessments. In fact, some individuals had multiple ED visits and/or hospitalizations within a short period of time. • The primary care providers did not adequately address risk in the AMA, particularly the risk of aspiration. The IPN notes failed to document adequate plans for individuals returning from the hospital with pneumonia. Several individuals had recurrent pneumonia and no medical plan change was documented by the PCP. • There were several hospital admissions related to ileus. The PCP documentation in the IPNs did not reflect appropriate supports or interventions. • Medication monitoring needed improvement. EKGs, eye exams, and labs were often noted to be overdue. • Several individuals received non-crushable medications via enteral tube. The subsequent section of this report will discuss details related to these issues and provide specific examples. **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 • 10 of 10 (100%) 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. • 12 of 15 (80%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 15 of 15 (100%) AMAs included information regarding the potential to transition The medical staff was still in the process of transitioning to the state AMA template. Thus, the AMAs reviewed were found in a variety of formats. Some AMAs had missing information, such as data for immunizations. Overall, the most notable improvement was the completion of plans of care related to the active problems. There was still a need to ensure that all active diagnoses were listed in the AMA. The medical director indicated that moving forward, the AMAs would include a discussion of medical risk factors. <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: • 8 of 10 (80%) records included current QMSs The primary providers began completing QMSs in October 2013. The state template was being used to complete the summaries. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL 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> Documentation in the IPNs varied by providers. One provider documented in SOAP format. It appeared that the second provider was unaware of the need to document in	

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		SOAP format because IPN entries were consistently completed in non-SOAP format. Moreover, the legibility was poor and the notes failed to include the appropriate positive and negative findings. This problem was noted in the previous compliance review and no improvement was demonstrated. Physician Orders 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. Orders were also written to provide non-crushable medications through enteral tubes. The facility revised the standing orders, but the monitoring team remained concerned about the use of some protocols. There was the potential to administer OTC medications when use was contraindicated. For example, adolescents with flu-like illnesses could receive Pepto-Bismol for nausea or dyspepsia if nursing was not aware that salicylates should not be administered in this setting. Moreover, individuals who were not examined could have eardrops instilled and ear irrigation performed by nursing. Medication orders are discussed further in section N1. Consultation Referrals The monitoring team observed multiple formats for documenting information in the IPN. Overall, the requirements for documentation were not being met. A new template was implemented in the weeks prior to the compliance review, but it was not being consistently utilized. Again, documentation was very provider specific. One of the two primary PCPs consistently failed to document the required information. Consultation referrals are discussed in further detail in section G2. 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 improved. Compliance with prostate cancer screening decreased. 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.	

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		Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 7 of 10 (70%) forms included the signature of the provider The Preventive Care Flowsheets were found in 100% of the records reviewed. Most had recent data, but some did not appear to be updated with the annual assessment. As noted in previous reviews, the PCFS continued to include guidelines for preventive care that were not consistent with state guidelines. Immunizations • 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 • 9 of 10 (90%) individuals received the Td vaccination • 9 of 10 (90%) individuals had documentation of varicella status The facility submitted the immunization database at the request of the monitoring team. A number of blanks were noted in the document. Additionally, data in the database was not always consistent with the information found in the records. There were also several individuals that were not vaccinated against varicella and did not have antibody documentation of immunity based on date of birth. The CDC does indicate that individuals born before 1980 can be considered immune to varicella. However, it is incorrect to apply this standard in a long-term care facility. Specific recommendations are made for health care professionals, residents, and staff in nursing homes and residential settings. The varicella vaccination is recommended for those individuals. The monitoring team discussed the use of the federally required Vaccine Information Statements with the medical director, medical compliance nurse, and CNE. They were not aware of the requirements related to providing this information to individuals. Staff subsequently reported that the VISs were provided as part of the consent process. State policy indicated that informed consent was to be obtained for all immunizations. However, medical policy did not explicitly state the requirement for provision of the VIS or the documentation of the VIS. The National Childhood Vaccine Injury Act requires that all health care providers in the US, who administer to any child or adult certain vaccinations, such as, but not limited to, varicella, tetanus, influenza, and hepatitis B,	

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		provide prior to administration of each dose, a copy of the "relevant current edition VIS produced by the CDC." Health care providers are also required by this federal law to "make a notation in each patient's permanent medical record at the time vaccine information materials are provided" the version of the VIS and the date provided. This is a requirement in addition to noting the vaccine manufacturer and name of the person administering the vaccine. Although key staff was not initially aware of the requirement to provide VISs, it appeared that the documents were provided. One record included in the record sample included a copy of the VIS. Nonetheless, the facility did not comply with the requirements related to documentation. Screenings • 10 of 10 (100%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing Prostate Cancer Screening • 2 of 6 males met criteria for PSA testing (based on state guidelines) • 1 of 2 (50%) 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 39 males: • 27 of 39 (69%) males had current PSA screening The accuracy of the data reported should be reviewed by the medical director. Neither of the two individuals (Individual #288 and Individual #379) reviewed in the record sample was included on the PSA listing. The American Cancer Society recommends that starting at age 50 or 45 if high risk, men should discuss the pros and cons of testing with their physician so that they can make an informed decision with their health care provider about screening for prostate cancer. High-risk groups include African Americans and men who have a first-degree relative diagnosed with cancer before the age of 65. Most major professional organizations have issued similar statements. Thus, providers should consider the discussion with the individual/LAR when making a decision to defer testing. Breast Cancer Screening • 2 of 4 females met criteria for breast cancer screening • 2 of 2 (100%) female had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 29 females, the date of the last mammogram, and explanations for any lack of testing:	

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		• 19 of 29 (65%) females had current screenings • 5 of 29 (17%) females had no screening due to age • 1 of 29 (3%) females had no screening due to sedation risk • 4 of 29 (14%) females had no screening due to refusal, inability to cooperate, or other reasons <u>Cervical Cancer Screening</u> • 4 of 4 females met criteria for cervical cancer screening • 2 of 4 (50%) females completed cervical cancer screening within three years A list of females age 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: • 39 of 73 (53%) females had current screenings • 7 of 73 (10%) females refused examination refused • 6 of 73(8%) females had hysterectomies • 4 of 73 (5%) females had pap d/c'd by MD/IDT with no other explanation • 4 of 73 (5%) females did not have screening due to sedation risk sedation • 2 of 73 (3%) females were new admits new admits • 2 of 73 (3%) females had no guardian concern guardian consent • 2 of 73 (3%) had no documentation • 2 of 73 (3%) females were excluded due to age > 65 • 5 of 75 (6%) females had screening discontinued with no documented explanation6 of 75 (8%) females had pending evaluations • 5 of 73 (7%) females had no screening due to virginal status or cooperation <u>Colorectal Cancer Screening</u> • 4 of 10 individuals met criteria for colorectal cancer screening • 3 of 4 (75%) 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 75 (53%) individuals completed colonoscopies • 2 of 75 (2%) individuals did not complete colonoscopies due to problems with bowel preps • 4 of 75 (5%) individuals refused screening • 2 of 75 (2%) individuals had pending screenings • 11 of 75 (15%) individuals had screening discontinued due to sedation risk	

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		• 5 of 75 (6%) individuals had screening discontinued due to refusal • 4 of 75 (5%) individuals had screening discontinued with no explanation submitted other than "see IPN" • 5 of 75 (6%) individuals had screening discontinued due to age • 1 of 75 (1%) individuals had no screening because GI declined • 3 of 75 (4%) individuals had no explanation for lack of screening **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. Pneumonia The facility submitted a list of individuals who were diagnosed with pneumonia from December 2013 through May 2014. Data for that period are shown in the table below.	

Pneumonia 2013 - 2014						
	Dec	Jan	Feb	Mar	Apr	May
No. of Cases	5	3	1	2	3	1

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		There were 15 pneumonia incidents reported from December 2013 to May 2014. The facility continued to have challenges reporting pneumonia data. Staff reported, and meeting minutes documented, that data entry was problematic. Thus, the accuracy of the pneumonia data is questionable. Review of the active records also revealed that the PCPs did not adequately discuss risk in the AMAs and did not formulate a plan to address aspiration risk. The monitoring team attended the Pneumonia Review Committee conducted during the week of the compliance review. Four individuals were reviewed. For each individual, the committee reviewed the pneumonia review checklist, which covered a series of items including precipitating factors, positioning, CXR results, lab results, type of nutrition, and oral hygiene. This information was utilized to determine if the individual was appropriately diagnosed with pneumonia. This process resulted in some good discussion and sharing of information. Notwithstanding the value of this discussion, the monitoring team observed that the participants needed to have more in depth discussions with regards to precipitating factors. There was no discussion or review of medications, such as psychotropics and AEDs that contributed to problems with dysphagia and sedation, thereby increasing aspiration risk. The monitoring team also noted that the committee did not engage in adequate discussions related to the change in plans for identified issues. For example, Individual #66 was noted to have an	

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		increased gastric residual associated with emesis and subsequent development of aspiration pneumonia. There was no exploration of how to address this problem. Individual #134 received oral nutrition and had continued to have episodes of aspiration. The monitoring team inquired about the plan and was informed that the individual was not a candidate for enteral tube placement due to a history of a sub-endocardial MI. The timing of this cardiac event was not clear nor was the rationale for not endoscopically placing a tube. Individual #90 was reported to have problems swallowing secretions, but there was no recommendation to address this. The Pneumonia Review Committee meeting minutes were reviewed. The minutes did not always provide an adequate explanation for the pneumonia classification. In some instances, the reader was referred to the attached review tool, but no attachments were submitted. Based on the meeting observation, meeting minutes, record reviews, and AVATAR data, the monitoring team is concerned that this process may not be accurately capturing all pneumonia cases or accurately classifying the incidents. Furthermore, observation of the pneumonia meeting indicated that greater critical thinking was needed in order for staff to provide a clear set of recommendations to the IDT relative to risk minimization. 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 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 (and/or current processes reviewed and improved). This may involve a monthly review of multiple data sets, such as a list of all individuals that 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. Diabetes Mellitus Five 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, (4) administration of pneumococcal vaccination and	

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		(5) administration of yearly influenza vaccination: • 3 of 5 (60%) individuals had adequate glycemic control • 4 of 5 (80%) individuals had urine microalbumin documented • 5 of 5 (100%) individuals had documentation of eye examination • 5 of 5 (100%) individuals had documentation of influenza vaccine administration • 4 of 5 (80%) individuals had documentation of pneumococcal vaccine administration • 4 of 5 (80%) individuals had documentation of receipt of an ACE/ARB for renal protection The facility identified 18 individuals with diabetes mellitus. The facility should develop a checklist/audit tool to ensure that all diabetics are reviewed at least quarterly for compliance with the ADAs guidelines. This process and resulting data should be included in the medical quality program. The medical compliance nurse reported that 23 individuals had metabolic syndrome. QDRRs and the active records identified several individuals with abnormal HbA1c levels, but who did not reach the cutpoint to be diagnosed with diabetes mellitus. According to the American Diabetes Association, "it is reasonable to consider an A1C range of 5.7–6.4% as identifying individuals with prediabetes." Prediabetes is the term used for individuals who have a relatively high risk for the future development of diabetes. Appropriate interventions at this stage have the ability to decrease the likelihood that an individual will subsequently develop diabetes. It is, therefore, important that individuals with pre-diabetes and metabolic syndrome are identified, so that aggressive interventions may be implemented. See section N3 for additional discussion. <u>Hepatitis</u> Two individuals in the record sample had the diagnosis of hepatitis. Although the facility did not have a specific protocol for management of Hepatitis B and Hepatitis C, both individuals received the appropriate monitoring for this condition. One individual was referred to gastroenterology and had surveillance done as required. The other individual had the appropriate diagnostics and was determined to have a history of infection with Hepatitis C based of the absence of Hepatitis C RNA. The monitoring team continues to recommend that the medical director develop an algorithm for evaluation and treatment of hepatitis, so that all future medical staff will be familiar with the appropriate management of these conditions.	

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		Case Examples Individual #66 • The individual returned from the hospital, following admission for left lower lobe pneumonia and was evaluated by the PCP on 1/21/14. There was no documentation of physician follow-up. The next medical entry was on 3/10/14. At that time, the PCP documented that the individual had a slightly distended abdomen and no recent bowel movements. Feedings were held. There was no documentation of medical follow-up. • On 5/11/14, the PCP documented a low-grade fever of unknown etiology. The plan was to complete a "sepsis evaluation," including a CBC and a chest x-ray. On 5/12/14, another PCP entered "temp normal this am. Cont to monitor." • On 7/12,14, the PCP noted a questionable ileus. Feedings were held and x-rays were ordered for the am. During follow-up on 7/13/14, the PCP documented that the individual had emesis the previous day and possibly aspirated. An order was written to obtain a chest x-ray the next morning. It was noted that the ileus seemed to be improving. Additionally, un-timed addendum documented that the chest x-ray and KUB were normal. • On 7/18/14, the PCP made an IPN entry documenting marked elevations in the liver enzymes done on 7/13/14. It was noted that these would be checked again on Monday. Over a period of days, the enzymes fluctuated, but remained elevated. Consideration was given to obtaining an ultrasound, but this was not done. On 8/2/14, the individual had a temperature of 101 and was referred to the ED for evaluation. On 8/4/14, the PCP documented that the individual had an elevated white blood cell count and was referred to the ED again. The diagnosis was acute cholecystitis and pneumonia and the individual was admitted to the hospital. During the Pneumonia Review Committee meeting, the medical director indicated that one of the PCPs had "long suspected" that this individual had gallstones. The monitoring team was not clear on why the ultrasound was not done given this clinical suspicion. • Upon return to the facility on 8/7/14, the individual was seen by the PCP and a CXR was ordered to be done the following day. There was no further documentation until 8/14/14 when the individual was referred to the ED for evaluation of sustained tachycardia and abdominal distention. The diagnosis was left pneumonia. • The individual was seen on 8/19/14 following return to the facility. The PCP noted the diagnosis of pneumonia and pancreatic mass. The documentation did not include a specific plan to address either problem. On 8/25/14, the PCP indicated that there would be a meeting with the mother to discuss treatment of the pancreatic mass. • This individual had multiple EKGs that demonstrated an early repolarization	

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		variant with j-point elevation. While this is typically not pathologic in young individuals, it should be documented for future comparisons. The early repolarization variant was never acknowledged on any of the EKGs. Individual #288 • There was no family history in the AMA. • The PCFS was incomplete with no data entered for several sections. • The individual received non-crushable Alendronate through an enteral tube. The use of Alendronate was questionable given the history of significant GERD. • This individual had a history of a sigmoid colectomy in 2008 and was admitted on 3/15/14 with diagnoses of adynamic ileus and large bowel parasternal hernia that resulted in an exploratory celiotomy. • On 7/6/14, nursing documented diarrhea. The PCP was notified and the diarrhea protocol was implemented. There was no MD evaluation. On 7/8/14, the PCP documented increased stool, abdominal distention, low-grade fever, and emesis. The individual was transferred to the ED and admitted. • On 7/14/14, the MD documented a hospital return note indicating the individual was admitted with the diagnosis of ileus. The next documentation was on 7/16/14 due to concern for a possible stool problem. There was no follow-up evaluation documented in the IPN. • The consulting neurologist made no mention of the VNS, which was received on 1/30/14. Individual #117 • The individual had the diagnosis of chronic hepatitis B (carrier) and was followed by gastroenterology. Management and surveillance were appropriate. • On 8/15/14, the individual fell and complained of left hip pain. The assessment was rule out fracture, but x-rays were deferred to the next day. The MD did not document the results of the x-rays or a follow-up assessment. • The new consult template was utilized in August 2014, however, the form was incomplete. The consult date and summary were blank. There was no comment on agreement or disagreement with the consultant's recommendations and the IDT referral section was blank. • On 7/15/14, the PCP evaluated the individual for respiratory problems. The assessment was acute bronchitis and a CXR was requested for the following day. Antibiotics and nebulizer treatments were prescribed. Follow-up evaluation and CXR results were not documented.	

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		Individual #354 • Monitoring for hypothyroidism associated with lithium use was not done. • The IPNs and consults documented gait abnormalities considered to be associated with drug use. All medications were discontinued. There was no ADR form completed. • Several consultants indicated that the individual had rhabdomyolysis based on elevated CPKs. The PCP disagreed with the diagnosis based on the lack of myoglobinuria. It should be noted that the presence of myoglobinuria is not necessary to make the diagnosis of rhabdomyolysis since 50% if individuals do not have this finding. • There was only one post-hospital note associated with the June 2014 hospitalization. Individual #199 • This individual had an EKG interpreted as sinus bradycardia with a first degree AV block. There was no cardiology over-read. • The individuals did not have documentation of Pneumovax vaccination and there were numerous discrepancies in the active record and vaccination database. • The individual was admitted in December 2013, but did not have an initial neurology evaluation until April 2014. • There was no plan to address the low vitamin D level. The Vitamin D was consistently low with no change in treatment. • On 3/1/14, nursing documented a hand injury and noted swelling, redness and deformity. There was no physician assessment. On 3/6/14, the PCP documented "not examined," but noted a negative x-ray.. Individual #227 • This individual had a diagnosis of Hepatitis C infection. Based on the absence of Hepatitis C RNA, the diagnosis was correctly changed to history of Hepatitis C because the infection had apparently cleared. • There was no height or weight noted in the AMA, yet the diagnosis of obesity was given. The individual had elevated triglycerides, low LDL, and received medical treatment for diabetes mellitus. Individuals #379 • This individual was seen on 2/7/14 and diagnosed with acute bronchitis. Antibiotics were prescribed and a chest x-ray was ordered. There was no documentation of a follow-up assessment. The CXR was documented as normal on 2/13/14.	

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Seizure Management
A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 62 individuals. Those data are summarized below:

- 18 of 65 (22%) individuals received 0 AED
- 42 of 65 (64%) individuals received 1 AED
- 20 of 65 (30%) individuals received 2 AEDs
- 3 of 65 (4.6%) individuals received 3 AEDs

The facility did not provide neurology services onsite. Individual were referred to a neurologist at Shannon Medical Center. The number of appointments is summarized in the table below.

Neurology Clinic Appointments 2013 - 2014	
Dec	8
Jan	17
Feb	8
Mar	6
Apr	8
May	13

A total of 69 appointments were completed for the reporting period of December 2013 to May 2014. The average number of individuals seen each month was 10, which was a slight decrease from the last reporting period 11.5.

The facility reported that 3 of 62 (5%) individuals had refractory seizure disorder. Two individuals had undergone VNS implantation. Eight 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.

During the February 2014 compliance review, it was reported that there were problems with the provision of neurological services. The medical director reported that issues related to receipt of consults was resolved. The facility still did not refer refractory individuals to an epileptologist and there was no process in place to ensure adequate integration of neurology and psychiatry.

The monitoring team requested neurology consultation notes for 10 individuals. Records for 10 individuals seen in neurology clinic were submitted. Nine of the consultations were for management of seizure disorder. These individuals reviewed are

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		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%) records had documentation of the seizure description • 8 of 9 (88%) records had documentation of current medications for seizures and dosages • 5 of 9 (22%) records had documentation of recent blood levels of antiepileptic medications • 8 of 9 (88%) records had documentation of medication side effects. • 0 of 9 (0%) records had documentation of information included in the MOSES and DISCUS evaluations. • 8 of 9 (88%)records had documentation of recommendations for medications • 0 of 9 (0%) records had documentation of recommendations related to monitoring of bone health, etc. The neurologist dictated very thorough evaluations, including seizure type/frequency, prior medication use and resulting effects, current medications, side effects/adverse effects of drugs with a description of actions taken to monitor/address potential side effects, and polypharmacy reduction. The notes also included information obtained from staff accompanying the individual, vital signs, and a physical examination. Drug levels and labs were often not included, but at times, this appeared to be the result of not having the information. There was also no evidence that the facility provided the MOSES and DISCUS evaluations for review. Overall, the consultation notes were thorough. Even so, there were some concerns related to seizure management: • The facility did not have an adequate means of integrating neurology and psychiatry. • Individuals with refractory seizure disorder were not referred to a qualified epileptologist. • Several individuals were documented to be over-medicated and the neurologist commented on this in the notes and made recommendations for medication reduction and simplification. However, because of an ineffective integration of neurology and psychiatry, he was not sure if AEDs were being used for a psychiatric indication. For example, for Individual #280, the neurologist wrote "on a multidrug regimen that is more complicated than it needs to be…. I do not consider Depakote to be an ideal medication. If this medication is not essential from a psychiatric perspective, then long term one might consider tapering off." The individual remained on Depakote at the time of the May 2014 consult.	

#	Provision	Assessment of Status	Compliance
		Access To Specialists The medical department continued to lack data related to the timeliness of clinic appointments. The spreadsheet submitted included the date of the appointment, but did not provide the date that the request was made or needed. 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 provision of timely consultation appointments is a key quality metric that must be monitored and included as a structural indicator in the medical quality program. The facility must be able to accurately track the needs of the individuals and the response of the facility to those 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 15 individuals. Data submitted by the facility are summarized in the table below.	

	Failure To Thrive	Dementia	Mother's Request	Other
No. of Individuals	4	4	2	5

The facility submitted Ethics Committee minutes for Individual #134, Individual #384, and Individual #85. There was no documentation submitted for the other 12 individuals. Given the recent implementation of a new state policy for out of hospital DNRs, the monitoring team recommends that the facility review the current list to ensure that all DNRs have been implemented in accordance with state policy.

Compliance Rating and Recommendations
The monitoring team agrees with the facility's self-rating of noncompliance.
To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration:

1. The facility should continue to recruit to fill the PCP vacancy.
2. The medical director must ensure that all PCPs are aware of the requirements related to the Health Care Guidelines and state policy.
3. Physician documentation of care must be addressed.
4. The medical director should review the data related to preventive care and ensure that all individuals are receiving the appropriate cancer screenings. A specific reason for deferring screening must be documented.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></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 9 of the medical audits 5/8/14 to 5/9/14. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines. All elements were considered essential. There were questions related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. A total of 12 records were reviewed for the general medical audit. The facility submitted data for the external audits. Those data are summarized below:
<table>
<tr><th colspan="2">Round 9 - General Medical Audits
Compliance (%)</th></tr>
<tr><td>May 2014</td><td>93.5</td></tr>
</table>
Compliance scores were 80% or greater for all 46 questions.

In addition to the general medical audits, medical management audits were also completed. Nine charts, three for diabetes mellitus and osteoporosis, and two for pneumonia were reviewed. The results are presented in the table below.
<table>
<tr><th colspan="4">Round 9
Medical Management Audits
Compliance (%)</th></tr>
<tr><td></td><td>Diabetes</td><td>Osteoporosis</td><td>Pneumonia</td></tr>
<tr><td>May 2014</td><td>75</td><td>76</td><td>72</td></tr>
</table>
Corrective action plans were developed by the QA department. Nine action plans for the general medical audit and 12 for the medical management audits were developed. At the time of the onsite review, those corrective action plans had not been completed.

Overall, the facility completed the external review within the required timeframe, and developed corrective actions for identified deficiencies. However, the facility did not provide documentation that the identified deficiencies were remediated. The monitoring team is also concerned about the power of this audit process. That is, the ability of the audits to detect problems that actually exist. Record reviews demonstrated that a number of problems were seen in the majority of records included in the record sample. Problems, such as poor documentation of follow-up and failing to document resolution of medical concerns and poor legibility were consistently noted in record reviews, but not detected via the audit process. The numerous other pervasive issues discussed in section L were not reported. The audits are of limited value if the process fails to adequately detect significant problems.
</td>
<td>Noncompliance</td>
</tr>
</table>

#	Provision	Assessment of Status	Compliance
		Mortality Management at SGSSLC Seven deaths occurred in 2013 and four had occurred in 2014 at the time of the compliance review. There were two deaths since the last review. Document IX.18 included a list of individuals who died since the last compliance review. The requested data, such as cause of death, date of death, completion of autopsy, and medical documentation were not submitted. The monitoring team met with the facility director, medical director, CNE, medical compliance nurse, and QA nurse to discuss mortality management at the facility. The medical director reported that clinical death reviews were completed, but he did not specifically review the records of all deaths. Thus, there continued to be a lack of an objective physician review. It was reported that state office conducted mortality reviews and provided recommendations to the facility. Additionally, Quantros continued to complete reviews and provide recommendations. The medical director reported that the last Quantros meeting was three to four months ago. The facility did not provide documentation or minutes related to the Quantros meetings. The monitoring team inquired about the facility's use of mortality data. That is, whether the facility conducted a longitudinal review of mortality to look at the causes of death, age at time of death, etc. The medical director indicated that this was not done. The CNE, as the former section H lead, had done some preliminary work in this area, which was presented in a prior review. These efforts were not continued. The monitoring team reviewed the facility reported aggregate mortality data for the past five years. A summary is presented in the table below.	

Mortality					
	2010	2011	2012	2013	2014
No. of Deaths	8	5	3	7	4
Average Age at Death	76.7	80.8	72.3	64.4	62

#	Provision	Assessment of Status	Compliance
		Based on these data, it appeared that the average age at the time of death was decreasing. Discovery of such findings should result in a more in depth review of the facility's mortality data. The monitoring team is concerned about the lack of an objective medical review. This review should be completed by a physician, preferably one not associated with the facility. The physician should be trained in the area of primary care medicine. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review.	

#	Provision	Assessment of Status	Compliance
		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. • There was a continued need to have an objective review of medical care by a physician other than the primary care provider. It would be logical that this would be done by a primary care provider, such as an internal medicine or family medicine trained physician for adult deaths. Facility staff reported that a mortality review was done by state office. However, the findings were not provided to the monitoring team. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The sample size of the external reviews should be increased. 2. Address the recommendations related to mortality reviews.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	Internal Medical Reviews Round 9 of the internal medical audits were completed in May 2014. The results are presented in the table below. Round 9 - General Medical Audits Compliance (%) May 2014: 92.5 The external and internal audits for Round 9 were completed at the same time to allow for assessment of inter-rater reliability. There were no significant differences in scoring. Compliance scores was less than 80% for the following questions: • Q26 - Was the PCFS updated at the time of the last annual assessment? Medical management audits were also completed in May 2014. The findings for the eight charts reviewed are listed below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Round 9 Medical Management Audits Compliance (%)			
	Diabetes	Osteoporosis	Pneumonia
May 2014	75	76	72

Corrective action plans to address the general and medical management audits were developed by the QA department. As discussed in section L2, the facility did not provide evidence that the corrective action plans were completed. The second internal audit for Round 9 should have been completed in early August 2014. That review was not completed at the time of the compliance review, nor had it been scheduled.

Medical Quality Program

The facility submitted a document summarizing medical quality improvement activities. The following actions were listed:

1. The Integrated Clinical Services Governing Body was developed.
2. A master scheduler was developed to assist the PCPs in completing timely AMAs.
3. A medical department QA meeting was held.
4. There was an ongoing process to review the risks of individuals with a diagnosis of constipation.
5. The Pneumonia Review Committee met regularly.

The monitoring team requested reports and results of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken.

Minutes were provided from two Medical Department QA meetings held on 2/14/14 and 6/25/14. The meeting conducted on 6/25/14 was attended by the medical director (staff physician at that time), two compliance nurses, and the department secretary. Based on meeting documentation, data related to section G and section H were discussed. The medical director and medical compliance nurse acknowledged that a comprehensive set of indicators had not been developed and there was no structured medical quality program. During previous reviews, the section H lead shared several draft audit tools that were developed based on identified clinical indicators. It appeared that the work done in that area was suspended and the audit tools were never utilized.

Quality programs require a number of structures, including a QI Committee, calendar, clinical practice guidelines, policies and procedures, peer review process, chart audits, tracking systems, and data sources. The monitoring team identified some processes that had the ability to measure quality. For example, the medical department maintained data on cancer screenings and compliance with obtaining EKGs. Data related to

#	Provision	Assessment of Status	Compliance
		hospitalizations and key neurology metrics were also maintained, but this information was not utilized for the purpose of performance improvement. While the medical director reported that a medical QA meeting occurred, he was the only member of the medical staff in attendance. Moreover, the meeting did not include a presentation of data elements (e.g., metric dashboard) that would typically be included as part of a medical quality meeting. Quality committees have a number of roles including review of medical policies and procedures (by staff with the appropriate content expertise), developing and monitoring a dashboard of key performance indicators/metrics, and reviewing sentinel events and root cause analysis reports. Meeting minutes should be maintained and should document the dashboard of metrics presented along with the analysis and trending of data, results of performance improvement projects, discussion of any RCAs completed, and review of policies and procedures. SGSSLC should identify metrics (process, outcome, and structural) to be measured and develop a medical quality committee. Participants should include, but may not be limited to, the medical staff as well as representatives from habilitation services, nursing services, and the QA department. A medical Quality Committee should be formed with the medical director serving as the chairperson. Minutes should be taken and forwarded to the facility director and QA department. Quality is an integral part of an organization's culture. The facility will not know the adequacy of the care provided if it is not properly measured. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must proceed with developing a comprehensive medical quality program as discussed above.	
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	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. Many of the key medical policies had not been reviewed or updated in several years. Per the self-assessment, "guidelines, policies were not consistent with current, generally accepted standards of care." Moreover, training rosters indicated that not all PCPs were trained on the current policies and guidelines outlining the accepted standard of care. The medical director reported this would be done during the monthly medical meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
	identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The medical director will need to ensure that policies and procedures are updated. The medical care policy needs more detailed explanations related to the duties and responsibilities of the medical staff, particularly the requirements for post-hospital follow-up on weekends and holidays. It is standard practice for policies, procedures, and guidelines to reflect the implementation and revision dates. Policies and procedures must be signed and dated by the appointing authority. <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, hepatitis, and other identified conditions. 2. Local policies should be developed based on state issued guidelines. 3. The medical department should maintain written documentation of all training and in-services that are provided 4. The department should establish a system for annual review of <u>all medical</u> policies and procedures. 5. The medical care policy should include a section that thoroughly defines the duties and responsibilities of the PCPs.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: ○ SGSSLC Section M Self-Assessment, updated: 7/24/14 ○ SGSSLC Section M Action Plan, updated: 07/21/14 ○ SGSSLC Section Presentation Book ○ Active Record Order and Guideline ○ Map of Facility ○ SGSSLC Nursing Services Organizational Chart including titles and names of staff currently holding management positions ○ SGSSLC Last six months Nursing staffing reports ○ SGSSLC Number of Budgeted Positions by RN and LVN ○ SGSSLC Last six months Nursing Meetings ○ SGSSLC Monthly News Letter "Nurses Corner," May 2014 ○ SGSSLC Daily Provider Meetings, August 18, 2014 through August 21, 2014 ○ SGSSLC Hospice of San Angelo Quarterly Meeting, dated: 4/9/14 and 7/1/14 ○ SGSSLC Hospice Care, dated: 7/29/14 ○ SGSSLC End of Life Care and Hospice, revised: 4/1/14 ○ Hospice/Palliative Care Screening Tool ○ SGSSLC Out-of-Hospital Do-Not-Resuscitate Orders, and Life-Sustaining Treatment ○ SGSSLC Death of an Individual, dated 7/29/14 ○ SGSSLC Shannon Partners Meeting Minutes, dated: 4/23/14 and 7/23/14 ○ SGSSLC Last six months of Ethics Committee Meeting Minutes ○ SGSSLC Nursing Quality Report, August 2014 ○ SSLC Guidelines: Comprehensive Nursing Review, Quarterly Nursing Record Review, Quarterly Physical Assessment, dated: January 2014 ○ SGSSLC Listing of RN Case Managers Tracking Logs, Nursing Assessments, IHCPs, MOSES, and DISCUS ○ SGSSLC Emergency Room Visits, Hospitalizations, and Infirmary Admissions for the last year ○ SGSSLC Acute Care Nursing Assessment Form ○ SGSSLC List of Delinquent Staff CPR certification ○ SGSSLC Emergency Response, revised: 12/16/13 ○ SGSSLC Emergency Equipment Walk Through Checklist, revised: 12/16/13 ○ SGSSLC Listing of Emergency Bags/Automatic External Defibrillator (AEDs) Locations ○ SGSSLC AED, Emergency Oxygen Tank, Suction Machine, and Emergency Crash Bag Checklists by units, dated 7/1/14 through 7/31/14 ○ SGSSLC Last six months Emergency Drill Checklists, Corrective Action Plans, raw data ○ SGSSLC Last six months summary and analysis Nurse Manager Review of Monthly Emergency Checklists ○ SGSSLC Last six months Skin Integrity (SIT) meeting minutes

	○ SGSSLC Skin Integrity Meeting Agenda and associated documents, 8/19/20 ○ SGSSLC Last six months Environmental/Safety Committee Minutes ○ SGSSLC Infection Control Policies, revised: 5/14/15 • Home Cleanliness Committee, • Infection Control Committee • Proper Sanitizing of the Dining Area • Intravenous Therapy and Infection Control • Catheterization of the Urinary Bladder and Infection Control • Care of Sterile Equipment and Supplies • Decontamination of Manikins in CPR • Employee Health Services • Individuals Immunizations • Reportable Diseases of Texas • Procedure for Notification for Infections Disease in Texas • Support Services • Lice Control Protocol • Scabies Protocol • Shaving, Razor Use, and Proper Disposal • Clostridium Difficile Infection Policy • Tuberculosis Control • Hibiclens Bathing Policy • Exposure Control Plan ○ SGSSLC Line Listing of Individuals with Known Infectious Conditions/Diagnosis Update, not dated ○ SGSSLC Quarterly Infection Control Meeting Agenda, and associated documents, dated: 8/19/14 ○ SGSSLC Last six months of Antibiogram ○ SGSSLC Line Listing of Blood Borne Exposures, not dated ○ SGSSLC Immunization Tracking Log, not dated ○ SGSSLC Immunization Record, revised: 9/25/12 ○ SGSSLC List of individuals with a gastrostomy tube, colostomy, tracheostomy, and Foley catheter ○ SGSSLC Last six months Infection Control Meetings Minutes ○ A list of individuals ever diagnosed with human immunodeficiency virus (HIV) ○ 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 ○ SGSSLC Medication Room Audit Inspections ○ SSLC Medication Administration Guidelines, revised: 1/14 ○ SGSSLC Medication Observation Form, dated: 7/18/14 ○ SSLC Medication Observation Guidelines, revised: 7/18/14 ○ SSLC Medication Variance Policy #053, effective: 9/23/11 ○ SGSSLC Medication Variance Report Form, dated: 11/3/11 ○ SGSSLC Hours Commonly Used for Scheduled Medications and Treatments, dated: 7/24/14

	○ SGSSLC Last ten Medication Variances and Corrective Action Plans (CAP) ○ SGSSLC Medication Variance Committee Meeting Agenda and associated documents, dated: 8/20/14 ○ 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 ○ SGSSLC Mortality Clinical Review Committee Meetings, Clinical Mortality Summaries, and Recommendations for the last six months ○ A List of Individuals At Risk for: aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes GI concerns, hypothermia, infections, injury, medical concerns osteoporosis, polypharmacy, respiratory, seizures, skin integrity urinary tract infections, and weight ○ Records of: Individual #246, Individual #77, Individual #352, Individual #111, Individual #72, Individual #189, Individual #379, Individual #369 Individual #346, Individual #248, Individual #268, Individual #331, Individual #116, Individual #68, Individual #129, Individual #186, Individual #201, Individual #235, Individual #248, Individual #268, Individual #329, Individual #292, Individual #397, Individual #76, Individual #218, Individual #40, Individual #127, Individual #110, Individual #140, Individual,#294, Individual #153, Individual #375, Individual #146, Individual #236, Individual #48, Individual #203, Individual #101, Individual #112, Individual #98, Individual #217, Individual #251, Individual #214, Individual #16, Individual #28, Individual #98, Individual #170, Individual #69, Individual #318, Individual #232, Individual #316, Individual #393, Individual #369, Individual #101, Individual #333, Individual #63, Individual #128, Individual #303, Individual #52, Individual #236, <u>Interviews and Meetings Held</u>: ○ Lisa Owen RN, Chief Executive Officer (CNE) ○ Anna Pittman RN, BSN, Nurse Operations Officer (NOO) ○ David Ann Knight RN, BSN, MSN, Director Nurse Education ○ April Watson RN, Program Compliance Nurse ○ Courtney Daniels RN, Infection Preventionist (IP) ○ Karen Brest RN, Assistant Infection Preventionist (IP) ○ Katherine Correa RN, BSN, Nursing Staff Scheduler/ Supervisor ○ Amanda Ramirez, RN, Case Manager Supervisor ○ Leslie Nixon RN, Hospital Nurse Liaison ○ Virginia Dooley, RN, Clinic Nurse ○ Angela Garner, RN, BSN, Quality Enhancement Nurse ○ Informal interviews with Nurse Managers, Staff RNs and LVNs ○ Melinda Gentry, Assistant Director Operations (ADOP)

	<u>Observations Conducted</u>: o Residential areas at various times of the morning and evening o Medication Administration Observations Passes: • Individual #76, Individual #246, Individual #218, Individual #40, Individual #127, Individual #110, Individual #140, Individual #294, Individual #153, Individual #375,Individual #146, Individual #236, Individual #48, Individual #203, Individual #101 o Medication Room Observations /Inspections of various units, with focused inspection of external, internal stock drugs, and refrigerators o Inspection of Emergency Equipment on various units o Nursing Coverage Meeting - 8/14/14 o Nursing Supervisor Meeting - 8/14/14 o Integrated Clinical Services Governing Body Meeting (ICSGB) - 8/19/14 o Skin Integrity Meeting (SIT) – 8/19/20 o Infection Control Meeting – 8/19/14 o Nursing Management Meeting – 8/20/14 o RN Case Manager Meeting - 8/20/14 o Medication Variance Committee Meeting - 8/20/14 o Pneumonia Committee Meeting - 8/20/14 o Daily Clinical Provider Meetings - 8/19/14 and 8/21/14 o Focus Nursing Meeting -8/21/14 o Mortality Meeting - 8/21/14
	Facility Self-Assessment: SGSSLC submitted its self-assessment for section M. For each sub-section, SGSSLC 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 facility: • Instituted real-time auditing in April 2014. • Established inter-rater reliability. The inter-rater reliability did not include all nursing monitoring/audit tools utilized by the facility. • Had a process and procedure for conducting monitoring, and/or observing each tool. • Produced data in the form of graphs that included a summary of the findings, trends, and an explanation of the trends. • Instituted a change in conducting medication observations, to include the sample size and grading criteria. The facility rated itself as being in substantial compliance with section M2, and in noncompliance with the other five provisions. The monitoring team did not agreed with the facility's self-ratings for M2 and M6.

	The monitoring team found M2 to be in noncompliance, and M6 was found in substantial compliance.
	Summary of Monitor's Assessment: The Nursing Department had significant turnovers in Nursing Leadership, and RN Case Managers. Turnovers included the positions of the CNE, Director and Assistant Director for Education, RN Case Manager Supervisor, Nurse Manager and five RN Case Managers. The facility experience a number of shifts that fell below minimum staff levels due to vacancies. Staffing was augmented with agency nurses, and nurses from the facility volunteering for additional shifts when request were posted. The Nursing Department began the process of conducting real-time monitoring in April 2014. Nurse Educator had made changes in the structure of didactic, and bedside competencies, i.e., medication administration. Nursing assessments and the development or lack of development of sufficient plans of care in response to the individual's needs, appeared to be hampered by the significant turnover of nursing positions. The Hospital Liaison, in collaboration with the Medical Director, continued to facilitate positive partnerships with the health care community, including hospice and the hospital. Current hospital information was consistently provided via visits and remote access to "live" records. The facility had an active and responsive Skin Integrity Committee that was collaborative in the development of policies and in educational preventive strategies to minimize pressure ulcers. Infection control continued its positive practices of hand hygiene campaigns, and revision of policies. Infection control implemented and followed nationally recognize standardized established Surveillance Definitions of Infections (McGeer) in June 2014. The monitoring team found substantial compliance with section M6.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and	The monitoring team conducted its own independent review of the facility's self-assessment, action plans, and in section M Presentation Book. The monitoring team held interviews and meetings with the CNE, NOO, RN Case Manager Supervisor, Compliance Officer, RN Nursing Staff Scheduler/Supervisor, Hospital Liaison Nurse, Infection Control Preventionist, Nurse Educator Director, Clinic Nurse, Nurse Managers, ADOP, QA RN, direct care RNs, LVNs, and direct support professionals. The monitoring team also reviewed individuals' records, conducted nursing interviews, made observations on each unit, and attended a variety of meetings. The monitoring team made rounds with two of the Nurse	Noncompliance

#	Provision	Assessment of Status	Compliance
	keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Managers for the units where they provided supervision and oversight. During the review, the monitoring team observed 23 individuals during various times of the day and evening across all of the units. Fifteen individuals were observed receiving their medications on six of the homes. The monitoring team observed 17 nurses on the units, LVNs, Nurse Managers, RN Case Managers while they were administering medications, transcribing orders, administering enteral feeding, or performing assessments. <u>Staffing, Structure, and Supervision</u> SGSSLC census at the time of the monitoring visit was 217. There were a number of changes in the nursing leadership team since the last visit. The CNE was promoted from her previous role as a QA RN. The RN Case Manager Supervisor was promoted from her previous role as an RN Case Manager. The RN Director of Education was promoted from her previous position in the QA Department. The NOO performed additional duties as the interim CNE and s RN Case Manager Supervisor until those positions were filled. The Hospital Liaison also assumed additional responsibilities to support Nursing Case Management and to complete Post Hospital Nursing Assessments. As of 8/20/14, the following, with the exception of the RN Assistant Director of Education, were filled. • CNE • RN Case Manager Supervisor • RN Case Managers (5) • RN Director of Education • RN Assistant Director of Education Even so, the nursing department remained challenged with daily staffing, reporting in their June 2014 data, vacancies in RN positions and LVN positions, consistent with the previous six months. The facility data showed in graphic format, for the last six months, shifts that were below minimum staffing by day and by shift. This ranged from March 2014 of 24 shifts to May 2014 of five shifts. The facility continued to use agency staffing, and had withdrawn its mandatory staffing plan requiring leadership and RN Case Managers to provide shift coverage. Thus, nurses volunteered for a shift that was acceptable to their schedule when shift needs were posted. Nurses were no longer shifted to homes that they were unfamiliar with. The CNE, NOO, and Nursing Leadership revamped aspects of the nursing department (i.e., how nursing positions were allocated and expectation for those allocations). The following changes were implemented: • Assigned a direct Care RN II to each unit/home. • Adjusted LVN's workloads.	

#	Provision	Assessment of Status	Compliance
		• Revised Nursing Management roles/responsibilities. • Modeling expectations were implemented for creating a positive working environment, and expected standards for responding promptly to individuals and requests or needs. • Development of an RN Scheduler/Supervisor Role by decreasing the number of RN Nurse Managers from four to three, where the role focused on scheduling and staffing 24/7, with new processes for requests for time off, to assure adequate nursing coverage. • Re-organization of areas where individuals were observed, received their medications, nurses conducted physical assessments, and performed documentation, for consistency among the units. • Established Nursing Focus Meetings. • Continued Nursing Meetings with Managers, Supervisors, ADOP, Direct Care RNs, LVNs, and Nurse Managers. • Members of the Nursing Department made visits to sister facilities to observe their practices (e.g., medication administration, staffing). • Nurse Recognition Program for Nurses Scoring 100% on Audits. • Assigned (and empowered by ADOP) as Administrator on Duty Call for members of the RN Nursing Leadership Team. • Established process for individuals returning from the hospital to assure individuals were re-evaluated promptly. Throughout the rounds, the positive changes that had been made were apparent. This included availability of necessary resources/tools to perform their work, and areas that set the occasion for nurses to perform nursing functions. It was also very positive to observe the consistent positive and professional interactions between the CNE, NOO, Nurse Manager, and the Nursing staff. The CNE and NOO, when accompanying the monitoring team, were "hands on" and provided any necessary prompts to support nursing staff. The Nurse Managers and RN Case Manager Supervisor were observed giving positive reinforcement and, when necessary, performance counseling. The Nursing Department should further challenge themselves by re-visiting their staffing to assure acuity is a component of staffing. Nurse Managers remained housed in the main Nursing Administration building, however, their job assignments and responsibilities required them to be on the units, which the monitoring team consistently observed occurring, with them engaged with the nurses during the morning, day, and late evening. The inability to re-position the nurses on the units was related to a logistic issue of available space. The monitoring team attended nursing meetings, and consistently found that the nurses	

#	Provision	Assessment of Status	Compliance

		brought forth new issues, discussed items that were not resolved, and had discussions with the ADOP (who was present for the meetings) for advisement. For each of the meetings, minutes were maintained. The Nurses openly reported that the ADOP was available, accessible, and supportive of the needs for nursing, and consistently provided guidance to ensure there was ongoing integration with other disciplines. Evidence of this was an inservice given by nursing regarding the identification process for administering medications. In addition, the ADOP had empowered the Nursing Leadership as the Administrator on Duty (AOD) that included taking assigned call and making rounds on the units and, as necessary, making administrative decisions.
		
		Availability of Pertinent Medical Records
		During the onsite visit, records were accessible, including the individual notebooks. During the monitoring team's offsite review of records, all records were available with exception of missing nursing assessment pages.
		• The monitoring team reviewed, onsite, the individual notebooks for Individual #346, Individual #244, Individual #Individual #236, Individual #52 and Individual #112 and found:
		  o Five of five (100%) of the records were easily accessed on the units, and were in order as defined by the tabs.
		  o Five of five (100%) of the individual's ISP, and applicable staff instructions were found in the individual notebook.
		  o Individual, #244's, Do-Not Resuscitate document in the individual notebook did not include the most current annual review date, in accordance with facility policy. The CNE notified the Hospital Liaison to follow-up on the issue of concern.
		• A review of the 10 records selected for a comprehensive review found:
		  o Nursing IPNs showed some notable improvement for documentation using an applicable NANDA diagnosis.
		  o Nursing IPNs were consistently dated, and timed for the entry.
		  o Late entries, when entered, followed the standard of practice for documenting.
		  o Nursing IPNs continued to have problems with the use of inappropriate abbreviations, legibility of entries, nursing titles and signatures.
		  o ACPs, for the applicable acute events, were not consistently located in the records, or were never initially developed.
		
		Hospitalization and Hospital Liaison Activities
		The Hospital Liaison was observed performing a multitude of duties. She was observed:
		• Re-stocking the established area for performing individual post hospital assessments.	

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		• Attending Morning Medical Meetings and providing current hospitalization information that included her findings from her face-to-face observations of the individual, conversations with the individual's physician, results from laboratory x-ray findings, and discharge plans. In addition to these observations, the monitoring team met with the Hospital Liaison who provided a comprehensive and organized presentation, including supporting documents for: • Communications between the facility, Hospitals, and Hospice. Examples of the communication included specific details advocating for individuals to ensure that necessary equipment and supplies were available and that staff understood how they were to be used. • Tracking of Do-Not-Resuscitate Orders • Hospital Liaison Reports • Hospital/ER Admission Tracking Spreadsheet • Performed Audits • Shannon Partners Meetings • SGSSLC and Hospice Meetings • Facilitated the SGSSLC Ethics Committee Meetings • Conducted daily face-to-face visit with hospitalized individuals, and assigned direct support professionals (Monday through Friday - Weekend coverage via phone contact by the Nursing Supervisors) • Completed Hospital Liaison reports, and communicated to members of the IDTs • Followed-up on medical appointments and coordinated hospital consults • Followed-up on facility or hospital identified issues of care related to the individual • Audit examples of completed Documentation/Hospital Transfer • Daily, conferred with Infection Preventionist to assure necessary lab reports were provided • Participated in the development of policies (e.g., End of Life Care and Hospice, revised 4/1/14). The Hospital Liaison Nurse was also in the process of working with the hospital to add additional users to remotely access "live records" from the hospital. The IPs would be included as future users. The Hospital Liaison was awaiting hospital confirmation for the identified users. The Hospital Liaison provide examples, found in the SGSSLC/Shannon Partners meeting minutes, that included a variety of topics addressed by each entity, such as Lab, PNMP/diets, and skin breakdown during hospitalizations; for actions taken, and actions	

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		planned.
		
		The following were individuals with a change in status who were hospitalized. ACPs are addressed in M3.
		• On 5/1/14, the IPN Nursing notes indicated Individual #217 (high risk for aspiration, respiratory compromise) was being monitored for a diagnosis of bronchitis. The MAR indicated that the antibiotic therapy was completed on 4/28/14. The IPN indicated the bronchitis problem was resolved on 5/9/14 at 1:15 pm. The record was problematic for:
		  ○ No acute ACP and associated staff instructions were found in the chart for the diagnosis of bronchitis, even though the Nursing IPN alluded to the resolution of the ACP.
		• On 6/4/14 at 11:00 am, the Individual #217 was sent, via 911, to the hospital due to "decreased mental status." She was admitted with Pneumonia and UTI. The record was problematic for:
		  ○ Omission of nursing assessment on the day of the event. The minimum standards for documentation were not followed.
		  ○ Omission of nursing assessments that the individual was being sufficiently monitored, for her high risk choking, aspiration, and respiratory compromise.
		  ○ IHCP, dated 7/8/14, goals were based on the individual having "zero incidents of aspiration in the next year," even though the record indicated the Pneumonia Committee had met, and determined, on 5/22/14, that the individual had aspiration pneumonia from a previous respiratory incident, and had been hospitalized on 6/4/14 for pneumonia. The goals on the IHCP did not appear in alignment with the individual's risk, or risk factors.
		  ○ IHCP Section for "Monitoring Frequency and Location of Documentation", indicated quarterly for the identified risk. The IHCP indicated "Nursing will follow the Respiratory distress/aspiration protocol card for issues in the area as needed. " Thus, it appeared assessing for risk would be conducted reactively.
		
		The monitoring team reviewed the Hospital Liaison Hospitalizations Reports for Individual #98, who was hospitalized for seven days, and Individual #217 who was hospitalized for six days.
		• 10 of 13 (77%) had a documented daily visit by the Hospital Liaison.
		• 10 of 10 (100%) of the available reports contained pertinent information to keep the team informed of the health status of the individuals	

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		The monitoring team also reviewed three of the most recent Post Hospital/ER/LTAC Nursing Assessment, Transfer Form and IPN notes for Individual #98 and Individual #217and found: • One of two (50%) Post Hospitalization/ER/LTAC Nursing assessments/IPN Notes contained sufficient information about the discharge and current health status of the individual. • Two of two (100%) records contained an Acute Care Plan or staff instructions for the individual's acute care problems. • No (0%) records contained applicable ACPs documentation revision or resolution date, for the Pneumonia, UTI, and Athlete's foot implemented on 6/12/14. • Two of two (100%) of the Post Hospitalization/ER/LTAC Nursing Assessments IPN Notes documented the assessment within one hour in accordance with facility policy. The facility's overall Nursing Post-Hospitalization/ER/LTAC Documentation for Quality for December 2013 through June 2014 was 69%. The monitoring team's findings were similar. Infirmary The facility's infirmary document submission for 12/21/13 through 5/13/14 showed: • Seven admissions • Length of stay between 1 day and 29 days • Three individuals had a length of stay 29 days or more. One individual remained in the Infirmary due to the high frequency of her skilled nursing needs Overall, the number of admissions and length of stays were decreased by 50% from the last report. The facility did not have a rationale for the decrease. Documents that the facility had taken action in response to previous recommendations for review/revision current policies were not provided to the monitoring team, (e.g., Admission from Hospital to Infirmary). If the facility is to retain the Infirmary, there should be established guidelines for admissions, discharges, and transfers within and external to the facility that clearly delineate the roles and responsibilities of disciplines responsible for the care and services to be provided in the Infirmary. Wound and Skin Integrity The monitoring team reviewed the January 2014 through May 2014 Skin Integrity Committee (SIT) Meeting Minutes. The monitoring team also attended the SIT Committee Meeting where there was active participation by members. Their discussions led to decisions that resulted in:	

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		• Development of Skin Integrity Guidelines
		• Training of DSP on Skin Integrity Guidelines (completed 4/23/14)
		• Training for Nurses completion of the POST/ER/Infirmary Hospital Assessment for completing back of the form for identified skin integrity issues (completed and now ongoing, 3/24/14)
		• Conducting an analysis for each month. For example, the May 2014 Analysis identified that Integrated Health Care Plans were not located in the charts, and that there was incomplete training to staff on the IHCP. The minutes also noted problems with having no process for acute care plans, which appeared to be a logistical problem with ensuring records were filed timely and were accessible in the active record.
		• The facility reported that the number of pressure ulcer for March 2014 was one, and zero for April 2014 through July 2014. The one was documented as hospital acquired. The committee held discussions for addressing each of the skin integrity issues, including preventive strategies.
		• Even though the numbers were low, the facility should continue their positive progress toward the goal of maintaining zero pressure ulcers.
		
		<u>Infection Control</u>
		The Infection Preventionist provided the monitoring team a document book that showed their accomplishments since the last visit, which included the following improvements:
		• Continued current memberships in the National Organization of Association for Professionals in Infection Control and Epidemiology (APIC).
		• Established relationships with State and Local health department Public Health Nurses for consultation on infections or public health related issues.
		• Implemented and following nationally recognized standardized established Surveillance Definitions of Infections (McGeer Definitions).
		• Completed a review and update of 19 policies:
		  ○ Home Cleanliness Committee,
		  ○ Infection Control Committee
		  ○ Proper Sanitizing of the Dining Area
		  ○ Intravenous Therapy and Infection Control
		  ○ Catheterization of the Urinary Bladder and Infection Control
		  ○ Care of Sterile Equipment and Supplies
		  ○ Decontamination of Manikins in CPR
		  ○ Employee Health Services
		  ○ Individuals Immunizations
		  ○ Reportable Diseases of Texas
		  ○ Procedure for Notification for Infections Disease in Texas
		  ○ Support Services	

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		- Lice Control Protocol - Scabies Protocol - Shaving, Razor Use, and Proper Disposal - Clostridium Difficile Infection Policy - Tuberculosis Control - Hibiclens Bathing Policy - Exposure Control Plan (draft revision) • Conducted 34 Random Handwashing Audits monthly • Conducted 100% audits of infections • Conducted real time infection control audits for sample size of five monthly • Oversaw the Infection Control Home Inspections completed by Shift RNs • Maintained a line listing of MDROs • Developed Antibiograms Infection Control Meetings The meetings were chaired by the Infection Preventionist, and the membership was represented by Nursing, Medical, Pharmacy, Residential, Risk Management, and Maintenance. The IP provided information on infections that had increased or decreased and suggested analysis for the change. The Post Exposure Plan draft, and its associated discussions, took a larger part of the meeting, for which the committee planned to have additional focused discussion with medical, IP, and pharmacy. The monitoring team will follow-up at the next visit as to the Post Exposure Plan. The monitoring team was provided with June 2014 and July 2014 data using the recently implemented McGeer definitions. From highest to lowest, the facilities data indicated Urinary Tract Infections were four in June 2014, and showed a decline by two in July 2014. Respiratory showed infections, such as aspiration pneumonia, pneumonia, or bronchitis decreased by five in July 2014. Soft tissue infections showed an increase from June 2014 of three to eight in July 2014. The IP stated they had just begun, in June 2014, to collect data using the McGeer definitions, and had not begun to provide infection rates based on their in-resident days. The monitoring team will follow-up at the next visit for the status of the facility's data collection, analysis of their data, and prevention strategies for preventing transmission of infections. Immunization/Immunity Status of Individuals The monitoring team requested that the facility provide the most recent individuals who received their immunizations. The monitoring team requested the records to include the individual's consent, immunization record, titers, physician orders, and the Vaccine Information Sheet Publication applicable to the date of the vaccine administered for Individual #303, Individual #63, Individual #333, Individual #101, and Individual #217.	

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		The vaccines were administered between the dates of 1/31/14 and 8/15/14. Two received Hepatitis A, two received Hepatitis B, and one PPSV vaccine. • Five of five (100%) of the records contained a physician order for the vaccine to be administered. • Five of five (100%) records contained documentation the consent was signed prior to administration of the vaccine. • One of five (20%) records contained the applicable Vaccination Information Sheet in accordance with the date the vaccine was administered. • Five of five (100%) documented the vaccine in the individual's record. • None of the five (0%) were documented on a current nationally recognized immunization form that included a place for documenting the VIS and its publication date. • Much education was needed regarding the VIS and the associated required state/federal regulations with vaccinations. See also section L1 of this report.	

Immunization/Vaccine Data/PPD Testing

The facility reported the status of vaccinations for each individuals residing at SGSSLC by percentages.

MMR	TDaP	Varicella	Hep B #1	Hep B#2	Hep B#3	Hep A	Meningococcal	Pneumococcal	HPV	Zoster
90%	96%	89%	94%	92%	91%	83%	84%	90%	77%	96%

- 98% of the individuals at SGSSLC received their flu vaccination for the 2013 year.
- 79% of staff at SGSSLC accepted the free flu vaccinations for the 2013 year.
- 26 of the total census (207) were TB convertors and, as reported by the facility, had documentation of active symptoms. The facility maintained a line listing of all TB convertors, and the results of their skin tests, chest x-ray, and questionnaires for evaluating their symptoms.

Emergency Response

The Nursing Department requires the nurses to check the emergency equipment in the medication room and the emergency equipment bag in the DSP Office daily.

- For the 31 AEDs Risk Management checks and reports of any identified issues, the data were submitted to nursing for auditing and trending, however, the monitoring team could not discern how nursing and risk management used the findings from the data collected.

The Clinic RN performs weekly checks of AEDs, and reports any problems. The facility reported a faulty alarm battery identified in the March 2014 inspection had not been

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		addressed by the inspection date in April 2014. The item was repaired with in four days of the inspection. The facility provided a summarization of the emergency response mock drills, number conducted, total passed, and total failed, with the accompanying raw data. A separate report was generated for each month. No aggregated data were provided. The facility reviewed results at various facility committees (e.g., QI Council, IMRT). Based the monitoring team's observations of the emergency equipment for each of the six selected homes, 100% of the AED/Emergency Equipment was located. Most did not have signage posted. • For each of these sites, (100%) of the nursing staff proficiently demonstrated that the oxygen, AED, and the suction machine (electrical) were (100%) functionally operating. Each of the homes had a hand pump for suctioning. • 100% of the Emergency bags were present, clean, stored properly, and secured with a numbered pull lock. • An onsite review, for the AED and Emergency Bag, Emergency Oxygen Tank and Suction Machine Checklists for July 2014 were (100%) completed. • The monitoring team reviewed the checklists for each of the medication rooms. The findings were consistent with the facility's data for five missed daily checks. • During rounds, it was positive to find that when the monitor asked the nurses where the AED or their emergency equipment was located, without hesitation the three that were interviewed quickly pointed out the location of the items. • Nurses were quizzed on how they would respond in a disaster if the facility experienced power outages and, without hesitation, eight of the nurses interviewed stated the correct response, including identification of where emergency red plugs were located in their home. The Course Due/Delinquent Report run date for 6/5/14 for nursing showed no delinquencies. Other categories provided a list of eight individuals. The list contained an updated explanation that one individual had completed the course on 6/10/14, the remaining were new hires as of 6/1/14, but were scheduled for class on 6/17/14. <u>Quality Enhancement Efforts</u> The Compliance Nurse and monitoring team met to discuss quality assurance initiatives by the nursing department. The Compliance Nurse prepared detailed colored graphs that included data for June 2014 and July 2014. The Compliance Nurse explained the process for each audit. The documents prepared included an outline of who performed the monitoring, the frequency of the monitoring, an overall aggregate, and a summary of the aggregate. The document also identified trends and contained an explanation for any	

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		increases or declines. The document included any current plans for the audits based on staffing assignments. The document included a prediction of outcomes. The Compliance Nurse compiled, trended, and explained the following data: • Medication Variances • Medication Room Audits • Medication Observation Passes • Assessment Timelines • Assessment Quality • MAR Audits • Emergency Equipment Daily Checklists • AED Equipment Checks (AED Equipment Requiring Maintenance) • Inter-rater reliability data performed The monitoring team also interviewed the Quality Assurance Nurse who had recently transferred from the CNE position. She was receiving orientation from the previous QA Nurse and was working collaboratively with members of the Nursing Department. Determinations had not been finalized to what Nursing Audits the QA Nurse would be conducting. These decisions were to take place in future meetings with nursing and other administrative supervisors. The monitoring team will follow-up at the next visit to review next steps taken by nursing and the QA Department. Although new to QA, the QA nurse had begun to complete the required mortality summaries, and tracking of mortality recommendations. The monitoring team also facilitated the Mortality Meeting attended by the CNE and QA nurse. A review of the submitted recommendations pertinent to nursing for the three deaths occurring between 2/6/14 and 5/29/14 found: • Name of the individual, recommendation, person responsible, date of completion, and a comment section for each of the 24 recommendations, for which, 19 were nursing. • 19 of 19 (100%) of the recommendations had been addressed; two that involved the participation of other disciplines had an extension date of 9/30/14. The nursing recommendations were not consistently written in measurable terms. The document for tracking the recommendation did not include evidence based documentation that the recommendation was carried out, but rather relied on a statement that they met or that there was an existing improvement plan. The recommendations did not include a plan for how the facility would ensure the recommendations when implemented and completed, resulted in change positively or negatively, or produce alerts for lesson learned. The facility reported that these were considered to be informal recommendations to be taken up by the Clinical Death Review Committee.	

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		<u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The monitoring team attended the Daily Clinical Provider Meetings, chaired by the Medical Director. Each department, and their selective representatives, were represented in the meeting. Nursing represented the largest discipline. This included the CNE, NOO, Hospital Liaison, and the Infection Preventionist. Data for the meeting were gathered primarily through the nursing 24/7 reports. Lists were maintained for individuals who would not accept their medications (medication refusal logs), were being treated, were referred for consultation, or were admitted to outside health care facilities. Available information regarding individuals' consultations, hospital admissions, transfers, and discharges were reviewed daily. There was discussion of planned admissions and discharges, as applicable. The meeting forum was positive in that it was open for members to make suggestions, to accept recommendations, have more discussion about recommendations, or ask questions. Individual #364 was observed on 8/20/14 by the monitoring team to sustain a fall while in the canteen. Staff in the canteen immediately came to see about him. The monitoring team requested the canteen staff call for a nurse. An LVN arrived who summoned an RN to further assess. The individual's injuries were assessed by the nurse and the physician was called and saw the individual. X-rays were ordered. A review of the record found the individual was High risk for fractures. The current IRRF indicated the team had determined the individual was identified as high risk for falls. The individual, from 7/30/14 through 8/20/14, had experienced 12 fall occurrences with varying times throughout the day and evening. The record was problematic for: • For each of the occurrences, the falls protocols was not sufficiently implemented. • The 8/20/14 record indicated neuro checks were instituted for mild head injury. • Omission of an 8/20/14 Neurological Check Sheet in the record. • Omission of documentation of the mild head injury protocol for monitoring. • Omission of a review of the active record for incidents of falls, or the underlying reason for the increase in the falls. • The individual was assessed by nursing for each of the falls and referred once to the physician for the fall occurring on 8/20/14. The facility should convene an IDT meeting for this individual to review any underlying reason for the falls, or supports need to prevent the falls. The facility's self-assessment stated "This provision is not in substantial compliance because nurses are not appropriately identifying, reporting, monitoring, and documenting individuals' health care needs sufficiently to readily identify change in status." This was consistent with the monitoring team's findings.	

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		The Nursing Department should: 1. Ensure that there is appropriate identification of health/mental health problems, and when problems are identified, that there is continuity of practice when assessing, documenting, and providing continuity of care to resolution. 2. Ensure Nurses have sufficient training and education on immunization requirements to include documentation in accordance with regulatory guidelines. 3. Nursing Department should develop minimum staffing standards that include an acuity component. 4. The facility and Infection Preventionist should continue their positive practices for an infection control program that uses current nationally recognized surveillance methods for infections, and for practices that decrease or minimize the risk of infection and the transmission of infections.	
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 was recently promoted from her position as an RN Case Manager. At the time of this review, all RN Case Manager positions had been filled, and the RN Case Managers were receiving training, and orientation to RN Case Management. The RN Case Manager Supervisor assured that each individual had a designated RN Case Manager. The RN Case Manager Supervisor ensure that the following activities, set by the previous RN Case Manager Supervisor, continued. • Held weekly meetings with RN Case Managers to provide opportunities for review of their Annual/Quarterly Nursing Assessments and associated IHCPs. • Conducted individual reviews with each Case Manager and provided performance counseling, as appropriate, related to their roles/responsibilities, and findings from audits. • Send reminders to RN Case Managers for due dates for their Annual/Quarterly Nursing Assessments, MOSES, and DISCUS. • Maintained a comprehensive spreadsheet for tracking and monitoring 100% of Annual/Quarterly Nursing Assessments/Physical Assessments, MOSES, and DISCUS . • Nursing leadership attempted to assist the RN Case Managers by providing guiding prompts for training of the Annual/Quarterly Nursing Assessments within the pre-determined format. Nursing reported this was not accomplished because the established form fields were not conducive for adding prompts. Training/Education • Re-trained RN Case Managers on the Annual Assessments related format for recommendations, June 2014.	Noncompliance

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		The monitoring team reviewed the most recently completed Admission, Annual, and/or Quarterly Assessments from the facility's High Risk List across seven homes completed by six different RN Case Managers. The dates for the 18 assessments were between 4/4/14 and 8/20/14, for Individual #28, Individual #373, Individual #72, Individual #214, Individual #16, Individual #98, Individual #112, Individual #203, and Individual #217. Each of the nursing assessments were documented on the revised format. • 17 of 18 (94%) of the assessments contained the required components of the assessment, the record review, and the physical assessment. • Two of two (100%) Admission annual reports were completed within 30 days of the admission, in accordance with facility policy. • Seven of eight (88%) Annual assessments were completed within 10 working days prior to the date of the ISP meeting. • Seven of eight (88%) Quarterly assessments were completed by the last day of the month in which the quarterly assessment was due. Individual #251's physical assessment was either missing or was not done. • The facility data showed that the overall average of timeliness for Annual/Quarterly Comprehensive Assessments August 2013 through July 2014 was 87%. The monitoring team's overall percentage was 92%. • Seventeen of the Admission/Annual and/or Quarterly Nursing Assessments were reviewed using a monitoring tool, and the SSLC Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The monitoring team's overall score for all items was 76%. • 13 of 17 (76%) annual/quarterly assessments were deficient in consistently and sufficiently addressing the status of the individual, in terms of progress, stability, and/or regression. The areas listed below had significantly low scores, which evidenced that nursing staff could benefit from training and education regarding immunizations (i.e., how immunity is established, current required vaccinations, schedules that confirm "up to date" status). • Two of 10 (20%) of the Admission/Annual Assessments Section I for the applicable area contained sufficient summary statements. An improved example was Individual #112. • None of the four (0%) assessments that identified infections contained a sufficient summary statement about the infections. • One of 10 (10%) immunizations assessments documented the required date of the vaccination. This was for Individual #72. • Two of six (33%) individuals' history for polypharmacy, in the assessment, did not sufficiently addressed the effectiveness and response to medications. For example, Individual #217.	

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Assessments	Aug. 2013	Sept.	Oct.	Nov.	Dec.	Jan. 2014	Feb.	Mar	Apr.	May	Jun.	Jul.	Overall Average
Timely Annual Assessment	83%	57%	88%	95%	76%	87%	88%	100%	95%	91%	96%	85%	87%
Timely Quarterly Assessment	79%	75%	95%	94%	92%	86%	95%	100%	82%	84%	85%	77%	87%
Quality Annual Assessment					74%	70%	71%	83%	81%	99%	91%	91%	83%
Quality Nursing Physical Assessments	94%	96%	93%	92%	95%	96%	93%	93%	95%	99%	95%	95%	95%

The RN Case Manager audited two physical assessments for each tenured Case Manager and 100% of physical assessments for each new RN Case Manager. Decrease in timeliness was due to the vacancies of five RN Case Managers.

The facility's self-assessment stated they had met compliance with M2. The monitoring team's reason for disagreement was based on nursing assessment summaries. The summaries did not consistently include substantive statements that qualified the status of each individual's risks, response to interventions, and demonstrate whether or not the individual is progressing or regressing toward his/her IHCP goals.

The Nursing Department should:

1. Ensure nurses have ongoing oversight and supervision that assures they have the knowledge, skills, and abilities to analyze, summarize, and document health issues when making determinations as to whether or not the individual is making progress toward their stated health goals.

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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	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection. The facility indicated monitoring for this provision had not been implemented, as tools to capture data for M3 were developed, but not yet implemented. The noncompliance finding from the last review stands. The monitoring team reviewed the ACPs for eight individuals with 13 recent changes. Six (42%) had a corresponding ACP and staff instructions. • Individual #98 (2, diarrhea, aspiration pneumonia) • Individual #28 (head injury) • Individual #16, (skin integrity) • Individual #214 (congestion) • Individual #251 (3,UTI, athlete's foot, Foley catheter) • Individual #393 (SIB injury, loss of tooth) • Individual #203 (G-tube) • Individual #217(2, Pneumonia, UTI).	Noncompliance

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	are developed or revised.	For the 13 Nursing Assessments and Documentation, see sections M1 and M4. • Six of 13 (46%) individuals with recent acute changes had corresponding ACPs and associated staff instructions. • Five of six (83%) contained documentation that staff were trained on the plan. • Two of the six (33%) were individualized. • Two of the six (33%) ACP plans had baseline data that sufficiently described the issue for the implementation of the plan. • Three of the six (50%) plans contained nursing goals sufficient to identify the outcomes from their acute illness/injury. • Five of six (83%) plans were implemented within the timeline in accordance with the ACP policy. • Of the applicable plans due for revision, two (33%), contained documentation that the plan was revised or resolved. For example, Individual #217 The monitoring team reviewed five of the recent community discharges for Individual #170, Individual #69, Individual #318, Individual #316, and Individual #232. The monitoring team's review found: • Five of five (100%) of the records were documented in the new format. • One of the five (20%) Nursing Services Comprehensive Assessments (CLDP) was sufficiently completed to include addressing any special preferences needed to receive their medications. • One of five (20%) CLDPs sufficiently addressed the health/mental health issues of the individuals that would specifically guide the community staff in providing coordination and continuity of care for the individual. • Five of five (100%) of the CLDPs were completed for the individuals prior to discharge/transferring to the community. CLDP Nursing Assessments showing improvement. For example: • Individual #318's submission for recent community discharge contained the required completed Nursing Services Comprehensive Nursing Review. In addition, the submission contained a current physical assessment and a current scored Braden scale. Even though these documents were not required by policy prior to discharge, it was positive that the individual had a current physical assessment. The Comprehensive Nursing Assessment recommendations section provided recommendations/actions to be taken to assure coordination, continuity of care, and identification of what to report, and who to report to for changes in health status. Even so, the recommendations needed improvements in substantial statements for what issues needed to be monitored and reported regarding individual risk in order that the receiving agency could understand.	

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		CLDP Nursing Assessments required improvement. For example: • Individual #170's record documented that the individual would need assistance with her medications, but failed to document actions/support she would need. The recommendations and actions did not sufficiently address the individual's health problems and associated risks to sufficiently guide community staff. In addition, it was perplexing that the immunization/immunity status (i.e., MMR, Polio) indicated that information could not be located, even though the individual was admitted to the facility in 2009. The facility's self-assessment stated that the provision was not in substantial compliance because the health care plans continue to be incomplete, delinquent, and/or not completed within the appropriate time frame. Further, staff training per facility policy was not sufficient to address each individual's health care needs. This was consistent with the findings of the monitoring team. The Nursing Department should ensure individuals with changes in status (i.e., acute illness and injury) will have an applicable associated plan of care, and that the plan is individualized. Staff instructions should be individualized and written in understandable measurable terms.	
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.	The Nursing Education Director and Assistant Director positions were vacated since the last review. The Nursing Educator Department Director vacated position was recently filled. The Assistant Director position had been posted, and the Nursing Education Director planned to fill it in the very near future. The Nursing Education Director held a bachelors in nursing with masters of nursing, specializing in nursing education. The Nursing Educator Director provided a review of the main classroom. It had a large screen for didactic training and individual classrooms for obtaining skill competencies. The Nursing Educator Director also provided information on improvements. The improvements included an increase in opportunities to demonstrate skill in the classroom and at the bedside. All RNs in the Nursing Department, from the CNE to direct care RNs, were required to demonstrate competency in the classroom and bedside, and received ongoing medication observations to be maintained as certified as an medication administration observer. In addition, the certified RNs were expected to consistently model safe medication practices, provide shoulder-to-shoulder observations, and offer guidance to assure safe medication practices. This was a positive improvement. The Nursing Educator Director maintained information on each nurse's educational courses, including a line listing of nurses receiving remediation.	Noncompliance

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		New Protocols/Guidelines • Nursing Protocol: Weight Management Education/Training Competencies	

Course	% RN Trained	% LVN Trained
RN Assessment	100%	100%
Documentation	100%	100%
Medication Administration	100%	100%

The monitoring team randomly selected seven records from the sample of 10 individuals. Applicable ACPs are addressed in M3

Negative examples:

- On 5/30/14 at 8:20 pm, staff reported Individual #98 "had two watery stools."
  - The Nursing Protocol that guides nursing assessment for diarrhea was not sufficiently applied, including documentation of any recent history of antibiotic use, (i.e., Cefaclor).
  - An ACP and associated staff instructions were not found in the record.
- On 5/27/14 at 5:15 pm, the IPN Nursing note for Individual #28 reported that she was pushed down by a peer and "bumped my head." Nursing assessment documented a "2 cm x 2 cm" bump to her head.
  - The record did not address the difference in the assessments for pupil size, documented on the Neurological Checklist.
  - The record indicated the individual was to be referred to the practitioner/physician in the am (5/28/14). No information was contained in the record that the individual was actually evaluated by the practitioner/physician.
  - An ACP and associated staff instructions were not found in the record.
  - No documentation was found in the record that the identified head injury was followed to resolution.
- On 8/21/14 at 6:46 a.m., 8/13/14 at 8:41 p.m., 8/13/14 at 3:03 p.m., 8/8/14 at 7:37 p.m., and 8/8/14 at 9:37 p.m., Individual #203's record documented seizure activity.
  - The Nursing Protocol that guides the nursing assessment for seizures was not sufficiently applied, including absence of a review of the last bowel movement (antecedents, such as constipation).
- On 6/26/14 at 6: 00 p.m., staff brought Individual #16 to the nurses station for a skin integrity issue on his right arm for "2 scrape/cut."
  - No documentation was found in the record that the skin integrity issue

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		was followed to resolution. o An ACP and staff instructions were found in the record. • On 8/1/14 at 2:40 p.m., Individual #214's record indicated that he had a complaint of "congestion." A PRN order was obtained for cough/chest congestion. The MAR indicated the medication was administered. o No documentation was found in the record of the response to the effectiveness of the medication. o No documentation was found in the record as to the resolution of the individual's complaint of congestion. o As ACP and associated staff instructions were found in the record. • On 6/5/14 at 3:15 pm, Individual #251's record documented that antibiotic therapy (i.e., Bactrim DS) for his UTI was ordered. o The Nursing Protocol that guides the nursing assessment for Antibiotic therapy was not sufficiently applied for documenting a comprehensive evaluation (i.e., vital signs), effectiveness of treatment, and side effects of medications. o An ACP and associated staff instructions were not found in the record. o No documentation was found in the record as to the resolution of the antibiotic therapy or UTI problem. o No documentation was found that implemented the Pain Protocol associated for the assessment of pain on the initial UTI diagnosis (6/5/14). Positive Example: • On 8/16/14 at 3:05 pm, Individual #292's Nursing IPN reported that the individual had a self-inflicted bite mark on her wrist, and that her tooth had fallen out as a result of the injury. The LVN contacted the RN who came and assessed the individual. The RN notified the physician of the skin integrity and dental issue. Orders were received for antibiotic therapy and notification to the dentist. The Dentist was notified. The on-call AOD/Infection Preventionist was also notified of the skin integrity issue (human bite). o The Nursing Protocol that guides the nursing assessment for Pain Protocol was followed. o The Nursing Protocol that guides the nursing assessment for Antibiotic therapy was followed. o The Nursing IPN documented that the Antibiotic therapy was resolved on 8/19/14 at 5:05 am. o An ACP and staff instructions were found for the Human Bite (SIB) and Loss of Tooth.	

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Individual #329's record contained typed documentation sheets inserted within the Nursing IPNs for the dates below. The sheets for these were labeled "Nursing Protocol: Abdominal Distention/Pain."

- On 5/24/14 at 11:25 p.m., 6/13/14 at 9:45 p.m. 6/27/14 at 11:59 p.m., 7/2/14 10:50 p.m., and 8/1/14 at 8:20 p.m., Individual #329's Nursing IPNs documented six complaints associated with epigastric pain (heartburn). The record indicated the individual received a prn (when needed) form of an antacid.
    - Five of five (100%) Nursing IPNs indicated the individual received an antacid.
    - Two of five (40%) Nursing IPNs contained documentation that followed the facility's "Abdominal Distention/Pain Protocol." For example, on 5/24/14, the Nursing IPN the record did not contain a full set of vital signs, including SPO2.
    - One of the five (20%) documented the individual's response to the medication, in the Nursing IPN.
    - The record was problematic because the active record was not sufficiently reviewed to include information related to medication side effects, dietary intake, or bowel habits for each of the five separate complaints of epigastric pain.

For Protocol Audits conducted from December 2013 through July 2014, the overall average was 60%.

Protocol Card/ Audits	Dec. 2013	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Overall Average
Head Injury	57%	49%	59%	52%	77%	90%	80%	75%	67%
Respiratory	52%	62%	30%	71%	42%	87%	84%	92%	65%
Constipation	59%	33%	46%	58%	74%	75%			57%
Vomiting	61%	62%	68%	58%	62%	81%	62%	85%	67%
Antibiotic					33%				33%
Diarrhea					52%	51%		67%	57%
Elevated Temperature					100%	38%	75%	60%	57%
Pain					50%	60%	57%	60%	57%
PICA					100%	100%	75%	87%	91%
Pretreat/ Post Sed.						100%			100%
UTI						67%			67%
Seizure						67%		57%	62%
Suspected Fall								53%	53%

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		The facility's self-assessment stated the provision was not in compliance because nursing assessments and reporting protocols were not sufficient to address the health status of the individual. This was consistent with the findings of the monitoring team. Throughout this report, to varying degrees, nursing assessments, response to care, medications, and change in status in accordance individual's presenting signs and symptoms of their illness/injury or chronic health/mental problems when documented, were not consistently followed to resolution. The individual's identified risks, frequently were not in alignment with the clinical indicators, and the clinical indicators were not individualized or being adequately monitored. The Nursing Department should provide opportunities for: 1. Nurses to demonstrate critical thinking through the use of protocols that guide the nursing assessments. 2. Develop skills in developing clinical indicators that are measurable, and the frequency of the monitoring are aligned with the individual's health conditions/risks.	
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 parties agreed the monitoring team would conduct reduced monitoring for this subsection, (i.e., a reduced sample). The facility indicated monitoring for this provisions had not been implemented, as tools to capture data for M5 were not yet developed. The noncompliance finding from the last review stands. The Nursing Department continued to track accountability by reviewing Section I ISP assessment spreadsheet for determining if IHCP documents were completed prior to the annual ISP, and posted in accordance with facility policy. From December 2013 through May 2014, of the plans, 122 IRRFs (99%) were completed. Of the 99% completed, 85% were completed timely. Nursing attendance for the same period showed a consistent 100%. Even so, the facility's tracking for the occurrence of staff training related to plans within 14 day of being finalized for IHCPs showed an overall average of 64%. The monitoring team selected, from the sample of 10, five ISPs, IRRFs, and IHCPs that identified and/or contained information about the individual's High Risk for infections: Individual #251, Individual #217, Individual #203, Individual #98, and Individual #112. Individual #112 was also High Risk for Aspiration, Choking, and Respiratory Compromise. Individual #203's record submission did not include the updated ISP (7/18/14), thus, a sample of four were reviewed. • One of the four (25%) sufficiently identified significant changes in health status since the last review. • None of the four (0%) Risk Actions for health sufficiently were sufficiently	Noncompliance

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		correlated . • Two of the four (50%) nursing assessments sufficiently provided data to assist in determining risk. • Four of four (100%) were found to have an IHCP. • None of the four (0%) IHCPs (or their draft) included the specific individualized clinical indicators, aligned with the assessments contained in the nursing protocol. • The frequency of the monitoring was included for each of the individuals. However, the majority of plans frequency did not appear to be in alignment with the individual's determined risk. For example, Individual #217's monitoring by the nurse, under the header "Monitoring Frequency and Location of Documentation," was quarterly. The monitoring team also reviewed the records for Trigger Sheets for May 2014 through July 2014 for Individual #98 and Individual #112 and found: • Two of two (100%) of the individuals' records identified as being at High Risk for Aspiration, Choking and Respiratory Compromise contained Trigger sheets. • None of the two records (0%) contained individualized triggers for the identified risks. • None of the two records (0%) Trigger Sheets were consistently initialed daily on all shifts by nursing staff. The facility self-assessment stated that the provision was not in substantial compliance because the facility was not proficient in processes used to identify risk or changes in risk. This was consistent with the findings of the monitoring team. Nursing should ensure that the information derived from the Comprehensive Nursing Assessments is in alignment with the individual's health risk, and should include the frequency of the clinical indicators to be measured. (e.g., daily, shift).	
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	New/Revised Polices/Procedures/Guidelines • Medication Administration Observation Guidelines, revised • Medication Administration Refusal Procedure, new • Blood Glucose Monitoring tool, revised • Initial Dose of Medication Policy, revised • Control Drug Sheet, revised • Refrigerator Temp log and process for reporting, revised • Pharmacy Reference for Do Not Crush, High Alert Drugs, new	Substantial Compliance

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	errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	New Training/Education/Inservices • Privacy Medication Administration/Identification of the Individual, included presentation of In-service with Advocacy Groups • Medication Administration didactic and in vivo medication observation for nursing staff and all nursing administrator mentors/observers (100% nurses trained) • Adverse Drug Reaction (ADRs) (100% nurses trained) • Medication Variances (100% nurses trained) Monitoring Team's Medication Administration Observations The monitoring team made various observations across the homes and units, and selected various homes for conducting unplanned medication pass observations during the week on both the first and second nursing shifts. The monitoring team used the facility's own Medication Observation Tool for conducting Medication Passes. A member of Nursing Leadership was in attendance for each of the observations. Fifteen individuals were observed across 11 different nurses administering the medications. The medications were administered via the various routes of oral, crushed, prepared with mediums or thickeners, injectable, and topical. Overall, the medication passes followed acceptable standards when administering medications for following the eight rights. It was also evident to the monitoring team that the nurses were accustomed to being monitored, on a frequent basis. Each of the 11 nurses demonstrated their skills consistently, and with confidence. The following individuals were observed: Individual #76, Individual #246, Individual #218, Individual #40, Individual #127, Individual #110, Individual #140, Individual #294, Individual #153, Individual #375,Individual #146, Individual #236, Individual #48, Individual #203, and Individual #101 • 15 of 15 (100%) of the individuals were assisted by both the DSP and the nurse to assure the individual's privacy when receiving their medications. • 15 of 15 (100%) were observed participating or being assisted by the DSP to participate in hand hygiene prior to receiving their medications. • 15 of 15 (100%) were identified using two methods of identification, prior to receiving their medication. • 20 of 20 (100%) of the medications were administered in accordance with nursing standards for administration, that is, the accepted standards of eight rights (right individual, right medication, right dose, right route, right time, right reason, right medium, right texture, and right documentation). • 20 of 20 (100%) of the observations, the nurse engaged the individual and DSP to remind them of the reason for the medications and what side effects to report from the medications. • 20 of 20 (100%) of the medications were documented on the MAR in accordance	

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		with the facility's medication policy. • Five of five (100%) with a PNMP plan, the plan was followed. • One of one (100%) non-medication pass, for enteral feeding, the nurse followed acceptable stands of practice, and the individual's PNMP plan for positioning. • 11 of 11 (100%) nurses performed the techniques of hand hygiene correctly when administering medications. • 11 of 11 (100%) nurses followed infection control standards of practice, before, during, and after the medication administration. • Individuals who did not have fluid restrictions were encouraged by the nurses to drink additional fluids, of their preference. It was positive to find the many improvements made in the medication rooms to ensure privacy and minimize distractions when medications were being administered. These included a designated area large enough to support the individuals with the necessary items, such as special equipment, wheelchairs, and the medication cart. Each room had access to a sink, with running water, soap, and paper towels. Hand sanitizer was accessible in each of the medication rooms. In each of the eight medication rooms observed, a nursing resource book was located, and nurses were familiar with how the book was to be used. Measuring cups were present on the carts, to assure correct measurement of liquids or enteral feedings that required more than 30 cc, which is limited by the medicine cup. Medication rooms were clean and uncluttered, and had sufficient storage for their bulk and prn medications. The following were improvements instituted by the Nursing Department and were observed and/or reviewed by the monitoring team. • All medication administration observation passes were in accordance with generally accepted practices. • Infection control procedures associated with medication administration included all individuals participating and/or being assisted by the DSP in his or her own hand hygiene. • Aseptic technique was observed as being followed for an individual who received an alternate route for their fluids and for administration of an injectable. • Prescribed orders for the measurement of blood pressure, pulse, residuals, and their perimeters were followed. • The Nursing Department re-vamped its existing medication administration competency training/check offs, and oversight for medication administration. The Nurse educator maintained a list of individuals who were current and/or were receiving medication remediation. • Completion of 40 Unit Nurse Manager MAR audits each month. Results were tracked, trended, and reported within the Nursing Department.	

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		• Inter-rater reliability was instituted in April 2014 for Medication Room Audits. Inter-rater reliability for April 2014 was 100%. • Decrease in the number of blanks found on the MARs when audited showed October 2013, 480 blanks, and April 2014, 80 blanks. • Instituted 100% reconciliation of narcotic count sheets. <u>Monitoring Teams Oversight and Monitoring of Medication Administration Practices</u> • Eight of eight (100%) focused medication room inspections conducted found controlled substances drawers located within the carts, were doubly secured, and accounted for in accordance with control logs. • Eight of eight (100%) focused reviews for storage found all medications with current expiration dates, and opened medications were dated, and stored in accordance with accepted standards of practice. • Eight of eight (100%) refrigerator/temperature logs for 8/1/14 through 8/20/14 documented the temperature. No temperatures were found out of range of the perimeters. • 15 of 15 (100%) of the MARs submitted as part of the medication observation review for August 2014, no omissions (blanks) were found. Quality Control Glucose Monitoring Check Strip Test Log was reviewed for 12 individuals across 10 homes for Individual #246, Individual #77, Individual #352, Individual #111, Individual #189, Individual #379, Individual #369, Individual #346, Individual #248, Individual #268, Individual #331, and Individual #116. The monitoring team found: • 12 of 12 (100%) were completed on the new revised form dated 4/14/14. • 12 of 12 (100%) included for each date of the high and low control results. • 11 of 12 (92%) documented the range perimeter for the manufacturer's high and low. <u>Medication Variance Administration Meetings</u> The monitoring team attended the Medication Administration Committee meeting. The meeting's discussions included: • process changes for reviewing medication variances as a multi-disciplinary team, nursing, medical, and pharmacy. The monitoring team will follow-up at the next visit as to the status of the process change. The monitoring team's review of the SGSSLC submission for 10 of the most recently completed Medication Variance Reports for Individual #68, Individual #129, Individual #186, Individual #201, Individual #235, Individual #248, Individual #268, Individual #346, and Individual #292, and Individual #397. The monitoring team found	

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		improvement in the timely reporting of medication variances, completion of forms, corrective action taken, and notification to the practitioner/physician. • 10 of 10 (100%) of the Medication Variance Report were completed for all applicable items on the report form. • 10 of 10 (100%) Medication Variance Reports included notification to the physician. • Eight of 10 (80%) of the Medication Variances were committed by nursing. The remaining two (20%) were pharmacy. • Six of 10 (60%) were discovered within 24 hours, three (30%) within three days, and one (10%) in 13 days. The medication variance report discovered in 13 days was an omission of an injectable medication menstrual cycle suppression to be administered every 91 days. The physician was notified and an alternate date was arranged to administer the medication in collaboration with pharmacy and when the individual would accept the injectable medication. Nursing tracked medication variances using longitudinal graphs for variances by shift, home, node, varices by type, and severity. Nursing prepared medication variance reports for the Medication Variance Committee. Additional information, regarding medication variances is found in section N of this report. The facility's self-rating indicated this provision was not in substantial compliance. The monitoring team disagreed and found, through independent record reviews, interviews, and direct observations, that substantial compliance was demonstrated. To maintain compliance the facility should continue its positive efforts of ongoing unplanned medication observations and record reviews. The facility should follow through with their planned action process for reviewing all medication variances through a multi-disciplinary process that includes nursing, medical, and pharmacy.	

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: ○ Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines ○ DADS Policy #009.2: Medical Care, 5/15/13 ○ SGSSLC Self-Assessment for Section N ○ SGSSLC Action Plan Provision N ○ SGSSLC Provision Action Information ○ SGSSLC Organizational Charts ○ SGSSLC Pharmacists Prospective Review Of Medication Orders, 11/17/11 ○ SGSSLC "PRN" Medication Pharmacy Review, 11/17/11 ○ SGSSLC Quarterly Drug Regimen Review, 11/17/11, rev 5/15/14 ○ DISCUS - Monitoring of Medication Side Effects and Tardive Dyskinesia, 9/22/11 ○ MOSES – Monitoring of Side Effects 4/26/11 ○ SGSSLC Suspected Adverse Drug Reactions 1/27/11, Rev 11/17/11 ○ SGSSLC Pharmacy and Therapeutics Committee, 4/19/12, rev 5/16/14 ○ SGSSLC Drug Utilization Evaluation 11/17/11 ○ SGSSLC Lab Matrix ○ Pharmacy and Therapeutics Committee Meeting Minutes, ○ Medication Variance Review Committee Meeting Notes, 4/30/14 ○ Polypharmacy Committee Meeting Minutes, 2013 ○ Single Patient Intervention Reports ○ Notes Extracts ○ Adverse Drug Reactions Reports 2014 ○ Drug Utilization Calendar ○ Drug Utilization Evaluations • Pneumovax Vaccination ○ Quarterly Drug Regimen Review Schedule ○ Quarterly Drug Regimen Reviews for the following individuals: • Individual #340, Individual #100, Individual #235, Individual #223, Individual #337, Individual #327, Individual #377, Individual #354, Individual #367, Individual #338, Individual #346 Individual #379, Individual #199, Individual #66, Individual #288, Individual #31, Individual #117, Individual #46, Individual #227 ○ MOSES and/or DISCUS Evaluations for the following individuals: • Individual #63, Individual #22, Individual #371 Individual #32, Individual #271 Individual #398, Individual #97, Individual #349 Individual #16, Individual #53, Individual #251, Individual #348, Individual #291, Individual #380, Individual #385 Individual #73, Individual #295, Individual #223 Individual #236, Individual #134,

	Individual #233, Individual #202 Individual #118 Individual #298, Individual #93, Individual #369, Individual #250, Individual #101, Individual #77, Individual #119, Individual #81, Individual #370, Individual #43, Individual #3, Individual #346, Individual #379, Individual #199, Individual #66, Individual #288, Individual #31, Individual #117, Individual #46, Individual #227, Individual #354 Interviews and Meetings Held: ○ Janis Rizzo, MBA, RPh Pharmacy Director ○ Sarah Dempsey, PharmD, Clinical Pharmacist ○ David Joliet, MD, Medical Director ○ Angela Gardner, RN, QA Nurse ○ Lisa Owens, RN, Chief Nurse Executive Observations Conducted: ○ Pharmacy and Therapeutics Committee Meeting ○ Medication Variance Committee Meeting ○ Polypharmacy Oversight Committee Meeting ○ Daily Clinical Services Meetings ○ 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 substantial compliance with provision N1. All other provisions were rated as noncompliance. The monitoring team found the facility to be in noncompliance with all eight provision items.
	Summary of Monitor's Assessment: The pharmacy department made limited progress in two areas of this provision. The overall lack of progress did not appear to be due to a lack of effort. In fact, there was evidence that a great deal of work had been done. The pharmacy director had done a considerable amount of training with the pharmacy and nursing staffs and had worked closely with the medical department. However, the SGSSLC pharmacy department had significant deficits as a result of years of poor practices and a lack of attention to many aspects of the Settlement Agreement.

	The pharmacy department was staffed with a pharmacy director, staff pharmacist, and clinical pharmacist. The staff pharmacist resigned in April 2014 and the position was filled with a locum tenens pharmacist. A new staff pharmacist was hired just prior to the compliance review. The pharmacy director, who did a significant amount of medication dispensing, reported that the clinical pharmacist was needed to dispense meds. There were two pharmacy technicians. It appeared that the pharmacy was engaging in activities that were not clearly the responsibility of pharmacists. The pharmacy department had a computer, which received laboratory diagnostics, and the pharmacists frequently contacted the medical staff with culture results, drug levels, and other lab results. This was never reported as a function of the pharmacy department by the previous pharmacy director. Progress was seen in the documentation of communication between prescribers and pharmacists. Nonetheless, the single interventions failed to document resolution of identified problems for a good number of documented interventions. It also appeared that the pharmacist simply determined the indications when none were written in the physicians orders. Documentation indicated that the pharmacist often made a recommendation to the nursing staff about the appropriate indication. There was evidence that the pharmacy department was working with the medical department to improve order writing. However, serious concerns about physician order writing remained. Medications were written when allergies were documented and orders were written for wrong dosages. Thus, the value of the Intelligent Alerts was not clear. The goal of implementing this module was to ensure that appropriate laboratory monitoring occurred for a select group of drugs. Documents and records continued to show lapses in drug monitoring for these drugs. The facility's QDRR system continued to be challenged by timelines. Only 27% of individuals had a current QDRR. This was lower than the 30% seen during the last compliance review. Moreover, there was a decline in the quality of the content of the evaluations. The facility has been unable to correct this deficiency over a period of more than two years. Improvement was needed in monitoring for metabolic syndrome. The primary system for doing this was the QDRRs, but as discussed, there were major deficiencies in this process. Moreover, the QDRRs were not providing adequate and accurate information on the risk for metabolic syndrome, and individuals with pre-diabetes were not identified. The MOSES and DISCUS evaluations were completed by nursing, but problems persisted with the prescriber review. ADRs were under-reported. The monitoring team easily identified several ADRs that were not reported. In addition, the reporting form was revised to remove the probability threshold, which determined the likelihood that an ADR did occur. The facility conducted a DUE on pneumococcal vaccination administration. This DUE provided data that should be collected by the infection control nurse and shared with the medical department. The facility continued to report medication variances. The overall number of variances was decreasing. Medical variances were increasing due to better reporting, but there was no evidence to support that

	medical had taken appropriate corrective actions and addressed the providers who continued to have troubling prescribing practices. While a series of changes were made with regards to pharmacy practices, those changes did not translate into positive outcomes for the department. In many instances, major changes were made in processes, but the changes were not codified in policy and procedure. The ADR process was altered, but the appropriate actions were not taken to revise the policy and procedure and have the revision approved by the appointing authority. Moreover, the fundamental policy for prospective review of physician orders had not been revised since 2011 and, therefore, did not reflect the facility's current practices inclusive of the use of the Intelligent Alerts. Many of the policies included in the document request had not been revised in nine to 10 years and were not consistent with current practices and requirements of the Settlement Agreement. While the pharmacy director often spoke of rebuilding the pharmacy department, there was a definite lack of attention to revising the basic policies and procedures that guide the operations of the pharmacy department. SGSSLC had never developed and approved a facility pharmacy services policy (localized state policy). The monitoring team was provided a copy of the state policy with the date changed to 8/12/13. Rebuilding the department requires that the framework be established and codified in policy and procedure so the current and future staff have accurate information on the operations of the department.

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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. There were two types of prospective reviews. Order clarification addressed orders with incomplete information, legibility issues, or other issues that required clarification form the prescribers. Clinical interventions involved questions regarding clinical decisions, such as appropriate drug choice, strength, frequency, and lab monitoring. The pharmacy director submitted single patient interventions as documentation of communication between prescribers and pharmacists. The facility also maintained data on the number and types of interventions that were documented. The data presented in the chart below reflect the number of clinical interventions documented for the reporting period. **Clinical Intervention 2013 -2014** | | Dec | Jan | Feb | Mar | Apr | May | | Interventions | 20 | 69 | 22 | 12 | 13 | 48 | Graphs included as part of the pharmacy departments QA Review indicated that incomplete orders were the most frequently documented interventions. Specifically, the lack of indication and duration of therapy were cited as problematic. The pharmacist addressed these issues with the medical staff. Clinical intervention data should be	Noncompliance

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		translated into information that is included as part of the medical quality program. At the time of the compliance review, the medical director did not appear to have an active role in this process. Pharmacy should provide data to the medical director and offer training. However, the medical director is responsible for ensuring the medical staff receives training and appropriate counseling related to the identified issues. The reports submitted to the monitoring team included no information on the individuals involved. Therefore, the monitoring team was unable to identify the individuals or make cross-references with regards to ADRs and medication variances. The intervention reports documented a number of concerns relative to safe medication use: • The documentation indicated that there were patterns with physician prescribing practices. Some prescribers had a greater number of troubling orders including inappropriate orders and wrong drug doses. • Medications were prescribed when allergies were documented. • Psychiatrists were repeatedly ordering psychotropics without an indication. The pharmacists dispensing the medications often documented a recommendation for the use of psychosis as the indication. • The pharmacy did not adequately document issues related to drug interactions. The level of the interactions was frequently not recorded. There was also no evidence that the drug monographs were consistently provided to the prescribers when potential severe reactions were reported. • Many of the interventions occurred with nursing. These were often due to a lack of a drug indication. In those cases, the pharmacist made recommendations for the indication rather than having the prescriber provide a valid indication. • Interventions for delinquent lab monitoring were frequently observed. The following are some examples of the interventions documented: • 1/11/14: Spoke to the medical director about MD once again writing for gentamycin 80 mg IM daily for 3 days as this is not an appropriate dosing for the drug. • 1/22/14: Overdue for EKG; on chlorpromazine • 1/24/14: Individual getting 5 ml of calcium carbonate instead of 2 ml. Will check calcium level. • 1/24/14: Emailed details about moderate interaction between clozapine and Cipro. There was no documentation of the resolution. • 1/31/14: Buspirone started on 1/16/14; consent obtained on 1/21/14. • 2/6/14: Bactrim prescribed with documented sulfur allergy. • 2/17/14: Drug interaction with Haldol and Geodon. Psychiatry contacted. • 2/17/14: High dose quetiapine – 1000 mg Seroquel a day. Contacted psychiatry nurse. Will get EKG.	

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		• 2/20/14: On Invega and Thorazine; the EKG done 1/27/14 with QT >500 ms. Repeat done 2/21/14 was 460 ms. No information on the gender of the individual was provided. A QT internal of 460 ms may be abnormal. • 2/20/14: CPK 1311. The Fenofibrate was discontinued. • 2/22/14: No indication for bisacodyl; nurse contacted and recommendation made for indication of constipation. • 2/24/14: Drug interaction between clozapine and Ativan. Printed out DDI reports and sent to PCP. The monitoring team did not find documentation of the prescriber's actions. • 3/17/14: On 78,000 units weekly of ergocalciferol. The last vitamin D was documented in April 2013. • 3/18/14: Wrong strength written for Vitamin D. • 3/21/14: Severe drug interaction between atorvastatin and fenofibrate; will monitor. There was no documentation of the drug monograph being provided to PCP. • 12/14/13: no indication for sulfacetamide sodium opht solution. The pharmacist recommended the indication of bacterial conjunctivitis. • 12/14/14: There was no indication for clonazepam. The pharmacist recommended the indication of irritability. • 1/19/14: "DDI Report" documented with no additional information. • 5/12/14: Ibandronate should not be crushed. Recommend denosumab. Medication was changed to alendronate solution. • 5/16/14: Bisphosphonates should not be crushed. Recommended changing to alendronate oral solution. There was no documentation of the prescriber's response or actions. • 5/2/14: Risk of QT prolongation with Geodon and chloral hydrate discussed with psychiatrist. EKG will be monitored. The monitoring team had no additional information on why chloral hydrate (a sedative/hypnotic) was being used at the facility. A significant number of interventions documented were related to labs. The pharmacy department received lab reports. The pharmacy director reported that the pharmacists used their own judgment to determine when to contact a physician. There were no parameters established for contacting the providers. She further reported that the pharmacists often were the first facility staff to review the labs. Documentation in the interventions suggested that a significant amount of pharmacy resources were expended notifying physicians of culture and sensitivities, drug levels, and some critical labs. The pharmacy should have access to the laboratory diagnostics, however, placing the responsibility of receiving labs and notifying physicians of lab results should not be a primary function of the pharmacy department. This was discussed with the medical	

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		director who indicated that labs were also received within the medical department. This provision item also required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The facility had implemented the Intelligent Drug Alert Module. The pharmacy director reported that the state-required drugs were monitored. Per the pharmacy director, the list of drugs monitored was expanded to include metformin, sulfonylureas, statins, and clozapine. The Intelligent Alerts Report for December 2013 through June 2014 was reviewed. No alerts for these drugs were identified. Record and other document reviews revealed that lab delinquencies were not uncommon. Many delinquent labs were related to drugs that were monitored by the Intelligent Alerts. The pharmacy director reported that the responsibility of the pharmacist was to ensure that the order was written, but not to follow-up to ensure that it was completed. It would appear, however, that other systems, such as completion of the QDRRs would detect delinquent labs. As discussed in section N2, the QDRR system was severely fractured at SGSSLC. The result was that many individuals did not have appropriate lab monitoring. The actual impact of the IAs was not clear. The outcome was well documented. That is, individuals were prescribed, and the pharmacy continued to dispense, medications when appropriate laboratory monitoring was not done. State office will need to review the guidelines for the IA system in order to improve the overall effectiveness of conducting the Intelligent Alerts. The ultimate goal is to ensure appropriate laboratory monitoring. 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 pharmacy director will need to continue to address documentation of communication. The pharmacist must document resolution of the identified concerns. 2. The pharmacy director should address the comments noted in the text above.	

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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.	A total of 17 Quarterly Drug Regimen Reviews were evaluated to determine compliance with this provision item. In accordance with state policy, the QDRRs 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. SGSSLC added an additional discussion of risk. Compliance with completion of QDRRs was 33% for the December 2012 review and 40% during the February 2014 review. There was no monitoring of pharmacy services during the August 2013 compliance review. For this review, compliance was approximately 33%. During each review, the monitoring team has been informed that corrective action plans were implemented. Data have consistently indicated hat the corrective actions have failed to remediate this deficiency. The February 2014 compliance report clearly documented that a deficiency of this magnitude will require vigilance and will be unlikely corrected with one clinical pharmacist completing these reviews. The following data for QDRR completion were submitted by the facility	Noncompliance

QDRR Compliance 2013 - 2014								
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
No. of QDRRs Due	--	--	72	70	70	70	70	70
No. of QDRRs Completed	--	--	41	48	34	14	10	24
% Timely Completion	--	--	57	59	49	20	13	34

The pharmacy director discussed during interviews and presented data at the Administrative IDT meeting documenting that 58 of 209 (27.7%) of individuals had a current QDRR. This was lower than the 30% compliance noted in previous reviews. This is 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. The low compliance rates were reported to be a result of staffing issues. The pharmacy director indicated that improvement would be seen because a new pharmacist was recently hired.

Problems with the QDRRs were not limited to timeliness. There was some decline in the quality of the content of the QDRRS. The disease management discussions, which were particularly well done in prior QDRRs, no longer provided the in depth thorough discussions. In fact, many were missing critical clinical information. In the past, 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

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		associated with the drugs. That was not seen in recent evaluations. The change in the quality of content was highlighted in the discussion of hypertension and diabetes mellitus. The monitoring parameters for hypertension were not consistently discussed. Similarly, the comments for diabetes mellitus were usually limited to documenting the most recent HbA1c. With regards to the monitoring for metabolic syndrome, the clinical pharmacist only stated the number of risk factors that were present and in several instances, this was inaccurately reported. The following are a few examples of the problems discussed above: • Individual #340, 5/10/14: Polypharmacy for treatment of hyperlipidemia was noted without any further commentary on the appropriateness or effectiveness of treatment. The clinical pharmacist also noted that an order was written on 3/20/14 for a TSH, but results were not in the record. • Individual #100, 4/28/14: The clinical pharmacist commented that levothyroxine was increased and labs were ordered on 12/5/13, but were not done. The six-month lithium level was also reported as overdue with the last being done in October 2013. • Individual #235, 4/28/14: No recommendation was made to alter therapy for the supra-therapeutic Vitamin D level of 59.6. There was also no discussion of topiramate monitoring. It was stated that the individual had one risk factor for metabolic syndrome. The individual had triglycerides of 231 and an HDL of 28. Treatment was also prescribed for hyperlipidemia. • Individual #223, 4/28/14: There was no discussion of topiramate monitoring. The individual had at least two risks for metabolic syndrome, but only one was reported. • Individual #327, 4/25/14: The individual was treated for hypertension. Blood pressure ranges were documented. There was no commentary on the other parameters, such as UA for protein, CMP, etc. The clinical pharmacist noted that the last EKG was done in 2012. • Individual #367, 5/1/14: There was no discussion of lithium monitoring. However, the clinical pharmacist did recommend that lithium not be crushed for administration. • Individual #346, 3/19/14: There were no comments about the supra-therapeutic vitamin D level of 62.6. The clinical pharmacist did not discuss diabetes mellitus parameters such as urinary protein and use of ACE/ARBs. • Individual #379, 7/1/14: There was no comment on the lack of a recent DEXA scan. • Individual #199, 3/18/14: There was no comment on hypertension monitoring, such as CMP, EKG, and UA. The only monitoring parameter documented for diabetes mellitus was the Hba1c, which was noted to be “in range.”	

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		• Individual #31, 1/22/14: Polypharmacy with constipation meds was noted, but there were no comments on appropriateness or effectiveness of therapy. There was also no monitoring for hypertension documented. It was noted that the last EKG was in 2012 and needed to be annually done. • Individual #354, 4/28/14: The individual received lithium. The clinical pharmacist did not document a TSH and there was no recommendation to obtain one. It was needed for lithium monitoring. 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 aggressively address the problem related to the lack of timely completion of QDRRs. The clinical issues documented above should also 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 to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications 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. The clinical pharmacist often mentioned polypharmacy, but provided no indication if the medication management was appropriate or even effective. There was no discussion of psychotropic polypharmacy. Rather, the clinical pharmacist indicated that polypharmacy was discussed in the monthly meeting. At the time of the compliance review, the facility was conducting monthly meetings for review of psychotropic polypharmacy. This is discussed in section J11. <u>Anticholinergic Monitoring</u> 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.	Noncompliance

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		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. Individuals were assessed for the risk of metabolic syndrome. However, the comments were usually limited to the number of risk factors present. As noted in section N2, all risks were not accurately documented. This had the potential to result in missed identification of some individuals with metabolic syndrome. Several individuals had abnormal HbA1c levels documented in the QDRRs and active records. These individuals did not meet the threshold to be diagnosed with diabetes mellitus. The American Diabetes Association considers individuals with an A1C range of 5.7–6.4% as having prediabetes and being at high risk for the future development of 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 metabolic syndrome and pre-diabetes 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. 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. 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	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. The pharmacists did not consistently document the outcomes of the discussions with the prescribers.	Noncompliance

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	clinical justification why the recommendation is not followed.	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, most individuals did not have a current QDRR. Six of 10 (60%) of individuals had a QDRR that was completed five to eight months prior to the compliance review. One individual was documented to have "none available." 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, ordering labs, etc. It is difficult to accomplish this in the absence of recent reviews. The one record with a review completed in July 2014 had no recommendations. The facility documented in the self-assessment that there were significant delays in prescribers reviewing and signing the evaluations. This provision item remains in noncompliance due to the lack of evidence to support that the physicians accepted and implemented the recommendations and facility reported data showing poor compliance with timely review of the QDRRs. 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 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	Noncompliance

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		sample and the most recent evaluations included in the record sample were reviewed. The findings are summarized below: Twenty-five MOSES evaluations were reviewed for timeliness and completion: • 21 of 25 (84%) evaluations were signed and dated by the prescriber • 7 of 25 (28%) evaluations had no prescriber review (blank) • 18 of 25 (72%) evaluations documented that side effects were indeterminate and no action necessary Thirty-six DISCUS evaluations were reviewed for timelines and completion: • 26 of 36 (72%) evaluations were signed and dated by the prescriber • 4 of 36 (11%) evaluations had no prescriber review (blank) • 4 of 36 (11%) evaluations documented the presence of tardive dyskinesia • 27 of 36 (75%) evaluations documented no tardive dyskinesia • 1 of 36 (3%) evaluations documented other The facility implemented the electronic version of the evaluations. The physician was required to complete the prescriber review electronically. The prescriber review did not print on the form, if not completed electronically. In recent months, the lead psychiatrist was completing all evaluations, even when the individuals were not in her caseload. As a result, the majority of the MOSES evaluations reported an indeterminate conclusion, noting that the individual would be assessed in clinic. Many of the older evaluations were not completed electronically and, therefore, the prescriber review was not printed on the report. In those cases, the psychiatrist simply dated and signed the evaluations. For the majority of the facility submitted sample, the providers were noted to review the evaluations promptly. This was in contrast to what was observed in the active record sample (random sample). Many of the most recent evaluations found in the active records documented delays of one to two months between completion and prescriber review. The clinical use of this information remained problematic. Record reviews did not reveal any documentation, on the part of the primary providers, of discussion of this relevant information. The MOSES and DISCUS information did not appear to be reviewed by the neurology consultants, 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.	

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		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 facility must take several actions: 1. The evaluation tools must be completed in a timely and adequate manner. 2. 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 encouraged to review.	
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 maintained a system for monitoring and reporting adverse drug reactions. The pharmacy director described a number of actions that were implemented to improve the facility's ADR system: • ADRs were discussed at the daily provider meetings. • All orders were reviewed for potential ADRs by the pharmacy director. If a potential ADR was identified, the physician was contacted for additional information. • Physicians were documenting the reasons for medication discontinuation in order that pharmacy could evaluate the possibility of an ADR. These actions resulted in some increase in the reporting of ADRs. Twelve ADRs were reported in 2013. At the time of the compliance review, 13 ADRs had been documented since the last compliance review. ADR reporting forms were submitted for only 10 of the suspected ADRs. Training was in progress at the time of the compliance review. The self-assessment documented that 86% of physicians, 50% of dentists, 96% of nurses, and100% of pharmacists completed training on ADR reporting and monitoring. A training module for direct support professionals was developed by the pharmacy director. It was reported that the module would be complete by the end of August 2014 and training would begin at that time. Moreover, the training was being submitted to state office for approval so that it could be added to iLearn. Notwithstanding these improvements, the monitoring team continued to encounter a number of ADRs through record and document reviews that should have been detected and reported by the medical staff. One ADR was noted by an off campus consultant, but should have been discovered by facility staff. Individual #237 received Depakote and had an elevated ammonia levels. The neurology consultant documented hat the elevated ammonia was likely due to the use of Depakote. The individual did not need Depakote for	Noncompliance

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		seizure management. The psychiatrist noted that the dose of Depakote was so minuscule that it would have little impact as a mood stabilizer. Thus, continued use of Depakote was not indicated (the facility later reported that the medication was discontinued in May 2014). This individual was treated with lactulose for hyperammonemia since February 2014. The neurologist noted this in June of 2014. The active records included information about other possible ADRs that were not reported. Individual #354 experienced a dystonic reaction that resulted in discontinuation of all medications. This individual also had elevated CPKs that were thought to be associated with drug use. Moreover, Cogentin was suspected to be one cause of the individual's lethargy. This individual did not appear on the ADR listing. Document and record reviews included information on a number of other ADRs that were not reported including hyperprolactinemia, abnormal liver enzymes, and blood dyscrasias. The pharmacy director reported that the ADR report form was revised. As part of this revision, the Naranjo probability scale was removed and the Hartwig severity scale was implemented. ADR reporting and monitoring systems require the use of <u>both a probability scale and a severity scale</u>. The probability scale determines the likelihood that an ADR occurred. Confirmed ADRs must also be rated by severity. The probability and severity scales are, therefore, not inter-changeable as each serves a different function. This requirement was discussed with the pharmacy director. These significant changes were made without any revision and/or approval of the facility's ADR policy. 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. ADRs should be reviewed by the primary provider, pharmacy director, and medical director. All three should be required to sign the ADR reporting form. The form should indicate who initiated it (reporter). 2. There should be increased reporting by the medical staff. 3. All suspected ADRs should 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.	

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		4. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct support 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 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 facility maintained a DUE calendar, however, the facility did not conduct DUEs as required. One DUE was conducted since the last compliance review. The DUE on Pneumococcal Vaccination was presented during the Pharmacy and Therapeutics Committee meeting held during the week of the compliance review. The objective of the evaluation was to assess the appropriate administration of Pneumovax 23 to the individuals supported by the facility. Data were collected through the review of infection control information, pharmacy reports of vaccinations dispensed, and vaccination records. The report documented that 182 of 209 (87%) of individuals received the vaccination. The report also documented a numerical value for age and diagnosis, but provided no information on these data. The significance of this information was not clear. There was no discussion of the reasons that 13% of individuals were not vaccinated. The recommendation generated by the DUE was to continue to offer the vaccination to individuals. The clinical pharmacist reported that this DUE was selected because staff of a sister facility suggested that completion of a vaccination DUE was quick and easy. The monitoring team agrees that these data were easily obtained even though they did not appear to provide any additional information for the facility. Tracking compliance with vaccinations should be a function of the infection control nurse and this information should be routinely reviewed as part of the Infection Control Committee. Moreover, the medical department should regularly review compliance with vaccinations. A DUE on vaccination administration would be indicated if concerns or problems were noted. The pharmacy director shared a Topamax DUE that was completed by state office for all 13 SSLCs. Each SSLC pharmacy was required submit data. The clinical pharmacist at SSLC deferred this task to nursing. The data reported showed that none of the individuals at SGSSLC who received topiramate were diagnosed with kidney stones. Further review by facility staff indicated that these data may not be accurate and are dependent upon the accuracy of the APLs. The facility should do a more though review of this area if deemed necessary.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 1. DUEs should be completed in accordance with state and facility guidelines. 2. The DUE policy should be revised to include requirements for the basic components of a DUE. 3. The DUE should specify the timeframe that the study is completed. 4. The P&T Committee minutes should document 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.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility continued to report medication variances. The medication data provided to the monitoring team are summarized in the table below.	Noncompliance

Medication Variances 2013 - 2014						
	Dec	Jan	Feb	Mar	Apr	May
Nursing	269	310	209	197	123	101
Pharmacy	117	96	110	117	137	135
Medical	0	1	14	10	8	14

Based on these data, there was an overall decrease in medication variances. Prescribing variances increased due to increased reporting by pharmacy and nursing.

The monitoring team attended the medication Variance Committee meeting held the week of the compliance review. The committee was chaired by the CNE. There was no agenda for the meeting and no review of the previous meetings minutes. There was no committee discussion of the actual variances during this meeting. Rather, the CNE read a quarterly report that summarized nursing and medical variances. The pharmacy director presented information on pharmacy medication variances and corrective actions related to those variances. The quarterly report presented during the meeting highlighted the following:

- A medication variance routing pilot was implemented on 8/1/14 to ensure that variances were discussed with staff in order to decrease the likelihood of a variance repeating.
- Guidelines for reporting were distributed to the disciplines.
- Nursing increased oversight by the nursing supervision.
- One pharmacist was assigned to checking the cart fill daily.

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		• Prescribing variance increased due to better reporting. The following corrective actions were reported by the CNE: • There were improvements in identifying blanks in MARS. • The pharmacy was reviewing all physician orders daily to ensure that variances were reported. Excess/short forms were also reviewed daily. • Physician order labels were created which delineated all required elements for physician orders. The monitoring team reviewed minutes from several Medication Variance Committee meetings. It was clear that the meetings focused on nursing issues. For example, the minutes from 4/30/14 documented a lengthy discussion on nursing's plans to collect the data that would be needed to achieve substantial compliance in provision M6. The meeting notes did not document discussion of variances, the etiology of the variances, and the actions taken to address the variances. The majority of the template was blank. The meeting minutes for 5/28/14 again focused on nursing, with some documentation of pharmacy errors. Notably absent in the minutes (as well as during the committee meeting observed) was a robust discussion of variances designed to understand the root causes of the problems. The meeting was a presentation of a report and not a committee discussion of medication variances. There were many issues related to prescribing variances, yet all were documented as "physician errors in order writing." There was no discussion during the meeting of why physicians continued to have the same types of errors. There was also no discussion by the medical director about how the issues were being corrected. State policy required that an error that occurred over days to weeks or months be reported as a single variance. As has been stated numerous times in previous reports, presentation of data in this manner is misleading and does not provide an opportunity to understand the magnitude of the variance. Problem solving paradigms require the once a problem is identified, the magnitude of the problem must be assessed. The magnitude of the problem takes into consideration the duration of the event. Thus, a single medication variance that results in the omission of one dose of medication does not have the same significance of a medication error that results in the medication being omitted (not received in accordance with the physician order) for several days or weeks. The facility's current data does not allow for differentiation between such errors. An omission of one MVI is counted as one error. An omission of a blood pressure medication for 14 days is also counted as one error. Should SGSSLC continue to use this definition of variances, it should correctly report variances as variance episodes indicating that the event may have involved multiple medications/doses.	

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		The medical, nursing, and pharmacy departments began working on a project related to the medication use system. This was essentially a plan to address all components of the system. Since variances may occur at every step in the medication use process, the workgroup should continue to refine the steps in the processes. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must follow state policy regarding presentation of data. Each discipline should present medication variance data along with the corrective actions that address the variances. 2. The facility should address the concerns discussed above.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ SGSSLC client list ○ Admissions list ○ Physical Nutritional Management Policy ○ PNMT Staff list, back-ups, and Curriculum Vitae ○ Staff PNMT Continuing Education documentation ○ List of Medical Consultants to PNMT ○ Section O Presentation Book and Self-Assessment ○ Section O QA Reports ○ PNM spreadsheets submitted ○ PNMT Evaluation template ○ PNMT Assessment Audit tools ○ PNMT Meeting documentation submitted ○ Daily Provider Meeting minutes ○ Pneumonia Committee meeting minutes ○ List of individuals on PNMT caseload ○ List of individuals referred to the PNMT in the last 12 months ○ PNM spreadsheets ○ Individuals with PNM Needs ○ Completed PNMP Compliance Monitoring sheets submitted ○ List of individuals with PNMP monitoring in the last quarter ○ NEO curriculum materials related to PNM, tests and checklists ○ Annual Refresher curriculum materials related to PNM ○ Documentation of staff training submitted ○ Hospitalizations for the Past Year ○ ER Visits ○ List of individuals who cannot feed themselves ○ List of individuals requiring positioning assistance associated with swallowing activities ○ List of individuals who have difficulty swallowing ○ Summary Lists of Individual Risk Levels ○ List of Individuals with Poor Oral Hygiene ○ Individuals with Aspiration or Pneumonia in the Last Six Months ○ Individuals with BMI Less Than 20 ○ Individuals with BMI Greater Than 30 ○ Individuals with Fractures ○ Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months

	○ Individuals With Falls Past 6 Months ○ List of Individuals with Chronic Respiratory Infections ○ List of Individuals with Enteral Nutrition ○ Individuals with Chronic Dehydration ○ List of Individuals with Fecal Impaction ○ Individuals Who Require Mealtime Assistance ○ List of Choking Events in the Last 12 Months ○ Individuals with Pressure Ulcers and Skin Breakdown ○ Individuals with Fractures Past 12 Months ○ Individuals who were non-ambulatory or require assisted ambulation ○ APEN Evaluations for Individual #150, Individual #66, Individual #98, Individual #295, Individual #217, Individual #180, Individual #90, Individual #134, and Individual #273. ○ PNMT Assessments and ISPs submitted for Individual #150, Individual #238, Individual #126, and Individual #288 ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. ○ PNMP section in Individual Notebooks for the following: • Individual #104, Individual #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. ○ 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. <u>Interviews and Meetings Held</u>: ○ Maria DeLuna, RN ○ Erin Bristo, MS, CCC/SLP ○ Dena Johnston, OTR ○ Judy Perkins, PT ○ PNMPCs ○ Various supervisors and direct support staff

	<u>Observations Conducted</u>: o Living areas o Dining rooms o Day Program areas o PNMT meeting o ISP Meeting for Individual #251 and Individual #130 o ISPA for Individual #118 o IDT meeting for individuals served by PNMT with Maria DeLuna
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, Habilitation Therapies Director, was again excellent. The assessment was clear, with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of the elements were addressed and used to determine compliance. Findings were consistently 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. This was consistent with the reports for QA/QI Council as well. The department leadership appeared on track with a plan to ensure that continued progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself in substantial compliance with provisions O.1, O.3, O.5, O.6, and O.7, though the monitoring team concurred with O.1 and O.5 only. Concerns noted in O.4 were related predominately to the use of pulled staff. There was an adequate system for training new, existing, and pulled staff, but the home manager in one of the homes had not adequately implemented that training plan. Discussions with her were extensive. It was also noted that these same staff had accompanied individuals to the Suzy Crawford day program area and, as such, were equally unprepared to address issues there. To add to that, the PNMPs were not available to staff in that area. Other provisions were self-rated in noncompliance and the monitoring team agreed. The monitoring system was established, but still required refinement and consistency. The monitoring team has confidence that strides in this area will be made over the next few months. To move toward substantial compliance with this provision, consider a focus on the following: 1. Ensure that all recommendations, actions, and outcomes identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 2. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. 3. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA.

	4. More consistent use of the ISPA process with clear documentation is encouraged. 5. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs. 6. IDT members associated with review and approval of the PNMP should be present at the ISP/ISPAs when these plans are reviewed and/or revised. 7. Direct increased training focus to transfers, toothbrushing, and bathing. 8. Continue to focus on staff performance through training, coaching, and monitoring by all supervisory staff and the Mealtime Coordinator. Reinforce their role and responsibilities in identifying and correcting staff performance errors. 9. Provide guidelines to home managers about the use of pulled staff to address low ratios during peak times. 10. Ensure that the training process for pulled staff was implemented consistently and reviewed for effectiveness. 11. Develop and implement a sound system to address training for pulled staff. 12. Ensure that home managers are competency-based trained to train others and assess their competency related to PNMP strategies. 13. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. A focus on actual observation of activities is recommended. 14. Establish benchmarks, a system to address the content and consistency for effectiveness monitoring by OTs, PTs and SLPs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. The PNMP could not be deemed effective if all areas were not reviewed routinely. 15. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 16. Ensure that trigger data sheets are completed as per facility policy. 17. Establish protocol related to the completion of assessments, especially related to nutrition evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 18. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. 19. 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.
	Summary of Monitor's Assessment: Gains had been made across all sections due to the efforts of a consistent and steady leadership. There was a full complement of PNMT members. They continued to refine their processes and documentation. The monitoring team observed a weekly meeting and an ISPA meeting in which the PNMT RN collaborated with the IDT related to reviewing individual status and supports. The interactions were very good between the two teams, though both needed to identify specific clinical indicators that were consistent between the PNMT evaluation and the IHCP. Efforts to develop ISPA guidelines were in progress, as well as QIDP

	training in this regard. The weekly meeting observed was excellent and it continued to be impressive that IDT members were consistently in attendance and participated. The team was encouraged to examine ways in which the actual core team members were more involved in the assessment, monitoring, and reporting because they tended to be more passive participants. The team clearly followed up on identified issues, documented this, and tracked their recommendations through completion. Documentation in the individual record needs continued work. There were definite improvements noted in the dining rooms. The environments, overall, appeared to be calmer, quieter, and more organized. For the most part, individual dining plans were followed. Mealtime Coordinators were present. They clearly understood their role to make the mealtime move smoothly, but did not appear to recognize their role as monitors and coaches for staff. Staff struggled in some cases in answering questions about the plans. They promptly recited the risks of aspiration and choking. They had more difficulty, however, describing the rationale for strategies in a more specific manner. A couple of issues were noted related to individuals who required prompts to take smaller bites or slow down, particularly individuals who ate independently. Staff were providing prompts that were not consistently effective. In addition, some of the foods pieces, particularly ground, were larger than the guidelines specified. These issues should be identified by the Mealtime Coordinators and corrected. These concerns were significant relative to the high incidence of choking events in the last year. Positioning was also improved. The system of staff training was excellent (O.5), but was not adequately implemented for pulled staff, which impacted performance and competency (O.4). Pulled staff did not know the individuals risks, had not read their plans and did not implement plans as written, in some cases. A focus on the following is indicated over the next six months: • 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 and that the information is presented clearly and succinctly. • Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA. • More consistent use of the ISPA process with clear documentation is encouraged. • Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs. • Clarification of the staff who had successfully completed all competency-based training was needed. • Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of Dining Plans appeared to occur infrequently. • Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP

	at the recommended frequency. • The consistency of monitoring and findings should be reviewed by the PNMT to establish effectiveness of existing supports for individuals referred to the team. • Review consistency of effectiveness monitoring as conducted by the OT/PTs and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements. • Ensure that ISPAs are held to address changes in status and changes in supports and services. There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. • Ensure use of trigger sheets was consistent with the facility guidelines. • Establish protocol related to the completion of assessments, especially related to nutrition evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. • Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. • 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. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 11 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. Sample O.3 consisted of individuals at SGSSLC who received enteral nutrition, for whom APENs were submitted. 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 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,	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. Some of these were operationalized into the At Risk Policy, the ISP Policy, QA Policy, and the Habilitation Therapy Policy (5/30/13). No changes had been made to the PNM policy in the last six months. The following elements were addressed: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); • The annual review process of an individual's PNMP as part of the individual's ISP; • The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; • The roles and responsibilities of the PNMT; • The composition of the facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; • Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); • The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; • Requirements for continuing education for PNMT members; • Referral process and entrance criteria for the PNMT; • Discharge criteria from the PNMT; • Assessment process; • Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; • The PNMT consultation process with the IDT; • Method for establishing triggers/thresholds; • Evaluation process for individuals who are enterally fed; • PNMT follow-up; • Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; • A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: ○ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,	Substantial Compliance

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	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.	○ 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), ○ Identification of monitors and their roles and responsibilities, ○ 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, ○ 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 ○ Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ 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, with the exception of the dietitian (see below). Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. This was consistent with the previous review. 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. <u>Consultation with Medical Providers and IDT Members</u> The current Medical Director, David Jolivet, MD was listed as the physician consultant to the team. There had been staffing changes since the document request. He (or a back-up representative) had attended 16 of the 16 weekly meetings (100%) from 2/5/14 through 5/28/14. This was consistent with the previous review. A physician routinely reviewed and signed each of the PNMT assessments. • For 4 of 4 individuals (100%) for whom evaluations had been completed in the	

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		last six months, evidence was provided of efforts by the PNMT to seek participation by medical staff review of assessment or and/or participation in the analysis of findings. This was consistent with the previous review. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to ensure their availability to the PNMT were established. IDT members, such as the RN Case Managers who served as a key link to the physician, attended 16 of 17 weekly PNMT meetings (94%). There was also consistent participation by the PNMT RN, OT, and/or SLP who attended each of the monthly Pneumonia Committee (100%), Skin Integrity, and Infection Control meetings (100%). These meetings addressed both individual-specific issues and systems issues. Daily medical provider meetings were held and the PNMT RN or designee was present at 81% of these meetings in May 2014 for which minutes were submitted, for example. By report, this was representative of routine participation in these meetings. Medical and IDT staff attended these meetings, serving as an excellent forum 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 17 of 17 PNMT meetings (100%) held from 2/5/14 to 5/28/14, there was evidence of participation by IDT members, including physicians, RNCMs, QIDPs, home managers, and DSPs. This was consistent with the previous review. Though IDT members routinely attended PNMT meetings, the PNMT consistently also reviewed their findings in an IDT/ISPA upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. 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. During the initial meeting, 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 recommendations, evaluation, and treatment. Action plans were the responsibility of the IDT in conjunction with the PNMT. <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. The license for Deanna Worden was expired on 2/28/14 per the DSHS website. When requested, a copy of her current license was submitted, however.	

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		• 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 licensed team members had over 108 years of experience in their respective fields and, together, approximately 52 years with individuals with intellectual disabilities. The back-up team members had significant experience as well. This was consistent with the previous review. <u>Continuing Education</u> • 5 of 5 PNMT core team members (100%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past year. Some courses listed did not indicate the course hours or CEUs. Back-up team members were also listed with related continuing education in the last year. This was consistent with the previous review. A number of relevant courses were attended by team members (it was unclear in some cases if the hours listed were CEUs versus contact hours): • Maria DeLuna, RN (28.85 contact hours in the last year) • Erin Bristo, MS, CCC/SLP (1.25 contact hours in the last year) • Deanna Worden, RD, LD (16.25 contact hours in the last year) • Dena Johnston, OTR (1.25 contact hours in the last year) • Judy Perkins, PT (25.25 contact hours in the last year) These included the following: • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • Socialization, communication, and Independence During the Mealtime • Nutritional Supplementation • Supports versus Restrictions Related to Rehabilitation • Sensory diets • Hospice Services • Kinesiotaping Association International-Fundamentals • Kinesiotaping Association International-Advanced • Kinesiotaping Association International-Clinical Concepts • Wound Certification Preparation course • Gus Eckhart Trauma Symposium 2014 • Overview of the Nutrition Care Process • Wellness Coaching Skills to Enhance Your Client Follow-up • HHSC Nutritional and Food Service Regional Meeting for State Hospitals and State Supported Living Centers	

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		• Big Country Academy of Nutrition and Dietetics
		• Getting Off the Chronic Disease Merry-Go-Round
		• Advance Glycation and Products in Food
		• Continuing Professional Education: EXPO Briefings
		• BPA and Health: Is any Exposure Safe?
		
		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.
		
		PNMT Meetings
		• Since the last review, the PNMT met at least once for 17 of 17 weeks (100%) from 2/5/14 to 5/28/14 (meeting minutes submitted for that period). A representative met additional times with the IDTs to review findings from assessments or discharge planning. This was an improvement from 92% in the previous review.
		• Based on review of the minutes, attendance at the weekly meetings by core PNMT members and/or back-ups for the meetings conducted during this period was:
		  ○ RN: 14/17 (82%) by core member, 2/17 (12%) by back-up, 94% overall.
		  ○ PT: 15/17 (88%) by core member, 2/17 (12%) by back-up, 100% overall
		  ○ OT: 15/17 (88%) by core member, 2/17 (12%) for back-up,100% overall
		  ○ SLP: 15/17 (88%)by core member, 2/17 (12%)for back-up,100% overall
		  ○ RD: 13/17 (76%) by core member, 2/17 (12%) for back-up, 88% overall
		
		Absences for listed core team members without a backup were noted only for Deanna Worden, on 2/16/14 and 4/9/14. Attendance was still above the criterion of 80% and well above the criterion of 90% overall for the licensed core team, with the exception of the dietitian. By report, attendance for this position had improved to 100% for June 2014 and July 2014.
		
		• Since 2/5/14, 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. This was consistent with the previous review.
		
		The meeting minutes were maintained and included the following elements:
		• Member attendance
		• Individual reviewed
		• Current weight	

#	Provision	Assessment of Status	Compliance

		• EDWR
		• Level of PNMT Involvement
		• Reason for referral
		• Discussion
		• Action Steps and Due Date
		• Next review date
		
		• The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies and procedures in place and evidenced in the monthly QA reports. There was a system of corrective action plans (CAPs) when system issues were identified. They addressed the following:
		  ○ Requirements that the QA matrix include key indicators related to PNM outcomes and related processes;
		  ○ Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed;
		  ○ 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);
		  ○ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan);
		  ○ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and
		  ○ 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.
		
		Section O required that the PNMP be reviewed at the individual's annual ISP 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 with 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 had previously determined that the facility was in substantial compliance with this element of section O and the facility documented a self-rating of continued compliance. The monitoring team concurred based on the above findings.	

#	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> There were 139 individuals living at SGSSLC who were listed with PNM needs. The facility indicated that these individuals may or may not be supported by a PNMP, but the list did not designate who did or did not. It was stated that they had attempted to integrate services and, when possible and appropriate, supports were integrated into the IHCP and the DSP Care Instructions. This was an appropriate approach. A PNMP was indicated for individuals, as per the Settlement Agreement, 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"). Per the self-assessment, there were 104 individuals with PNM needs and were provided a PNMP. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 41 individuals, (b) were dependent on others to eat: 5 individuals, (c) had difficulty swallowing: 55 individuals, and/or (d) were considered to be at medium or high risk of choking (approximately 103 individuals) or aspiration (approximately 55 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 100% were reported to be provided a PNMP. There were five choking events requiring abdominal thrusts (Heimlich) since the previous review (Individual #137, Individual #34, Individual #95, Individual #289, and Individual #343). Documentation for six events was submitted, however, four of these occurred in December 2013. Two of these had occurred since that time: Individual #343 on 5/18/14 and Individual #289 on 3/16/14. Even so, six choking events in a six month period was of significant concern. Both individuals with the most recent choking events were assessed by the OT at the next meal following the event. Individual #343 was eating an orange, though his prescribed diet texture was ground due to oral motor concerns. Thus, this event was related to permitting him to eat an unsafe texture. Additional concerns were noted by the OT in the follow-up assessment related to management of liquids suggesting a change in status since his admission on 11/6/13. It would be expected that he would have been reviewed via effectiveness monitoring at least once if not twice (quarterly) and that this concern related to liquids may have possibly been previously identified. He was currently listed at only medium risk of choking and low risk of aspiration. Per the ISPA dated 5/20/14, he had two near choking events since admission (11/21/13 and 2/5/14, self-cleared). At that time, the IDT indicated that he was at high risk for choking and that the SLP would re-evaluate him in three months. An MBSS was recommended on 5/19/14 date. There was no evidence that this had been conducted per the documents submitted.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In the case of Individual #289, the DSP documented the following at 1:28 pm on 3/16/14: "Individual 289 had a good day. He had a choking incident at lunch." By report, staff did not follow choking protocol in that they permitted him to return to eating right after the event and that they threw away the dislodged meat. The nurse was not called until after lunch was finished and staff had cleaned up. Follow-up by the OT was conducted during a snack on that date. Recommendations were to continue with his current diet texture and to implement a safe eating SAP with Spanish prompts. His regular diet texture had been downgraded to chopped (choking protocol). The IDT decided to maintain this texture until the SAP was implemented. A communication translator device was to be ordered for use when a Spanish-speaking staff was not available. Until it was received, flash cards were to be used. Per this individual's mother, he had choked before and typically ate too fast. She had used prompts to get him to slow down. Despite these factors, he was judged to be at only medium risk of choking. There was evidence that the SAP was implemented on 3/20/14, though the translator and his hearing loss were not addressed in his plan. It is clear from review of these serious choking events, that staff training was not adequate to ensure the safety of individuals during meals and other times that they were eating or drinking. It was noted, however, that follow-up by Habilitation Therapies was conducted in a very timely manner. <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;	

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		• 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. The PNMT could self-refer based on the post-hospitalization assessment completed by the PNMT RN. The PNMT was to meet within five days of the referral to review and determine their level of involvement required for each case (direct service or consultative service). When services were indicated, a PNMT representative attended the ISPA to discuss recommendations. From June 2013 to June 2014, there were 41 referrals of 33 individuals to the PNMT with several referred more than once during that period (Individual #104, Individual #238, Individual #26, Individual #140, Individual #134, Individual #59, and Individual #150). It could not be determined from the list submitted how many of these were self-referred versus those referred by their IDT, though only 14 of these had been referred since the previous review. Others were listed as referred since 6/11/13. Each individual on the current caseload was listed as referred in the last year, one or more times. Reasons for referrals listed included, but were not limited to: • Pneumonia • Pressure ulcers • Seizures • Lymphedema • Ileus • Alternation in mental state • Weight loss PNMT episode tracking for PNM-related concerns included issues, such as aspiration pneumonia, emesis, decubitus, falls, fractures, choking incidents, individuals monitored for weight loss, and hospitalizations, among others. This was intended to permit them to determine when and if an individual met any of the above criteria, in case this was not recognized by the IDT for referral. Individuals in Sample O.1 were reviewed for incidence of the concerns identified as requiring PNMT referral since February 2013. There were six individuals listed on the current active caseload for the PNMT (Individual #38, Individual #134, Individual #180, Individual #126, Individual #288, and Individual #150). Individuals were generally appropriately reviewed by the PNMT based on the criteria included in the facility policy,	

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		as well as other criteria indicating significant PNM needs, though it appeared that there were a number of individuals with multiple falls not referred (Individual #134, Individual #288, and Individual #104). • Individual #134 was already on the active caseload as of 6/11/13, though related to aspiration pneumonia. His falls were discussed in an ISPA on 7/1/14 and the PNMT nurse was present. He was listed with 11 falls between 12/1/13 an 5/31/14, with two injuries. His health status was complex and serious. Documentation on 12/15/13 indicated the need for a fall evaluation with no evidence that it was completed in the IPNs. The most current review by the PNMT on 8/20/14, appropriately postponed his discharge due to another recent occurrence of pneumonia. There was no mention of the frequency or circumstances of falls in that review. • An ISPA for Individual #104 was held on 5/29/14, related to a review of his risk levels. His level of risk for falls was increased to high due to the frequency of falls in the previous two months, some of which resulted in injury. A subsequent ISPA documented two falls causing injuries to both knees. He was listed with nine falls between 12/1/13 and 5/31/14, with nine injuries, at least one per fall. The frequency of falls over the course of the last year would have required previous involvement of the IDT therapist. Interventions provided by the IDT clearly had not been effective as of the time of this ISPA. Though the incidence of falls may or may not have met the established criteria listed above, it was apparent to the monitoring team that this warranted review by the PNMT, particularly related to the incidence of injury and risk of serious injury were that rate of falls were allowed to continue. • Individual #288 was on the active caseload for a variety of GI and other PNM-related health issues (referred on 3/15/14), but it did not appear that he had been referred for the frequency of falls. He was listed with eight falls between 12/1/13 and 5/31/14, and 3 associated injuries. There was no evidence of ISPAs that addressed this frequency of falls. His PNMT assessment reported that he was at high risk for falls and fractures, but that these were unrelated to his referral and, as such, were not addressed in the assessment. Discharge criteria were established for each individual via the assessment and at the time they were met, transition from the PNMT to the IDT was planned, including monitoring and re-referral criteria. There were only eight individuals listed who received enteral nutrition (though per the APEN, Individual #180 had tube placement in the last year and was not listed). One individual received enteral tube placement since the previous review (Individual #150): • 0 of 1 individual who received a feeding tube since the last review had been	

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		referred to the PNMT prior to the placement of the tube. Individual #150's tube was placed during hospitalization for aspiration pneumonia (emergency placement according to the facility). He was self-referred on the day he was discharged back to SGSSLC. • --% 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. This metric did not apply during this period. <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 included Individual #150 (6/4/14), Individual #238 (2/12/14), Individual #126 (4/2/14), and Individual #288 (4/23/14). • 4 of 4 PNMT assessments (100%) were initiated at a minimum within five working days of the referral, per the dates in the assessment, meeting minutes, and IPN documentation. This was consistent with the previous review. • 3 of 4 PNMT assessments (75%) were completed in 30 days or less of the date of referral, per the assessment dates (the signatures were not dated by any clinician). This was an improvement from 20% in the previous review. Based on review of these assessments, the following elements were addressed: • Date of referral by the IDT or self-referral and the referral source (4 of 4, 100%). This was consistent with the previous review. • Date the assessment was initiated (4 of 4, 100%). This was consistent with the previous review. • Evidence of review and analysis of the individual's medical history (4 of 4, 100%). This was consistent with the previous review. • Identification of the individual's current risk rating(s), including the current rationale (4 of 4, 100%). This was consistent with the previous review. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data (0 of 4, 0%) (Individual #238, Individual #126, Individual #150, and Individual #288). This was a decrease from 100% in the previous review. The PNMT reported risk levels, but did not document that they concurred with the IDT's. Again, there were no specific recommendations related to changes based on assessment findings. • Discussion of the impact of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (3 of 4, 75%) (Individual #288). This was an improvement from 60% in the previous	

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		review. In the case of Individual #288, it was noted that his behavior risk was identified as low, yet he had a PBSP for SIB. • Assessment of current physical status (4 of 4, 100%). This was consistent with the previous review. • Information about the individual's current respiratory status based on a physical assessment (4 of 4, 100%). This was consistent with the previous review. • Assessment of musculoskeletal status (2 of 4, 50%). This was limited. This was a decrease from 80% in the previous review. • Evaluation of skin integrity (4 of 4, 100%). This was consistent with 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 (4 of 4, 100%). This was consistent with the previous review. • Positioning that may impact PNM status was discussed to some degree, but did not consistently report findings from observations including bathing, medication administration, and oral hygiene (0 of 4, 0%). This was consistent with the previous review. For Individual #126, this was listed as recommendations for monitoring activities, but it was not clear they had conducted these as an aspect of her assessment. For Individual #150, documentation of observations in each of these areas was described under Recommendations/Monitoring. This section was used in the other cases to outline what monitoring was required after the assessment. This documentation referred to specific observations and findings on certain dates. It was not clear who had conducted these, however. • Evaluation of motor skills (4 of 4, 100%). This was an improvement from 80% in the previous review. • List of medications with potential side effects listed with individual allergies, though drug/drug or drug/nutrient interactions and/or actual side effects were less consistently addressed (4 of 4, 100%). This was consistent with the previous review. • Evidence of review/analysis of medication history, changes, and current medications, such as dosages, and side effects (4 of 4, 100%). Medication changes were limited to the last three months rather than the last year. This was consistent with the previous review. • **E**vidence of review/analysis of lab work (4 of 4, 100%). This was an improvement from 40% in the previous review. • Identified residual thresholds, if enterally nourished (1 of 1, 100%). Only Individual #150 was enterally nourished. This was an improvement from 67% in the previous review. • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (3 of 4, 75%) (Individual #150). It was reported that an	

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		oral motor assessment had been completed post-hospitalization on 5/13/14, the date of referral to the PNMP. It was stated that there were no noted changes, but this status was not included in the PNMT report. These findings would be pertinent to the analysis by the PNMT and should be included in their written report. This was an improvement from 60% in the previous review. • Evidence of observation of the individual's supports at their home and/or day/work programs (4 of 4, 100%). This appeared to be limited to the home only. This was consistent with the previous review. • Nutritional assessment was adequate (4 of 4, 100%). This was consistent with the previous review. • Evaluation of current assistive equipment (4 of 4, 100%). This was consistent with the previous review. • Evidence that the PNMT conducted hands-on assessment (4 of 4, 100%). This was consistent with the previous review. • Identified the potential causes of the individual's physical and nutritional management problems (4 of 4, 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 (4 of 4, 100%). This was consistent with the previous review. • Recommendations for measurable skill acquisition programs, as appropriate (n.a) • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP) (4 of 4, 100%). This was consistent with the previous review. • Recommendations for monitoring, tracking or follow-up by the PNMT (4 of 4, 100%). This was consistent with the previous review. • Discussion as to whether existing supports were effective or appropriate (4 of 4, 100%). This was consistent with the previous review. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (4 of 4, 100%). This was an improvement from 80% in the previous review. • Measurable outcomes related to baseline clinical indicators (4 of 4, 100%). This was an improvement from 67% in the previous review. • Signatures of all core team members (or alternate) with dates (4 of 4, 100%). It was noted that a physician and IDT members also signed these reports. This was an improvement from 80% in the previous review. Other findings included: • There were improvements noted across eight of the elements.	

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		• There were decreases across two areas. • Others remained consistent with the previous review, though one of these was 0% as it pertained to review of positioning during medication administration, oral hygiene, and bathing. • 100% of the assessments contained 25/30 (83%) of the applicable elements. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were four assessments submitted as completed by the PNMT since the previous review: Individual #288, Individual #126, Individual #150, and Individual #238. Individual records for all, except Individual #238, were requested. Plans contained in the individual records resulting from PNMT recommendations included the following: • In 0 of 3 (0%) individual plans reviewed, identified PNM needs as presented in the PNMT assessment were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. There was no evidence that the IHCP or IRRF for Individual #126 were reviewed and/or revised based on PNMT findings and recommendations. The plans outlined in the IHCP and IRRF, though reviewed and revised for Individual #150, did not specifically outline the findings and recommendations of the PNMT. For example, the IHCP merely referred to HOB elevation, but did not specify 45 degrees during feedings and 30 degrees at other times. Gastric residual threshold of 80 cc was also omitted from the IHCP. Individual #288 was hospitalized again during the course of assessment and intervention by the PNMT for bowel obstruction/ileus on 7/8/14. Despite revisions in the supports and outcomes by the PNMT, as of 7/21/14, the IRRF had not been revised since 4/25/14. Though the IHCP reflected some of these changes, this was incomplete. The only IHCP contained in the ISP was a Change of Status IHCP dated 7/16/14, that only addressed fluid imbalance and constipation and bowel obstruction. Other aspects of this plan were not contained in the individual record. • For 0 of 2 (0%) individuals for whom HOBE assessments were conducted, the recommendations were integrated into the individual plans. • For 3 of 3 (100%) 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. • 3 of 3 (100%) individual plans identified the frequency of monitoring. In general the IHCPs in particular were weak and did not adequately reflect the details of interventions to address individuals with PNM needs such as specific clinical indicators, individualized triggers, or timeframes that reflected clinical urgency. Most items included very generalized practices with a standard 12 month timeline for completion. The RN Case Managers, QIDPs, and DSPs/home managers typically attended all PNMT meetings and the PNMT members routinely attended ISPA meetings, as well. It would be expected	

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		that this level of collaboration would be better reflected in the ISP documentation. PNMT Follow-up and Problem Resolution Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion with timely implementation. • For 100% of individuals, implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For --% individuals (NA), action plan steps had been generally completed within established timeframes. This could not be determined based on the IHCPs because short term actions were not generally listed with completion dates. Intervals of PNMT review were not clearly stated in the assessments, but these appeared to occur on a timely basis and were well documented in the IPNs. These notes generally reflected actions taken, outcomes, and dates of completion consistent with the meeting minutes. All of this needed to be better reflected in the ISP process, as discussed above. Individuals Discharged from the PNMT Discharge was noted for the following individuals in the last six months: Individual #180 (7/10/14). • 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 1 of 1 individual (100%). • There was evidence of ISPA/ISP documentation and/or action plan for discharge of 0 of 1 (0%) individuals. • It was noted that in the meeting minutes, the team consistently provided an update on the status of established measurable outcomes for each individual on their caseload at the time of review. In a number of cases, discharge was considered with a transition back to the IDT (Individual #98, Individual #126, Individual #134, and Individual #38). For a variety of well-documented reasons, the PNMT had determined that discharge was not justified and, thus, continued to review their status and implement supports and interventions as indicated. In some cases, outcomes were appropriately revised. 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.	

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		The facility self-rated this provision in noncompliance and the monitoring team agreed. 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 all recommendations, actions, and outcomes identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 2. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. 3. Ensure that assessment, discharge and other key elements of support from PNMT service are 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, 100% of the individuals with identified PNM needs were provided a PNMP at SGSSLC. 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 is required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech and the PNMT 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 PNMT, 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 Sample O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. Pre-ISP documentation and ISPs were requested and submitted for individuals included in Sample P1. Review of the ISPs submitted was: • For 2 of 14 individuals (14%), all of the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. OT, PT, or both were present at each meeting and, due to the integrated assessment, current team assignments and routine clinical services meetings, this was an adequate approach. SLPs were present at 100% of the meetings. DSPs were present for 11 of 14 meetings. QIDPs, BHS, and RNCMs were present at 100% of the meetings. The RD was present at only five meetings. The PCP was present at six meetings and a psychiatrist was present at one meeting. Dental was present at three meetings. A PNMT representative was present at four meetings as designated. • For 10 of 14 individuals for whom pre-ISP required attendance sheets were submitted (71%), the designated team members were present for the ISP meeting per the sign-in sheet. Team members designated to attend, but not present to	Noncompliance

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		review the PNMP were DSP (2), the individual (7), OT (1), PT (2), RD (1), and the psychiatrist (1). In the case of the OT and PT, one or the other was present at each of the meetings. A dietitian attended only 5 of the 14 ISPs. This professional is a key team member, particularly as it related to PNM concerns. Regarding PNMP review: • 14 of 14 PNMPs (100%) indicated review by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs were significantly improved and a number of these were excellent. In some cases, there was clear evidence of review of the plan, but it was not clearly stated that the IDT had approved it. Other inconsistencies were noted in clear identification of required changes, efficacy of the plan, and monitoring. Overall, however, most of these were very good. This was an improvement from 93% in the previous review. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 14 of 14 individuals (100%) were current within the last 12 months. Only 13 individuals' records contained the most current version of the PNMP. This was consistent with the previous review. • PNMPs for 14 of 14 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 10 of 14 PNMPs (71%), there were large and clear photographs with instructions. Photographs are important to assist staff in the identification of specialized or personal equipment. Photographs of dining equipment were included in the Dining Plans, but other communication and assistive equipment was not photographed, in most cases. This was an improvement from 23% in the previous review. • 14 of 14 PNMPs (100%) identified the assistive equipment required by the individual with rationale and purpose. This was consistent with the previous review. • In 3 of 3 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, provided positioning instructions for the wheelchair. This was an improvement from 75% in the previous review. • In 14 of 14 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 14 of 14 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 14 of 14 PNMPs (100%), bathing instructions were provided. This was	

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		consistent with the previous review. • In 14 of 14 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 92% in the previous review. • In 14 of 14 (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 consistent with the previous review. • In 14 of 14 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 14 of 14 individuals' (100%) Dining Plans were current within the last 12 months. This was an improvement from 92% in the previous review. • 2 of 14 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 consistent with the previous review. • In 14 of 14 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 12 of 12 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 12 of 12 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was consistent with the previous review. • In 12 of 12 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 14 of 14 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 14 of 14 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was consistent with the previous review. • 14 of 14 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). This was consistent with the previous review.	

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		The PNMPs continued to be very good, with comprehensive content in most areas. • 100% of the PNMPs reviewed contained at least 95% of the essential elements. The only missing element was pictures of assistive and communication equipment. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> • Each of the individuals in Sample O.1 required changes to their PNMP in the last six months. There was no evidence of an ISPA for each of these changes for all individuals. For 3 of 14 individuals (21%) there was an ISPA that clearly discussed some specific changes to the PNMP and corresponded to changes made in their plans (Individual #26, Individual #150, and Individual #344). This was an improvement from 0% in the previous review. None of these included a clear rationale, plan, or timeline for implementation. Though clear timeframes for completion were not stated, they were usually made that day or within 48 hours. Other changes were made, however, and were not reflected in an ISPA. The monitoring team did not concur that the facility was in 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. More consistent use of the ISPA process with clear documentation is encouraged. 2. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs. 3. IDT members associated with review and approval of the PNMP should be present at the ISP/ISPAs when these plans are reviewed and/or revised.	
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 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, PNMPCs, and residential staff. Based on observations conducted by the monitoring team: • 87% of dining plans were implemented as written for at least 38 individuals observed. • 96% of PNMPs for approximately 50 individuals related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards. Based on additional observations: • 50% of four transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards (Individual #7 and Individual #21). The two that were not completed correctly involved pulled staff.	Noncompliance

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		• (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. • 50% of individuals' oral hygiene plans observed were implemented appropriately or consistent with the PNMP. • 100% of observations of medication administration by the monitoring team nurse were implemented appropriately or consistent with the PNMP. 8 of 10 (80%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. These questions pertained to rationale for assistive equipment, areas of risk and triggers, rationale for food textures and liquid consistencies, transfers, and positioning. Staff (including pulled 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. In home 516, the home manager reported bringing in pulled staff to address shortages during peak times. She indicated that her plan was to assign pulled staff to individuals while regularly assigned staff completed bathing, etc. During each of two observations by the monitoring team, pulled staff were assigned to assist individuals in the dining room and day room. They did not implement the plans as written and could not speak to the risks and strategies for individuals for whom they were responsible. In two cases, inappropriate transfers were observed. These staff admitted to not reading the plans. The facility implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in each of the homes. A number of errors were noted in a home where pulled staff were assigned. These staff admitted not reading the plans before beginning to assist individuals and errors in implementation were noted. In addition, they were not able to answer basic questions about individual risks and rationale for strategies for which they were responsible to implement. The facility self-rated this provision in noncompliance at this time and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team	

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		recommends that the facility consider the following for focus/priority for the next six months: 1. Direct increased training focus to transfers, toothbrushing, and bathing. 2. Continue to focus on staff performance through training, coaching, and monitoring by all supervisory staff and the Mealtime Coordinator. Reinforce their role and responsibilities in identifying and correcting staff performance errors. 3. Provide guidelines to home managers about the use of pulled staff to address low ratios during peak times. 4. Ensure that the training process for pulled staff was implemented consistently and reviewed for effectiveness. 5. Develop and implement a sound system to address training for pulled staff. 6. Ensure that home managers are competency-based trained to train others and assess their competency related to PNMP strategies.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. 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, techniques and equipment, lifting and transfers, positioning, dining/eating/oral intake, equipment, communication, and monitoring procedures. 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 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 that required check-offs including: • PNMP/Dining Plan review • Safe mealtime management • Positioning in wheelchair	Substantial Compliance

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		• Positioning in bed • Positioning during activities • Communication • Assisted mobility and transfers • Lifting 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. 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. • 100% of the 180 new employees required to attend PNM training from 2/1/14 through 7/31/14 completed NEO core foundational skill training and passed performance check-offs based on the participation reports and self-assessment. • There was a well-established system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators, well outlined. PNM Core Competencies for Current Staff Refresher courses for existing staff identified as requiring training related to PNM were required annually. Skill-based competencies (check-offs) were provided in the 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. Home managers had access to a database of trained staff for assignments and if no staff were available, they were to contact Habilitation Therapies. • 100% of the 180 new employees required to attend communication training from 2/1/14 through 8/1/14 completed NEO core foundational skill training and	

#	Provision	Assessment of Status	Compliance
		- passed performance check-offs based on the participation reports and self-assessment. - There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. There was a system to establish and maintain competency for staff who provided the training, conducted by the Director on an annual basis. - 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. - 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 yet 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 still be in process. Individual-Specific Training 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. Per policy, pulled staff were required to review all components of the PNM. Training was required for each pulled staff to assist an individual from the residential supervisor and/or Habilitation Therapy when indicated. As described above, there were pulled staff assisting individuals in home 516 and had not been trained. In some cases, these staff were not implementing the plan as written, and could not identify risks or provide a rationale for the strategies outlined in the plans. Concerns were noted related to implementation of PNMPs as cited above. 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. There were only a few individuals that required this for implementation of their PNMPs: Individual #344, Individual #180, Individual #90, Individual #66, Individual #273, Individual #118, Individual #384, and Individual #104. Home managers had access to a database of trained staff for assignments and if no staff were available, they were to contact Habilitation Therapies.	

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		The facility self-rated substantial compliance with this provision, and the monitoring team concurred based on the above findings.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> <u>Monitoring System</u> 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 was a rated scoring scale in which values were assigned to each element with regard to the critical nature of that element. For example, when staff were able to state who to contact if there were issues related to the equipment was less critical than whether staff could identify when an individual was correctly positioned in the bed and make corrections when they were not. • There were sufficient instructional guidelines for those using the forms to monitor. • Monitors (PNMPCs) were competent to monitor the PNMP elements. This was updated annually. Implementation of PNMPs was monitored for staff compliance across the following areas: • Safe mealtime • Communication • Assisted mobility and transfers • PNMP/Dining Plan review • Lifting • Bed positioning • Wheelchair positioning • Positioning during activities If staff failed the initial compliance drill, immediate on the spot training was provided. If total compliance fell below 80% then the PNMPC would conduct a follow-up drill. If a second drill was failed, again there was immediate re-training and an alternate PNMPC would conduct that follow-up in order rule out reviewer bias. The home supervisor was required to be present to determine if further corrective action was needed. Inter-rater reliability checks were conducted for the PNMPCs within three months of their hire date and repeated checks were conducted at least annually, or more often when indicated.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team requested compliance monitoring forms that were completed for individuals included in Sample O.1 for the last three months. Completed forms were submitted for only 11 of the 14 individuals in Sample O.1 with PNMPs. The monitoring conducted did not address all aspects of the PNMP and not for all individuals as follows: • Positioning in bed: 18 completed for eight individuals • Positioning during activities: 13 completed for seven individuals • Assisted transfers and Mobility: 14 completed for five individuals • Transfers: 11 completed for six individuals • Assisted Mobility: 9 completed for three individuals • Wheelchair positioning: 7 completed for five individuals • Safe mealtime management: 15 completed for four individuals • PNMP review: 11 completed for seven individuals Though much work had been done to refine the existing system since the last review, it was not clear that all areas of the PNMP had been consistently monitored. The Positioning During Activities forms (13) were submitted. Eight of the forms documented "NA" for bathing and 10 were marked "NA" for oral care. Each of these was marked as in compliance, and seven of these at 100%. This level of competence was scored based only on the individual's positioning at that time and staff's ability to describe what they should do, but not on demonstration of any other skills by the staff. In one case, the monitor marked both oral care and bathing as "NA" (on 5/31/14 for Individual #288). This observation was conducted at 5:32 am and it was not clear what activity was observed at that time. Staff were required to merely describe proper positioning during medication administration, but this was not directly observed for compliance. This was also true for enteral nutrition. While DSPs were not directly responsible for administering these, they would likely be in attendance and responsible to ensure that positioning was correct. The PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase other PNM risk particularly related to oral hygiene and bathing. Based on this submission, the routine frequency could not be determined. When a sample (16 per month in each PNM area) is used (and it was likely that all staff may not be monitored routinely throughout the year), it would be important to ensure that observations of staff demonstrating the skills were conducted. 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 conducted by the PNMPCs, but rather the effectiveness monitoring conducted by the licensed professional staff. Compliance monitoring was focused on staff performance, while effectiveness monitoring examined both staff compliance and program effectiveness. SGSSLC's system included compliance monitoring that was focused on staff performance and did not necessarily include every individual with a PNMP.	

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		• Assistive equipment was reviewed on at least a monthly basis to ensure that it was available and in good working order/condition. Concerns were reported and addressed consistently per the log submitted. The monitoring team noted that cleanliness of wheelchairs was a problem for some, however, including Individual #25, Individual #127, and Individual #40, among others. Only two individuals had work orders requiring more than 30 days (Individual #7 and Individual #384). The equipment was listed as new for Individual #7 and a replacement for Individual #384). The actual equipment was not identified. The due date for Individual #384 was 2/22/14 and the completion date was 4/11/14, 57 days after the work order was requested. In the case of Individual #7 the due date was 3/22/14 and the completion date was 5/21/14, 87 days after the work order was requested. The monitoring team did not concur with the facility's self-rating of 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. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. A focus on actual observation of activities is recommended.	
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> There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency was not reported as a recommendation in the annual assessments or the PNMT evaluations. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale Based on the sample of individuals selected for O.1, evidence of effectiveness monitoring for each was requested for the last six months. These were provided for each of the 14 of 14 individuals. The PNMP/Communication Program Effectiveness Monitoring form included sections that addressed effectiveness monitoring and compliance conducted by the OT and/or PT. Monitoring was documented on these forms as follows: • Mobility: 7 • Lifting: 1 • Mealtime: 13	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Equipment: 15 • Communication: 3 • Wheelchair positioning: 1 • Bed positioning: 2 • Oral care: 0 • Medication Administration: 0 • Bathing transfer: 0 (it was not clear why bathing positioning was not monitored) Additional effectiveness monitoring was documented in the IPNs. The quality and content of this varied across clinicians. Each monitoring should have a completed form and an IPN documenting the findings in the individual's record. Most appeared to be completed routinely on at least a quarterly basis, though some were to be reviewed monthly based on their identified needs. Only Individual #137 was reviewed once in the six month period, while each of the others was monitored at least twice or more. Per policy, individuals with red dot PNMPs were to be monitored monthly. This included Individual #384, Individual #104, Individual #66, and Individual #344 from sample O.1. Individual #66 was monitored in five months in an eight month time period (December 2013 through July 2014). Individual #104 and Individual #344 were monitored during four months, across the same time period. Individual #384 was monitored three months during that time. • IHCPs and PNMPs generally contained indicators identified to assess the individual's PNM status. Trigger sheets for individuals who had them were reviewed for individuals in O.1 with findings as follows: • For at least 7 of 7 individuals with Aspiration Trigger Sheets, there was evidence that the IDT identified the need for, and developed, individualized triggers. • Trigger sheets for 5 of 7 individuals were generally completed correctly (71%), with very few blanks, though the systems used varied across shifts and individual staff. • Trigger sheets for 7 of 7 individuals (100%) were reviewed at least daily by the nurse, though instructions were for review every shift. Though many were reviewed on multiple shifts, there were numerous blanks in the documentation suggesting that a shift nurse had not reviewed the data. RNCM review per instructions that this occur weekly was not consistently documented. This element was self-rated to be in substantial compliance. There was an established system of compliance and effectiveness monitoring implemented at near the intended frequency. The quality of documentation of the effectiveness monitoring was very inconsistent across clinicians and it was not clear that all areas related to PNM were	

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		adequately reviewed for compliance by the PNMPCs and clinicians at the required frequency. On this basis, the monitoring team did not concur with this self-rating. 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, a system to address the content and consistency for effectiveness monitoring by OTs, PTs and SLPs. The current system of review appeared to address the therapists' findings related to effectiveness and follow-up of issues identified. It is recommended that this be expanded to also address the process, content, and consistency of the effectiveness monitoring conducted. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 3. Ensure that trigger data sheets are completed as per facility policy.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Evaluation of Individuals who Received Enteral Nutrition</u> • The facility did maintain and update a list of individuals who were enterally fed, though Individual #180 was not included in the list submitted. Apparently, this individual had not yet received a gastrostomy tube at the time this list was submitted. There was a list of individuals that identified eight individuals who received enteral nutrition (only 4% of the current census). Individual #150 was identified in other documentation that he had a tube placed on 5/12/14 and was included on this list. Individual #180 had gastrostomy tube placement in 2013. Each of those listed had a gastrostomy tube. Three received intermittent feedings, 1 received continuous feedings, and four received bolus feedings. All were identified as NPO with no indication of any oral intake. Per his APEN, dated 2/14/14, Individual #180 had a gastrostomy tube, with nighttime enteral feedings, 10 hours per day. He also was provided three meals and three oral snacks daily of a ground texture with regular fluids. A sample of 10 APENs was requested, as completed since the previous review. Seven were submitted as completed for Individual #150, Individual #66, Individual #98, Individual #295, Individual #217, Individual #180, and Individual #90. Two others (Individual #134 and Individual #273) were provided this assessment based on the occurrence of aspiration pneumonia in the last year. • 8 of 8 individuals (100%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 7 of 9 individuals with APENs (78%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. Some did not appear to present a determination if the feeding schedule was the least restrictive or if	Noncompliance

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		there were potential modifications needed in preparation of transition to oral intake. • For 2 of 2 (100%) of individuals, for whom the IRRF were submitted (included in Sample O.1), there was evidence of adequate discussion by the team related to medical necessity (Individual #66 and Individual #150). IRRFs were not available for review for the other individuals. • --% 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> • One of the individuals who received enteral nutrition (Sample O.3) was adequately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. The APEN for Individual #150 was completed just after tube placement. Though the assessment was not adequate at that time, the APEN indicated that the IDT was planning to transition him to bolus feedings. Four others received bolus feedings and one had oral intake. • None of the individuals who were identified as potentially benefitting from oral motor treatment and/or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process • None of the individuals' 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. • None of the individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. • --% 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. • The IDT met and interventions in the return to oral intake plans were reviewed and changed, as appropriate, in a timely manner. This could not be determined. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan.	

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		PNMPs 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, though significant progress had been made in this area. 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 nutrition 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:** Documents Reviewed: o SGSSLC client list o Admissions list o Staff list o Section P Presentation Book and Self-Assessment o Section P QA Reports o OT/PT Procedures 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

	○ OT/PT Assessment template and instructions ○ OT/PT Assessment Tracking Log ○ Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to SGSSLC: Individual #86, Individual #289, Individual #167, Individual #79 and Individual #209. ○ OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT direct intervention for the following individuals: Individual #145, Individual #329, Individual #298, Individual #383, and Individual #70. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. ○ PNMP section in Individual Notebooks for the following: • Individual #104, Individual #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. ○ 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. Interviews and Meetings Held: ○ Dena Johnston, OTR, Habilitation Therapies Director ○ Erin Bristo, MS, CCC-SLP ○ Various supervisors and direct support staff Observations Conducted: ○ Living areas ○ Dining rooms ○ Day programs ○ ISP for Individual #130 ○ ISPA for Individual #118

	Facility Self-Assessment: The self-assessment completed by Dena Johnston, Habilitation Therapies Director, was again excellent. The assessment was clear, with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of the elements were addressed and used to determine compliance. Findings were consistently 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. This was consistent with the reports for QA/QI Council as well. Continued progress was noted, but improvements in the areas of assessments, monitoring, and direct intervention continued at a slow pace. The department leadership appeared on track with a plan to ensure that continued progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself in substantial compliance with provisions P.1 and P.4, though the monitoring team concurred with P.1 only. P.3 was also found in substantial compliance. Quality of assessments had improved, as well as timeliness. The monitoring system was established, but still required refinement and consistency. The monitoring team has confidence that strides in this area will be made over the next few months. While SGSSLC maintained substantial compliance with provision P.1, and substantial compliance with P.3, the other provisions in section P were not yet in substantial compliance. To move toward substantial compliance with this provision, consider a focus on the following: 1. 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. The one element that fell below this was related to one assessment only. Though given credit, one element was lacking in some aspects. Review of expectations for this should be reviewed with the clinicians to improve consistency. 2. Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. 3. It is recommended that the ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions. Review of standards is indicated. 4. Rationale in the pre-ISP process for therapist attendance or non-attendance and the need for assessment at the ISP needs to be sound and clearly supported. 5. 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. 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.

	7. Audits of documentation related to direct services are indicated to highlight the concerns and develop action plans to address these issues in order to establish consistency across clinicians and to ensure that basic standards are met. 8. Establish benchmarks, a system to address the content and consistency for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. The PNMP could not be deemed effective if all areas were not reviewed routinely. 9. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency.
	Summary of Monitor's Assessment: There was an exceptional departmental leadership. The clinicians continued to be successful in the development of PNM supports. The assessments completed had attained a high level of excellence and consistency across clinicians. OT/PT assessments continued to improve and substantial compliance with P.1 was maintained. The essential elements section should be carefully reviewed so that content of some elements can be further refined. Further integration of OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA. The clinicians should continue to be challenged to examine the existing plans to determine if supports are effective, but also least restrictive. A very clear and sound rationale must be delineated, rather than continue the same supports merely because they have been in place for some time. Through observations of ISPs and pre-ISPs, it was noted that the clinicians were generally well-prepared for these meetings and contributed important clinical data and recommendations. Several improvements are still needed, however. The therapists, as well as all IDT members, must participate in the pre-ISP process to present an overview of the effectiveness of existing supports and to generate specific questions that must be answered through assessment in collaboration with other IDT members, permitting them to come back to the table at the ISP with specific information that permits the team to outline appropriate supports and programs. There were still too many unknowns at the time of the ISP and then further assessment was required prior to the design and implementation of supports and SAPs. Finally, it was disappointing that the Life Skills program had not follow the functional direction that was originally identified. There was limited variety of meaningful activities and no apparent carry over into the context of the daily routine. It was understood that there was a plan to review the current activities. The facility is encouraged to develop a more creative and meaningful curriculum with functional goals across a wider array of skill sets for the participants. Consideration of acquiring the service from a professional with specific expertise in the provision of program for adults with autism is highly recommended. The following samples were used by the monitoring team: • Sample P.1: 14 individuals included in the sample selected by the monitoring team.

	• Sample P.2: Individuals admitted since the last compliance review (5). • Sample P.4: Individuals receiving direct OT/PT services (6)

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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.	<u>Assessments</u> Assessments were appropriately completed per the ISP schedule, change in status, or IDT request. The OTs and PTs completed a Comprehensive Assessment and/or an Assessment of Current Status/Update with the SLPs adding content related to dysphagia and a very limited overview of communication. The SLPs also completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update (section R). Per established policy, all individuals newly admitted to SGSSLC were to be provided a screening for therapy services completed within 30 days of admission. In the case that the screening identified any needs, a comprehensive assessment was to be completed within 30 days of identification. All individuals who were screened and did not require therapy supports, were rescreened every five years. All individuals who required direct and/or indirect services were to be provided a Comprehensive Assessment every five years, unless related to a significant change in status or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received direct and/or indirect services in years that a Comprehensive Evaluation was not required. There was a tracking log of assessments completed for ISPs from 12/17/13 through 6/30/14. The due dates listed were 22 calendar days versus the required 10 working days in order to better ensure timeliness. Timeliness related to the 10 working day deadline could not be readily determined for those assessments included in the log. There were 92 individuals listed as requiring a comprehensive assessment or ACS during that time period. Based on this log, timeliness of assessments, 22 calendar days prior to the ISPs 12/17/13 was 52%. All were submitted prior to the ISP meeting. It was also noted that at least 30 individuals were listed with no therapy services and, as such, a current assessment was not completed. Eleven of these had a comprehensive assessment listed as completed prior to 2011, indicating that they would not likely meet the standard established by the Settlement Agreement. In those cases, the indication that they did not require services was not well established and documented in an appropriate assessment that considered medical issues and health risk indicators in a clinically justified manner as required. The facility should conduct screenings to document this. The following individuals in Samples P.1 had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): 1. Individual #288 (4/2/14) 2. Individual #132 (7/8/14)	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		3. Individual #26 (12/20/13) 4. Individual #134 (3/24/14) 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 #150 (4/9/14) 2. Individual #344 (5/21/14) 3. Individual #384 (2/12/14) 4. Individual #66 (1/27/14) 5. Individual #126 (1/14/14) 6. Individual #180 (4/7/14) 7. Individual #38 (4/17/14) 8. Individual #251 (7/21/14) 9. Individual #137 (10/30/14) The ACS in the individual record for Individual #104 was not current in the last 12 months, dated 4/18/13. Timeliness of Assessments Thirteen individuals were listed as admitted to SGSSLC since the last review. Assessments were submitted for five of these (Individual #86, Individual #289, and Individual #167, Individual #79 and Individual #209). • 3 of 5 individuals in Sample P.2 (60%) received an OT/PT assessment within 30 days of admission based on the signature dates of the assessments submitted for review. Per the tracking log submitted, however, each of the 13 individuals was provided an assessment within 30 days of their admission. 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. Timeliness of the current OT/PT assessments was as follows: • 13 of 14 individuals' OT/PT assessments or updates (93%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 71% in the previous review. For individuals with ISPs since	

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		4/1/14, the timeliness of assessments per the assessment log was approximately 74%, with 16 individuals identified as not requiring as assessment. This log was based on 22 calendar day due dates in an effort to better ensure timeliness and appeared to be effective based on the above finding. • 13 of 14 assessments (93%) were current within 12 months for individuals in Sample P.1 who were provided PNM supports and services. The exception was Individual #104. This was consistent with the previous review. Though the tracking log indicated that a current ACS had been completed, it was not present in his individual record. <u>OT/PT Assessment</u> Only current Comprehensive Evaluations included in Sample P.1 were included in the following analysis (Individual #134, Individual #132, Individual #288, and Individual #26). Two additional assessments submitted were included for review (Individual #110 and Individual #232) to ensure an adequate sample size of at least three assessments for each of the current staff. 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: • 6 of 6 assessments (100%) were signed and dated by both OT and PT clinicians upon completion of the written report. This was consistent with the previous review. • 6 of 6 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 6 of 6 assessments (100%) included medical history. This was consistent with the previous review. • 6 of 6 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was consistent with the previous review. This was more specifically related to current health status and risk, but less so related to previous history and diagnoses. • 6 of 6 assessments (100%) addressed health status over the last year. This was consistent with the previous review. • 6 of 6 assessments (100%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. This was an improvement from 83% in the previous review. • 6 of 6 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This was an improvement from 83% in the previous review. • 6 of 6 assessments (100%) listed medications and potential side effects relevant to functional status. This was consistent with the previous review.	

#	Provision	Assessment of Status	Compliance
		• 6 of 6 assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 6 of 6 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. • 6 of 6 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. • Three individuals required a wheelchair for some level of mobility, though only Individual #26 and Individual #134 used a wheelchair as their primary means of mobility. The others used a wheelchair for long distances as needed. 1 of 2 assessments (50%) included a description of the current seating system with a rationale for each component and need for changes to the system were outlined as indicated, also with sufficient rationale. In the case of Individual #134, it was reported that he used a general use wheelchair with a custom seat cushion. It was further reported that a recommendation was pending for a personal wheelchair. Adequate specifics and rationale were not provided. This was consistent with the previous review. • 5 of 5 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. The frequency of monitoring was not reported, though this would be a good practice to ensure that it occurred as recommended by the clinicians in the assessment reports. • 6 of 6 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. • 5 of 5 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels, though this was somewhat general in nature. This was consistent with the previous review. • 6 of 6 assessments (100%) included discussion of the individual's potential to develop new functional skills. It was of concern, however, that the clinicians completing the OT/PT assessment for Individual #288 stated that he did not have the cognitive abilities to understand sequences and objectives for eating, dressing, or toileting. They did not address other areas of potential. He was described as having functional strength, ROM, and motor coordination. He was described as eating independently, dressing, and undressing with minimal assistance with fasteners and verbal cues. The role of OT and PT is to evaluate adaptations that may promote further skill acquisition or refinement, to promote independence and participation. This was consistent with the previous review.	

#	Provision	Assessment of Status	Compliance
		• 6 of 6 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. • 5 of 5 assessments (100%) included a monitoring schedule. This was consistent with the previous review. No recommendations were identified requiring monitoring for Individual #232. • 6 of 6 assessments (100%) included a re-assessment schedule. This was consistent with the previous review. • 6 of 6 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 6 of 6 assessments (100%) detailed the supports and services needed for successful community living. This was a strength of the assessments reviewed. This was consistent with the previous review. • 6 of 6 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 active record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in five 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. This appeared to be in place. There was a new assessment format 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 were nine individuals in Sample P.1 for whom records were submitted with current Updates/Assessments of Current Status and each had an associated Comprehensive Assessment in the individual record. As described above, Individual #104 did not have a current OT/PT assessment. • For 9 of 9 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, monitoring and re-assessment schedules. Findings from monitoring throughout the year were less consistently reported. There was little to distinguish these from the comprehensive assessments and this should be	

#	Provision	Assessment of Status	Compliance
		reviewed. There was continued overall improvement in the quality of OT/PT assessments for this review period, including an improvement of on-time assessments submitted 10 working days prior to the ISP. There was an audit system in place involving review for a sample of assessments. This continued to be an appropriate approach as all clinicians were reported to have demonstrated competency with the elements identified above. SGSSLC maintained substantial compliance with provision P.1. The facility continued to demonstrate improved compliance with the quality of OT/PT assessments and employed ongoing measures to ensure that assessments were completed by the due dates (10 working days prior to the ISP). To maintain substantial compliance with this provision, consider a focus on the following: 1. 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. The one element that fell below this was related to one assessment only. Though given credit, one element was lacking in some aspects. Review of expectations for this should be reviewed with the clinicians to improve consistency. o Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. 2. It is recommended that the ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions. Review of standards is indicated.	
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	Direct OT/PT Interventions: There were 12 individuals listed as participating in direct OT and/or PT and a sample of six individuals was included for review in Sample P.3 (Individual #145, Individual #329, Individual #298, Individual #208, Individual #383, and Individual #70). No documentation was submitted for Individual #208. Individual #145 participated in both OT and PT so two assessments or a combined assessment was indicated. • For 4 of 6 individuals (67%), an OT and/or PT assessment or consult identified the need for OT/PT intervention with rationale. In some cases, there was no evidence of an IPN related to assessment. In the case of Individual #145, he was evaluated by PT, but not OT though the services appeared to be separate. • 1 of 6 individuals had direct intervention plans (17%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety. • For 2 of 4 individual (50%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. In	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	other cases, therapy just stopped with no indication of why (Individual #70 and Individual #298).
		• The ISPs or ISPAs for individuals in the sample who participated in direct OT or PT services did not consistently establish the need to begin or terminate therapy.
		
		The system for documentation was not consistent across each of the individuals reviewed. There was a combination of session treatment notes, weekly summaries, IPNs, and monthly progress reports. The assessment and documentation forms appeared to be from another facility or agency with a rehabilitation focus. The documentation shorthand was not useful to other IDT members. There was no other documentation in the IPNs to report expected outcomes and progress with OT intervention. In one case, the COTA consistently used a SGSSLC form and clearly documented as indicated (Individual #145).
		
		Progress notes/IPNs:
		• 1 of 6 individuals receiving direct OT/PT Services (17%) was provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below:
		  ○ 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);
		  ○ A description of the benefit of the program;
		  ○ Identification of the consistency of implementation; and
		  ○ Recommendations/revisions to the indirect intervention and/or program as indicated in reference to 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. Additional SAPs or home programs were developed for implementation by DSP staff though it was not clear that effectiveness monitoring was conducted by the OT or PT, however, for these programs.
		
		<u>Integration of OT/PT Interventions, Supports and Services in the ISP</u>
		Review of the PNMP and Dining Plans were 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. 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 P1.	

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		Review of the ISPs submitted was as follows: • 100% (14 of 14) of the ISPs submitted were current within the last 12 months • 100% (14 of 14) of the current ISPs had attached signature sheets. • 43% (6 of 14) of the current ISPs with signature pages submitted were attended by both the OT and PT (Individual #118). • 29% (4 of 14) were attended by PT only. • 36% (5 of 14) were attended by OT only. • 0% (0 of 14) of the current ISPs had no representation by an OT or PT. Pre-ISP required attendance sheets were submitted for each of the 14 individuals. Six designated required attendance by OT and PT. Four of these were attended as designated by the IDT (67%). In the other two cases, only the OT attended both meetings (Individual #137 and Individual #66). Two designated an OT or PT representative to be present and both attended in one case (Individual #26) and the OT in the other case (Individual #38). In the case of Individual #251, the IDT designated that the OT should attend, but the PT was present. It would seem appropriate that an OT/PT representative be designated to attend in some cases as they conduct the assessment and develop interventions collaboratively. Another issue was related to the required assessments designated by the IDT. In the case of Individual #104, it was indicated that an assessment was not needed, but attendance at the meeting was required. 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 not be in substantial compliance and the monitoring team concurred. Very few individuals received direct therapy services, and documentation related to this was generally not within generally accepted standards of care. 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 and the need for assessment 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. 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. 4. Audits of documentation related to direct services are indicated to highlight the concerns and develop action plans to address these issues in order to establish consistency across clinicians and to ensure that basic standards are met.	

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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.	Substantial Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The facility had a current OT/PT policy and very detailed procedures that addressed the following 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. <u>Monitoring System</u> The facility implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. The standardized system for compliance monitoring of the PNMPs and Dining Plans consisted of a sample of 16 across each of the areas addressed by the PNMP, including PNMP review, assisted mobility, wheelchair, bed and activity positioning, as well as, mealtime. This was generally conducted by the PNMPCs and clinicians in conjunction with effectiveness monitoring. • The tools included adequate indicators to determine whether staff demonstrated	Noncompliance

#	Provision	Assessment of Status	Compliance
		competency to safely and appropriately implement the PNMP. • There were sufficient instructional guidelines for those using the forms to monitor. • All monitors (PNMPCs) and therapy clinicians were competent to monitor the PNMP elements based on the training submitted. Though much work had been done to refine the existing system since the last review, it was not clear that all areas of the PNMP had been consistently monitored based on the forms submitted. Positioning During Activities forms (13) were submitted. Eight of the forms documented "NA" for bathing and 10 were marked "NA" for oral care. Each of these was marked as in compliance, and seven of these at 100%. This level of competence was scored based only on the individual's positioning at that time and staff's ability to describe what they should do, but not on demonstration of any other skills by the staff. In one case, the monitor marked both oral care and bathing as "NA" (on 5/31/14 for Individual #288). This observation was conducted at 5:32 am and it was not clear what activity was observed at that time. There was also a system established for effectiveness monitoring by the therapists. The recommended frequency of this was generally reported in the annual assessments, though specific findings were not reviewed consistently. Individuals with red dot PNMPs were to be monitored at least monthly due to the complexity of their plans. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring for each was requested for the last six months. These were provided for each of the 14 of 14 individuals. The PNMP/Communication Program Effectiveness Monitoring form included sections that addressed effectiveness monitoring and compliance conducted by the OT and/or PT. Monitoring was documented on these forms as follows: ○ Mobility: 7 ○ Lifting: 1 ○ Mealtime: 13 ○ Equipment: 15 ○ Communication: 3 ○ Wheelchair positioning: 1 ○ Bed positioning: 2 ○ Oral care: 0	

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		○ Medication Administration: 0 ○ Bathing transfer: 0 (it was not clear why bathing positioning was not monitored) Additional effectiveness monitoring was noted as documented in the IPNs. The quality and content of this varied across clinicians. Each monitoring should have a completed form and an IPN documenting the findings in the individual's record. Most appeared to be completed routinely on at least a quarterly basis, though some were to be reviewed monthly based on their identified needs. Only Individual #137 was reviewed once in the six month period, while each of the others was monitored at least twice or more. Per policy individuals with red dot PNMPs were to be monitored monthly. This included Individual #384, Individual #104, Individual #66, and Individual #344 from sample O.1. It was noted, based on the documentation submitted that Individual #66 was monitored in five months in an eight month time period (December 2013 through July 2014). Individual #104 and Individual #344 were monitored during four months, across the same time period. Individual #384 was monitored three months during that time. This element was self-rated to be in substantial compliance. There was an established system of compliance and effectiveness monitoring, compliance implemented at the intended frequency. The quality of documentation of the effectiveness monitoring was very inconsistent across clinicians and it was not clear that all areas related to PNM were adequately reviewed for compliance by the PNMPCs and clinicians at the required frequency. On this basis, the monitoring team did not concur with this self-rating at the time of this review. 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, a system to address the content and consistency for effectiveness monitoring by OTs, PTs and SLPs. The current system of review appeared to address the therapists' findings related to effectiveness and follow-up of issues identified. It is recommended that this be expanded to also address the process, content, and consistency of the effectiveness monitoring conducted. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ DADS Policy #15: Dental Services, dated 8/17/10 ○ SGSSLC Dental Procedures Manual, 5/31/13, revised 8/19/13 ○ SGSSLC Organizational Charts ○ SGSSLC Self -Assessment Section Q ○ SGSSLC Action Plan Section Q ○ SGSSLC Provision Action Plan ○ SGSSLC Procedure, Missed Dental/Medical Appointments and Day Program Attendance, 9/15/11, 4/8/13 ○ SGSSLC Policy/Procedure, Comprehensive Provision of Dental Assessments, 8/30/10, revised 10/24/13 ○ SGSSLC Procedure, Pretreatment Sedation Notification and Referral to Assessment Process 2/22/11, 11/26/13 ○ SGSSLC Policy/Procedure, Dental Radiographs, September 2012 ○ SGSSLC Policy/Procedure Dental Care -Suction Toothbrushing, 5/18/10, revised 5/1/12 ○ SSLC Nursing Protocol: Pretreatment and Post sedation Monitoring, revised December 2013. ○ Presentation Book, Section Q ○ Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams ○ Listing, Individuals Receiving Suction Toothbrushing ○ Dental Clinic Attendance Tracking Data ○ Oral Hygiene Ratings ○ Complete Dental Records for the Individuals listed in Section L ○ Annual Dental Assessments for the following individuals: • Individual #57, Individual #172, Individual #142, Individual #183, Individual #50, Individual #58 Individual #112 Individual #189, Individual #327, Individual #239 ○ Annual Dental Summaries for the following individuals: • Individual #63, Individual #246, Individual #38, Individual #154, Individual #300, Individual #354 Individual #22, Individual #372, Individual #344, Individual #30, ○ Oral Surgery Consultations for the following individuals: • Individual #300 Interviews and Meetings Held: ○ William Todd Walker, DDS, Dental Director ○ Ken Reeves, DMD, Staff Dentist ○ Rob Weiss, Weiss, PsyD, Director of Behavioral Health Services ○ John Church, Assistant Director of Behavioral Health Services

	Observations Conducted: o Dental Department o Administrative IDT Meeting o Daily Medical Provider Meetings
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. The facility's lead/full time hygienist, who was no longer employed by the facility, completed the self-assessment. She 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 continued to reflect the major items reviewed by the monitoring team. 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 dental clinic continued to make progress in several areas: (1) compliance with timely completion of annual assessments increased to greater than 90%, (2) oral hygiene ratings continued to improve, and (3) radiograph compliance continued to increase. Notwithstanding these improvements, there were some concerns about the provision of dental care. SGSSLC did not have any arrangements to provide services for individuals who needed general dentistry procedures utilizing anesthesia/sedation, but who were determined to not be suitable for treatment with TIVA on campus. Additionally, records identified individuals who were considered candidates for TIVA in early 2014, but the facility had not conducted a TIVA clinic since 2/10/14. The dental director reported that the facility was in the early process of establishing a hospital dentistry program. This was discussed during the February 2014 compliance review and facility staff reported that discussions with external providers were ongoing. The frequency of dental assessments was based on the oral health of the individual. Individuals with poor oral hygiene were seen more often and were enrolled in the weekly suction toothbrushing program. The management of individuals who refused was challenging. The facility's average refusal rate continued to increase and was 11% for the reporting period. It was clear that the collaboration between behavioral health services and the dental clinic remained problematic. Behavioral rehearsal plans were developed for individuals with a history of refusal, but the programs were not effectively implemented. This was a troubling finding because individuals were identified in the records reviewed who were in need of treatment, but did not receive it due to challenging behaviors. Moreover, there was evidence that the efforts to address the refusals were neither consistent nor effective. A workgroup was developed to

	address these issues. The initial meeting was scheduled to take place the week after the compliance review. Finally, during the week of the compliance review, the dental clinic was not able to provide routine care. The full time RDH and dental assistant positions were both vacant and the part-time hygienist was on leave. The dental director reported there was no staff (hygienist or dental assistant) to provide chairside assistance in the dental clinic. The part time hygienist was scheduled to return in the near future. The facility will need to aggressively recruit staff so that clinic operations are not interrupted for an extended period of time.

#	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. Staffing At the time of the compliance review, the dental clinic staff was comprised of a full time dental director, part-time dentist, and part time hygienist. The part time dentist and part time hygienist both worked two days a week. Annual Assessments 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 - 2014						
	Dec	Jan	Feb	Mar	Apr	May
No. of Exams Completed	10	29	20	34	12	8
% Timely Completion	91	88	100	100	86	90

The average compliance score for the reporting period was 92.5%. This was an increase from the 85% reported during the previous review.

Ten Annual Dental Examinations were submitted as part of the complete records. All were completed with the state template. 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, suction toothbrushing needs, and risk ratings.

#	Provision	Assessment of Status	Compliance
		The 10 evaluations reviewed were thoroughly completed. A few did not include a response on the need for suction toothbrushing. None of the forms indicated that oral hygiene instructions were provided to staff. 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 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 services were also included. Copies of 11 Annual Dental Summaries were submitted for review. The following summarizes the data included in those documents: • 11 of 11 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use • 11 of 11 (100%) documented oral hygiene status • 11 of 11 (100%) documented oral cavity tissues • 11 of 11 (100%) included a completed odontogram • 11 of 11 (100%) documented treatment recommendations • 11 of 11 (100%) documented risk ratings specific to periodontal disease and caries • 11 of 11 (100%) included comment on community and living services • 11of 11 (100%) included comments on preferences, strengths, and goals. Several of the summaries appeared to paste information from other documents. Many included more than a page on leisure activities, relationship with family, etc. While this was good information, it did not necessarily improve the discussion related to oral health and was clearly already provided to the IDT in other documents. The summaries were all completed by the RDH. State policy did not define the responsible party. However, the dentist completed this assessment at other SSLCs.	

#	Provision	Assessment of Status	Compliance
		Initial Exams Fifteen individuals were admitted during the reporting period. All individuals completed initial assessments within 30 days of admission to the facility. Oral Hygiene 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 preventive appointments. The following data (based on preventive appointments) were reported:	

Oral Hygiene Ratings (%)			
	Good	Fair	Poor
Dec	28	19	3
Jan	73	19	8
Feb	66	32	1
Mar	60	36	3
Apr	58	34	8
May	59	34	7

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 a 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. At the time of the compliance review, three individuals were enrolled in the toothbrushing program. 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-four 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 director reported that the former dental hygienist (facility lead) continued to conducted quarterly audits of the required documentation to ensure that treatments occurred as ordered. The documentation of the audits was not submitted.

#	Provision	Assessment of Status	Compliance
		Competency based training in suction toothbrushing starting in NEO the month prior to the compliance review. It was taught by the facility lead. The dental director was planning to provide training during the next NEO session.	

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. A dental anesthesiologist was available to provide services when TIVA clinics were scheduled. 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 2013-2014						
	Dec	Jan	Feb	Mar	Apr	May
Oral Hygiene Instructions	32	37	32	32	46	26
Preventive	32	37	32	32	46	26
Emergency	0	0	0	0	0	0
Extractions	6	5	4	7	4	17
Restorative	9	16	13	21	23	18
Total	133	163	166	138	148	107

The facility continued to identify individuals and provide restorative treatment. 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 five years. Bitewing radiographs were completed annually. The facility reported data for compliance with radiographs. Those data are presented in the table below.

#	Provision	Assessment of Status	Compliance

Radiograph Compliance 2013 -2014						
	Dec	Jan	Feb	Mar	Apr	May
Radiographs Due	11	33	20	37	14	10
Completed	9	31	19	28	12	11
% Completed	82	94	96	75	86	100

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 88%. This was an increase from the 81% compliance reported during the previous review. The facility was obtaining radiographs in accordance with the general ADA guidelines. The requirements for radiographs should be explicitly stated in the dental radiograph policy.

Oral Surgery/Off-Campus Services
Individual #300 was referred to the oral surgeon for evaluation of a soft palate lesion. This was determined to be the result of a surgical procedure done during childhood and was not pathologic.

The dental director reported that most periodontal treatment was performed on campus. The facility was in the process of developing a hospital dentistry program for individuals who required sedation and anesthesia in a hospital setting. At the time of the compliance review, the facility did not have a means of providing treatment to individuals who required general dentistry services and anesthesia, but were not candidates for campus TIVA. Three individuals were identified, in a sample of 20, who needed anesthesia in a hospital setting.

Sedation/General Anesthesia/TIVA
The facility used very little pretreatment sedation. TIVA had not been used since the February 2014 compliance review. The number of individuals who utilized sedation is summarized in the table below.

General Anesthesia/Minimal Sedation						
	Dec	Jan	Feb	Mar	Apr	May
TIVA	3	0	4	0	0	0
Oral Sedation	0	0	0	0	0	3
Total	3	0	4	0	0	3

There were several individuals who were identified as needing TIVA in early 2014, but the facility had not conducted a TIVA clinic since February 2014. The facility dentist documented that Individual #354 was a candidate for TIVA. It was further noted that the individual was "gaming the system" and "the caries is becoming more advanced." A TIVA

#	Provision	Assessment of Status	Compliance
		clinic was scheduled for October 2014. During the February 2014 compliance review, it was noted that the facility did not conduct appropriate post-anesthesia monitoring. The facility had not conducted a TIVA clinic in recent months. However, the dental director developed a TIVA policy that outlined a number of important areas inclusive of indications for TIVA, selection criteria, pre-and post anesthesia monitoring, and qualifications of the anesthetist. <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. Training data indicated that staff was completing NEO and refresher training as required. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. Although the facility made considerable progress in several areas, SGSSLC has an obligation to provide adequate dental services for all individuals. In order to achieve this, the facility must have the ability to provide services to those who need procedures completed in a hospital setting. To move in the direction of substantial compliance, the monitoring team, makes the following recommendations: 1. The facility must be able to provide dental services for all individuals including those who require that dental procures are completed in a hospital setting. 2. The comments and recommendations in this report should be addressed.	
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;	<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 document request included several policies: • Comprehensive Provision of Dental Assessments, 8/30/10, revised, 10/24/13 • TIVA Anesthesia, 6/9/14 • Dental Radiographs, 9/27/12 • Dental Care Suction Toothbrushing, 4/22/14 • Annual Examination, 6/10/14 • Prophylaxis procedures, 8/1512 • Miss Dental Appointment, 6/10/14 • Initial Examinations, 6/9/14 • Infection Control Procedures, 4/13/14 • Oral Care for Those with GERD, 5/29/14	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Oral Care for Those with Dysphagia, 5/23/14 • Documentation, 6/10/14 Many of the policies and procedures submitted did not include an implementation or approval date. Moreover, the facility's policy and procedure listing did not reflect the revision of several dental policies. Those were not included in the document request. Thus, it was unclear if all of the policies and procedures that were revised had been appropriately approved. The dental services policy submitted had not been reviewed or revised since 2011 (though the facility later reported that a revision was done just prior to the onsite review). It is standard procedure for a health care services department to maintain a comprehensive manual and for employees to have access to either the electronic or hard copy of that manual. The dental director should ensure that policies are reviewed on an annual basis and updated as required. 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 number of appointments as identified and reported by SGSSLC are summarized in the table below:	

Failed Clinic Appointments 2013 - 2014						
	Dec	Jan	Feb	Mar	Apr	May
Missed/No show	24	13	33	23	18	5
Refused	16	18	11	14	20	13
Failed	37	31	44	37	38	18
% Failed	28	19	27	27	26	17
Total Appointments	133	163	166	138	148	107

The number of missed appointments decreased over the past six months. The average number of appointments missed each month for the reporting period was 19. This was lower than the average of 24 reported for the previous compliance review. Clinic staff

#	Provision	Assessment of Status	Compliance
		was required to call if the individuals did not keep the scheduled appointment. The majority of the missed/no show category was due to illness, inclement weather, and "unknown." The missed appointment logs included in the complete dental records documented missed appointments related to staffing and behavior that were not included in the document submission. The failure rate for the reporting period was 24%. This was a decrease from the average failure rate of 29% reported during the previous review. <u>Sedation and Dental Restraints</u> The facility documented that, for the reporting period, 0% 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. <u>Strategies to Overcome Barriers to Dental Treatment</u> The refusal rate for the reporting period was 11%. This represented an increase from the refusal rate of 9% reported for the February 2014 review. The refusal rate for the August 2013 review was 5.6%. Based on the reported data, refusal of treatment was increasing. 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 after one or two refusals. 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 16 behavioral rehearsal programs. During the February 2014 compliance review, it was documented 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. Staff reported that the lack of communication was not resolved. The monitoring team met with facility staff to discuss the facility's management of barriers to dental treatment. A number of issues were discussed: • It was reported that dental clinic submitted referral forms to behavioral health services when individuals refused treatment. Behavioral Rehearsal Plans were developed, but implementation was problematic because direct support	

#	Provision	Assessment of Status	Compliance
		professionals encountered difficulty implementing the plans. A new process was started in July 2014 in which behavioral health services and dental clinic staff met to review the plans. • Individuals who utilized TIVA were not being referred to psychology for evaluation. • The "round robin" process of having review of pretreatment sedation reviewed by the relevant clinical disciplines was essentially a document review with no discussion of the participants. The director of behavioral health services reported that a workgroup had been recently established and was scheduled to meet the Monday following the compliance review to discuss several issues related to pretreatment sedation, the Round Robin reviews, and other barriers to dental treatment. <u>Compliance Rating and Recommendations</u> 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 facility will need to continue to address the refusals and provide evidence that the behavioral rehearsal plans are effectively implemented. 2. The dental director must ensure that all policies are reviewed annually and updated as needed.	

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 QA Reports 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 individuals with PBSPs o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment 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 List of individuals receiving direct communication-related intervention o Competency/Compliance Monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessments/Screenings for individuals newly admitted to SGSSLC: • Individual #397, Individual #28, Individual #305, Individual #167, Individual #156, and Individual #286 o Communication Assessments/Screenings and ISPs for the following individuals: • Individual #217, Individual #338, Individual #287, Individual #154, Individual #189, Individual #34, Individual #40, Individual #21, Individual #185, Individual #144, Individual #98, and Individual #146. o Communication Assessments, ISPs, ISPAs, SAPs, intervention plans, IPNs, and other documentation related to communication for the following individuals: • Individual #331, Individual #266, and Individual #389. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251,

	Individual #344, Individual #137, Individual #288, and Individual #132. ○ PNMP section in Individual Notebooks for the following: • Individual #104, Individual #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. ○ 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 #180, Individual #134, Individual #66, Individual #38, Individual #150, Individual #384, Individual #26, Individual #126, Individual #251, Individual #344, Individual #137, Individual #288, and Individual #132. Interviews and Meetings Held: ○ Dena Johnston, OTR, Habilitation Therapies Director ○ Erin Bristo, MS, CCC-SLP ○ Various supervisors and direct support staff Observations Conducted: ○ Living areas ○ Dining rooms ○ Day programs ○ ISP for Individual #130 ○ ISPA for Individual #118
	Facility Self-Assessment: The self-assessment completed by Dena Johnston, Habilitation Therapies Director, and the lead SLP, Erin Bristo, was excellent. The assessment was clear, with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of the elements were addressed and used to determine compliance. Findings were consistently 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. This was consistent with the reports for QA/QI Council as well. Continued progress was noted, but improvements in the areas of assessments, monitoring, and direct intervention continued at a slow pace. The department leadership appeared on track with a plan to ensure that continued progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself not in substantial compliance with provisions R.2, R.3, and R.4 and the monitoring team concurred. R.1 was proposed to be in substantial

	compliance, but this was not the finding of the monitoring team. Two of the three SLPs had resigned as of July 2014 and replacements were not due until September 2014. SGSSLC supported a significant number of individuals with severe communication deficits and, as such, it was critical that caseloads be sufficiently small and consistent to ensure that adequate and appropriate supports are provided. The department continued to struggle with timeliness of assessments and there continued to be many that were just not completed per the documentation submitted. In order 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. Review the existing staffing plan and valuation of caseloads to ensure that it is adequate to meet the identified needs of individuals at SGSSLC. 2. Implement a plan to ensure timely completion of communication assessments. The assessments completed were excellent, as noted below, but they were frequently not available to the IDT for the development of an effective annual ISP. 3. Include clearly stated communication strategies in the assessments (including how the individual communicates, as well as, how staff would best communicate with them). 4. Ensure better integration of these strategies in the PBSPs and ISPs. 5. Implement a plan to ensure timeliness of assessments. 6. Ensure that Comprehensive Assessments were contained in the individual records with subsequent ACSs. 7. 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 consistent with the individual's communication function and methods of communication. 8. Ensure that information related to communication was effectively translated to the ISP. 9. Address the consistency and necessary elements of documentation of direct interventions. 10. Refine the system of effectiveness monitoring to address inconsistencies related to review of communication supports. 11. Review the consistency and accuracy of communication monitoring. 12. Continue to track findings of both effectiveness and compliance monitoring and timeliness of follow-up when issues are identified. 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. 13. Clearly document timely follow-up of issues identified in all monitoring conducted
	Summary of Monitor's Assessment: There was an exceptional departmental and section leadership. While the clinicians continued to be successful in the development of communication supports, the continued delay in completion of communication assessments relative to the ISP must be improved. The assessments completed attained a high level of excellence and consistency across clinicians. It was anticipated that with new clinicians arriving in September 2014, the provision of high quality assessments will be maintained.

	There were a fair number of communication systems in place, though integration of communication supports was not consistently integrated into the ISPs. Though improved, there was insufficient evidence that there was discussion related to the supports provided and their effectiveness. Generally, sections from the communication assessment were inserted into the ISP. There are key aspects of section R that require evidence of integration into the ISP annually and during interim ISPAs. This must include actual documentation that the IDT reviewed the communication dictionary, communication plans, and supports, and that the IDT specifically identified the effectiveness and any need for changes. This begins with the timely completion of the communication assessment. The facility should consider implementation of a peer review process to ensure that all clinicians continued to refine their assessment skills, particularly related to the need for AAC and environmental control. Consistency of documentation of direct supports and review of indirect supports was needed. Effectiveness monitoring should reflect a review of all communication supports and SAPs at least on a quarterly basis, but instead appeared to focus primarily on the PNMP. The following samples were used by the monitoring team: • Sample R.1: 14 individuals included in the sample selected by the monitoring team • Sample R.2: Individuals admitted since the last compliance review (5) • Sample R.3: Individuals for whom current assessments were submitted for each therapist (10) • Sample R.4: Individuals with AAC (4) • Sample R.5: Individuals receiving direct speech services (3)

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Staffing There was one full time SLP with responsibilities related to communication, Erin Bristo, MS, CCC/SLP. She was the section R lead and assisted with sections O and P. She served on the PNMT, had a caseload related to dysphagia, and was assigned to home 510B. She coordinated the contract SLPs, attended ISPs and ISPAs, conducted mealtime monitoring, provided direct therapy as needed, and attended the BSC meetings. Two contract SLPs provided services until the end of June 2014. Two therapists were to begin on 9/1/14. The facility document that listed budgeted and filled positions identified two budgeted positions for SLPs, with only one filled at the time of this review. Responsibilities of the full-time communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, attendance at ISPs and ISPAs, and monitoring the implementation of programs related to communication and/or dysphagia. The full-time SLPs provided supervision to the SLPAs, when available, as well as, providing mentoring and training to the Habilitation Therapy technicians to enhance their competency in the monitoring of	Noncompliance

#	Provision	Assessment of Status	Compliance
		communication supports and services.	

The elements for consideration to determine staffing needs included:

- Individuals with indirect communication supports
- Individuals with direct communication services
- Individuals with severe language deficits with coexisting behavioral issues
- Individuals with PBSPs including communication supports/strategies

The acceptable ratio was identified as 1:70. Individuals with behavioral issues and PBSPs were identified as requiring additional time to ensure integration with psychology. A higher value of service level was assigned to these individuals (1.5).

Census	208	Total Determined Service Level	Total Number with Adjustment as Per Identified Speech Service Level
Individuals with Indirect Communication Supports	61	1	28
Individuals with Direct Communication Services	0	1	0
Individuals with Severe Language Deficits and Coexisting Behavioral Issues	33	1.5	49.5
Individuals with PBSPs Including Communication Supports/Strategies	106	1 (The assigned value identified in the process was 1.5)	106

Per the self-assessment, the established ratio was 1:61 for three SLPs. It was not clear why the facility did not use the 1.5 valuation as described for individuals with PBSPs and communication supports and strategies. It was understood that not all those with a PBSP had communication-related replacement behaviors, but the actual number that did was identified as 106. With the assigned valuation of 1.5, the total was 159. At the time of this review, the ratio based on these values was 1:236.5. As of 9/1/14, when the two new contract clinicians begin, the ratio, based on this assessment would be approximately 1:79, above the established maximum of 1:70 as determined by the

#	Provision	Assessment of Status	Compliance
		facility and above the expected guidelines established by the monitoring team (1:60), though clarification was needed related to the actual number of individuals with communication-related issues and PBSPs. Staffing had remained stable since the previous onsite review until the end of June 2014, though SGSSLC did not provide an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services based on the ratio identified above. Qualifications: • The facility documented appropriate qualifications for licensed SLPs. • 1 of 1 speech staff, with responsibilities related to communication (100%) was currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 1 of 1 speech staff, with responsibilities for communication (100%) held current ASHA certification. This was consistent with the previous review. Continuing Education: Based on a review of continuing education completed since the previous review: • 1 of 1 current speech staff responsible for communication supports and services (100%) had completed continuing education within the last six months, though only two hours were related to communication. Prior to leaving the facility, the other two SLPs had not attended any communication-related continuing education in the last six months. 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 strongly encouraged 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 (5/30/14). The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services. Each of the following elements was clearly addressed in the policy in conjunction with other procedural documents and a well-established procedure was currently in practice:	

#	Provision	Assessment of Status	Compliance
		• 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. Though the existing SLP was well qualified and experienced, there was an insufficient allocation of speech staff resources, based on the current census and identified need. The current staff ratio and caseload sizes were high at the time of this review. Limitation 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 (including modeling and coaching) for the implementation of communication programs, and to adequately maintain the necessary equipment. It was also not clear that an acceptable ratio would be established as of 9/1/14, with the addition of two SLPs. The facility appeared to have difficulty in sustaining the minimum number of clinicians to meet the identified needs of individuals living at SGSSLC. In order 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. Review the existing staffing plan and valuation of caseloads to ensure that it is adequate to meet the identified needs of individuals at SGSSLC. 2. Implement a plan to ensure timely completion of communication assessments. The assessments completed were excellent, as noted below, but they were frequently not available to the IDT for the development of an effective annual ISP.	

#	Provision	Assessment of Status	Compliance
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.	Assessment Plan: SGSSLC had an established assessment plan clearly outlined in the policy dated 5/30/14 and included the following: 1. Individuals newly admitted would be provided a screening five working days prior to the ISP. In the case that the screening identified communication needs, a Comprehensive Assessment would be completed within 30 days. 2. If no communication concerns were identified, a screening would be completed every five years at the time of the annual ISP (10 working days prior). 3. Individuals without current services and/or did not have a completed Comprehensive Assessment since November 2011, were to be provided a screening to determine the need for further assessment at least two months prior to the annual ISP. In the case that issues were identified, a Comprehensive Assessment was to be completed at least 10 working days prior to the ISP. 4. Individuals who received indirect services only were to be provided a Comprehensive Assessment every five years. 5. Individuals who received direct and/or indirect services were to be provided an Assessment of Current Status annually, completed 10 working days prior to the ISP. 6. When a change in status was noted, an Assessment of Current Status was initiated and completed within in five days of the identification of the concerns. Assessments completed were tracked in the assessment log. At the time of this review, some changes had been made to the format for these reports and were implemented at the time of this review. Assessments Provided Communication assessments for individuals in Samples R.1 (14 individuals), R.3 (10 individuals), R.4 (four individuals), and R.5 (three individuals) were submitted as requested (duplications were submitted for Individual #38, Individual #331, Individual #384, Individual #66, Individual #134, Individual #180, and Individual #338): Speech Language Comprehensive Assessment 1. Individual #180 (4/22/13) 2. Individual #66 (8/7/12) 3. Individual #38 (5/29/13) 4. Individual #150 (5/6/13) 5. Individual #384 (3/11/14) 6. Individual #251 (9/4/12) 7. Individual #344 (6/7/13, incomplete per copy submitted) 8. Individual #137 (2/22/12) 9. Individual #132 (7/15/14)	Noncompliance

#	Provision	Assessment of Status	Compliance
		10. Individual #217 (7/3/13) 11. Individual #338 (6/19/12) 12. Individual #266 (10/23/13) 13. Individual #287 (2/4/14) Speech Language Evaluation 1. Individual #126 (7/8/10) Evaluation Update 1. Individual #104 (8/17/12) 2. Individual #288 (11/28/12) 3. Individual #154 (8/11/12) Speech Language/Communication Assessment of Current Status 1. Individual #134 (3/24/14) 2. Individual #66 (2/12/13 and 2/3/14) 3. Individual #38 (4/29/14) 4. Individual #251 (9/4/13) 5. Individual #189 (10/2/13) 6. Individual #338 (6/3/13 and 5/21/14) 7. Individual #331 (2/18/14) 8. Individual #389 (12/5/13) 9. Individual #34 (1/24/14) 10. Individual #40 (4/25/14) 11. Individual #21 (4/1/14) 12. Individual #185 (11/25/13) 13. Individual #144 (2/11/14) 14. Individual #98 (4/12/14) 15. Individual #146 (4/8/14) Speech Language Pathology Screen • Individual #26 (1/2/13) • 19 of 28 individuals (68%) in Samples R.1, R.3, R.4, and R.5 were provided an assessment or update current within the last 12 months, though the other nine individuals were provided at least indirect communication supports and/or AAC and/or annual assessment was recommended. This was an increase from 57% in the previous review. • 11 of 13 individuals admitted since the last review (85%) received a communication assessment/screening within 30 days of admission. Individual	

#	Provision	Assessment of Status	Compliance
		#199 and Individual #73 were provided screens, but after the 30 day time frame. This was an increase from 75% in the previous review. For 9 of 28 individuals (32%) in Samples R.1, R.3, R.4, and R.5 for whom assessments were indicated, the assessments or updates were dated as having been completed at least 10 working days prior to the annual ISP. This was a decrease from 53% in the previous review. No current assessments were submitted for nine individuals. Per the self-assessment, there were 41 individuals who required assessment for their annual ISPs from February 2014 through May 2014, though only 22 (54%) of these were completed in a timely manner. The tracking log listed 116 individuals with ISPs between 2/25/14 and 8/21/14. Forty-nine individuals did not require further assessment based on previous screening results. An additional nine others were determined to not require communication supports and services based on a screening completed during that time frame. Two others were listed as "no services" based on a previous assessment (Individual #295 and Individual #268). It was identified that an annual assessment was due for the ISP for the other 55 individuals. Only 20 (36%) of these had been provided a current Screening (6), Comprehensive Assessment (5) or Assessment of Current Status (9). Of the total assessments or screens required, only five (9% overall) had been completed on time, per the due dates listed (22 days prior to the ISP). This deadline was self-imposed per departmental policy to ensure that assessments were completed in a timely manner. Whether the others met the 10 working day deadline, was not clear. • For 1 of 6 (17%) of individuals identified with communication needs through a screening, a comprehensive communication assessment was completed within 30 days of identification. The assessments for Individual #286 and Individual #269 were completed, but Individual #286's was not within the 30 day time frame, but nearly four months later. The other three (Individual #79, Individual #156, Individual #305, and Individual #397) were not provided a comprehensive assessment, though one was indicated for each of these based on the findings in the screen. This was an increase from 5% in the previous review. Based on review of the assessments submitted and included in Samples R.1, R.3, R.4, and R.5, there were four individuals with comprehensive assessments completed within the last 12 months: Individual #384 (3/11/14), Individual #132 (7/15/14), Individual #266 (10/23/13), and Individual #287 (2/4/14). As such, the other assessments completed were not included for the following review of essential elements.	

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		The current state and local SSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the comprehensive communication assessments was as follows: • 4 of 4 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. • 4 of 4 assessments (100%) included diagnoses and relevance of impact on communication. This was consistent with the previous review. • 4 of 4 assessments (100%) included individual preferences and strengths. Ideas for how to integrate preferences into communication opportunities was not generally identified in these assessments. This was consistent with the previous review. • 4 of 4 assessments (100%) included medical history and relevance to communication. This was consistent with the previous review. • 4 of 4 assessments (100%) listed medications and discussed side effects relevant to communication. This was consistent with the previous review. • 4 of 4 assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 33%. This was consistent with the previous review. • 4 of 4 assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was consistent with the previous review. • 4 of 4 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. • 4 of 4 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 changes as required. This was consistent with the previous review. • 4 of 4 assessments (100%) included discussion of the expansion of the individuals' current abilities. This was consistent with the previous review. • 4 of 4 assessments (100%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 89% in the previous review. • 4 of 4 assessments (100%) included the effectiveness of current supports, including monitoring findings. This was an improvement from 44% in the previous review. • 4 of 4 assessments (100%) assessed AAC needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC. This was consistent with the previous review. • 4 of 4 assessments (100%) offered a comparative analysis of health and	

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		functional status from the previous year. This was consistent with the previous review. • 4 of 4 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was consistent with the previous review. • 4 of 4 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was consistent with the previous review. • 4 of 4 assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was consistent with the previous review. • 4 of 4 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 4 of 4 assessments (100%) supplied a monitoring schedule. This was consistent with the previous review. • 4 of 4 assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an improvement from 89% in the previous review. • 4 of 4 assessments (100%) made a recommendation about community referral and transition. This was consistent with the previous review. • 3 of 4 assessments (75%) included specific recommendations for services and supports in the community. This was a decrease from 100% in the previous review. Even in the case that the clinician did not recommend community placement at that time, the supports required and barriers to placement should be identified, so that these may be addressed. The clinician provided a clear rationale for why she did not recommend community placement and why the current placement was appropriate. This was a difficult call though, as the individual presented with dementia and was 84 at the time of the assessment. Many older individuals with dementia successfully experience a change in environment, but require careful consideration to minimize stress and confusion. Suggestions of this nature would be important to outline. • 4 of 4 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: • 3 of 4 assessments (75%) contained 100% of the 23 elements listed above. One assessment was missing one element. • The average for all four assessments was 99%. • There were improvements noted for three elements and one was decreased,	

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		while the others remained consistent with the previous review at 100%. It was reported that self-audits were conducted with findings consistently between 94% and 96% compliance during the last six months. Inter-rater reliability was reported to be 92% during the same period. Four current Assessments of Current Status (ACS) were submitted for Individual #251 (9/4/13), Individual #66 (2/3/14), Individual #38 (4/29/14), and Individual #134 (3/24/14) and included in Sample R.1. Eleven others submitted were part of Sample R.3 and R.4, though most of these were not included in the following metric because they were submitted as assessments only, without the associated comprehensive assessments as per the request. The Comprehensive Assessment (6/19/12) and subsequent Assessments of Current Status (6/3/13 and 5/21/14) were submitted for Individual #338 and, as such, was included in the following metric: • 4 of 5 Assessments of Current Status (80%) were completed consistent with the established schedule, the individual's need, and/or previous recommendations, and the associated comprehensive assessment was present in the individual record. There was no evidence of a Comprehensive Assessment or subsequent ACS (2013) in the individual record for Individual #134, though reference was made to a Comprehensive Assessment dated 6/29/12. Each of the Assessments of Current Status (the most current format for annual updates) submitted included the following minimum requirements: • The individual's 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 and re-assessment schedules. <u>SLP and Behavioral Health Collaboration:</u> There were approximately 33 individuals identified with behavioral issues and co-existing severe nonverbal or limited verbal skills. There were 106 individuals listed with PBSPs who also had replacement behaviors related to communication. At least 11 individuals in Sample R.1 were listed with a PBSP, and each was submitted in their individual record. Eight of these were current within the last 12 months (all but Individual #132, Individual #137, and Individual #384). Only five individuals with PBSPs had current communication assessments (Individual #132, Individual #384, Individual #134, Individual #251, and Individual #38). Individual #26 had been provided a screening on 1/2/13 that indicated she had no need for communication	

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		supports, yet it was noted that she was listed as having communication-related replacement behaviors associated with her PBSP. Thus, based on review of the current plans and communication assessments, only three individuals had both current assessments and PBSPs (Individual #38, Individual #251, and Individual #134). The following was noted related to these: • For 2 of 3 current communication assessments (67%) in Sample R.1 for individuals with identified challenging behaviors, there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. For Individual #38's assessment, there was no reference to his PBSP and target behaviors. For Individual #134, the function of his target behaviors were identified as escape and replacement behaviors were designed to teach him safe and effective ways to get his wants and needs met. But, clear communication methods to accomplish this were not identified by the clinician. Individual #251 also had a plan to address physical aggression. Both Individual #38 and Individual #134 were listed with replacement behaviors related to communication. • 2 of 3 communication assessments and PBSPs reviewed (67%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • 2 of 3 communication assessments (67%) contained evidence of review of the PBSP by the SLP. • For 0 of 3 individual (0%), communication strategies identified in the assessment were included in the PBSP. For Individual #134, the PBSP referred to a communication board not identified in his communication assessment. A voice output device was recommended in the assessment for Individual #38, but was not referenced in his PBSP. The social story book recommended in the assessment for Individual #251 was not integrated into his PBSP. A plan should be developed to ensure that individualized communication strategies are clearly outlined in the communication assessments, so that these may be accurately integrated into the PBSPs. • For 3 of 3 individuals (100%), communication strategies identified in the assessment were included in the ISP. Though the relationship to behavior supports were not clear. The following metric was not addressed because the Behavioral Health Meeting minutes that were submitted did not include a sign-in sheet to determine if any SLPs attended: • Based on review of the Behavior Health Committee meeting sign-in sheets from ________ through ________, participation by a SLP was noted in __ of __ meetings (%). Habilitation Therapies did not appear to track this information. • Facility staff reported that these meetings were not productive as they used to	

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		be because PBSPs were completed by the time this meeting occurred. Participation in the review of PBSPs during these meetings was one opportunity for collaboration between behavioral health and speech staff. There should be an effort to develop collaborative replacement behavior goals related to communication and to ensure that recommended communication strategies were consistent. By report, this was often not possible at the behavioral health support meetings because the PBSPs were finalized prior to their review. 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 Health Committee and, in that case, the facility is encouraged to document those efforts. There may be other means to accomplish this beyond the PBSP meetings, particularly during the pre-ISP planning and during the assessment process. The communication assessments did not consistently report communication and behavioral health issues related to the interpretation of the functions of target behaviors and whether there was a communication component. The facility self-rated this provision not in substantial compliance, and the monitoring team concurred. In order to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Include clearly stated communication strategies in the assessments (including how the individual communicates, as well as, how staff would best communicate with them). 2. Ensure better integration of these strategies in the PBSPs and ISPs. 3. Implement a plan to ensure timeliness of assessments. 4. Ensure that Comprehensive Assessments were contained in the individual records with subsequent ACSs.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Attendance at the annual ISPs for individuals was reviewed. Pre-ISP required attendance sheets were submitted for individuals in sample R.1. Only half of the individuals in the sample had a current communication assessment. Each of the pre-ISPs (with the exception of Individual #104) indicated that a communication assessment was needed. • For 13 of 14 individuals (93%), a SLP was in attendance at the ISP. A SLP was not designated to attend per the pre-ISP in four cases (Individual #26, Individual #126, Individual #137, and Individual #132). A SLP was present at all meetings with the exception of Individual #26. • For 3 of 14 individuals (21%), communication strategies identified in the assessment were included in the ISP. • In 10 of 12 ISPs for individuals with communication supports (83%), the type of	Noncompliance

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		AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for only 3 of 13 (23%), as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. • 12 of 14 ISPs (86%) included a description of how the individual communicated, though some provided a very limited description, and most were not guided by a current communication assessment. • 6 of 12 ISPs (50%) contained skill acquisition programs to promote communication. Some identified the need for SAPs, but these were not consistently translated to the ISP action steps. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was not consistently addressed in the ISPs reviewed. Few ISPs outlined that the dictionary was reviewed and that modifications were or were not required. Most had a brief summary of how the individual communicated, but had little as to how staff should communicate with them. The communication strategies outlined in the communication assessments were limited. The clinicians should clearly outline individualized communication strategies for staff to use with each individual that best complements how they communicate and understand others, and/or can enhance the effectiveness of their communicative efforts, to include the use of AAC. Consistent integration of these by listing them in the ISP would be a useful practice. <u>Individual-Specific AAC Systems:</u> By report, approximately 59 individuals had been provided one or more communication supports. There were 14 of those listed who were provided a communication dictionary only. 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. There were 33 individuals who were identified with behavioral health concerns and a coexisting severe language deficit. Each of these individuals was included in the group of 59 with a communication support of some kind, with the exception of Individual #137, whose system was reported to be discontinued. Seven of these were listed with communication dictionaries only. Only 25 of the 59 (39%) had a current assessment. The systems were generally portable, functional, and individualized. Individualized AAC device instructions were developed in most cases to provide a picture of the device and	

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		to clearly outline the purpose with staff instructions for use and care of the device. These generally appeared to be functional, though for Individual #104, on 7/30/14, his talking photo album was in the home manager's office and not readily accessible to him. There were only three individuals listed as participating in direct communication therapy intervention during the last six months (Individual #331, Individual #266, and Individual #389). No one was listed as participating in direct therapy at the time of this review. 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, such as to request a favorite item, food, beverage, music, vibration, or massage Communication dictionaries (CD) were also provided to many individuals (approximately 52 individuals were listed). Changes needed to the CDs were not specifically outlined in the ISP. In some cases, review and changes were stated as needed, but not specifically outlined, even in the communication assessments. 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. <u>Direct Communication Interventions:</u> There were approximately three individuals listed as having participated in direct communication-related interventions provided by the SLP. Records related to the provision of direct intervention for a sample of these individuals were reviewed (Individual #331, Individual #266, and Individual #389). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 0 of 3 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. In the case of Individual #389, this could not be determined because there was no assessment justifying the initiation of direct communication therapy on 10/7/13. The first documentation related to this intervention was noted on that date. There was no documentation of direct communication therapy for Individual #266 or Individual #331 submitted. • For 1 of 3 individuals (33%), an SLP assessment identified the need for direct intervention with rationale. The note written on 10/7/13 for Individual #389 was not an assessment, but rather documentation of the first session of intervention. An annual Assessment of Current Status was completed two	

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		months later on 12/5/13 that identified a need for continued therapy. The current assessments for Individual #266 and Individual #331 identified a need for direct therapy, but there was no evidence that this had been provided.
		• For 0 of 3 individuals (0%), there were measurable objectives related to individual functional communication outcomes included in the ISP/ISPA. The ISP for Individual #331 indicated that she was to participate in articulation therapy, but no measurable goals were outlined. There were no ISPAs submitted related to communication for any of these three individuals. Interestingly training had been conducted with the QIDPs related to ISPAs for the initiation and discharge of Habilitation Therapy services. This was a positive step, but this process must begin with an appropriate assessment by the clinician.
		• For 1 of 3 individuals (33%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). Documentation revealed poor implementation in many cases, and notes written were generally anecdotal rather than data based.
		• For 1 of 3 individuals (33%), there was a description of the benefit of the device and/or goal to the individual in the progress notes and/or monthly summaries.
		• For 0 of 3 individuals (0%), consistency of implementation was documented. Days on which therapy occurred was clearly documented for Individual #389, as well as, the duration. Frequency was not stated, however.
		• For 1 of 3 individuals (33%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. There was no evidence of documentation by any clinician for Individual #331 or Individual #266 to determine whether progress had been made and that recommendations for changes to the plans were indicated. For Individual #389, monthly summaries were noted for November 2013 and December 2013, but not for January 2014 or February 2014.
		• For 0 of 3 of individuals for whom direct intervention had been discontinued (0%), termination of the intervention was well justified and clearly documented in a timely manner. Each of the three individuals reviewed were listed as discharged from direct therapy (Individual #389, 3/27/14; Individual #266, 3/27/14; and Individual #331, 4/17/14).
		• 1 of 3 individuals (33%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the generally accepted indicators listed below:
		  ○ Contained information regarding whether the individual showed progress with the stated goal.
		  ○ Described the benefit of device and/or goal to the individual.
		  ○ Reported the consistency of implementation.
		  ○ Identified recommendations/revisions to the communication	

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		intervention plan as indicated related to the individual's progress or lack of progress. ○ Completed at least monthly. Data collection was addressed for each session. A monthly notation summarized overall progress for the month. There were session notes written for Individual #389 through 2/13/14 and they stated whether therapy had occurred on a specific day, but there was no evidence of review at least on a monthly basis to address each of the elements above after 12/5/13. The documentation described did not meet the standards of generally accepted professional standard of care. Therapy was often recommended, but there did not appear to be an adequate focus on the provision of these interventions and review and documentation of intended outcomes. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication plans, communication dictionaries, general use AAC, and communication-related SAPs. AAC supports were identified in the annual assessment and described in the PNMP and, in some cases, individual communication plans, including pictures of specific devices in conjunction with the PNMP. Other indirect supports should be developed in the form of SAPs implemented by DSPs in the home, day program, or work areas specifically related to communication and reviewed at least quarterly by the SLPs. There were a number of SAPs developed for replacement behaviors, though SLP involvement in the development of these and routine monitoring was not clear. SLPs are also encouraged to work closely with the program developers on new or existing SAPs (not only those related to communication) to ensure that communication strategies are well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended. This requires real-time modeling and coaching. Documentation for individuals who received indirect communication supports (SAPs or PNMPs that included communication supports) 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 in the ISP.	

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		• Staff instructions provided for individuals' AAC devices, including written step-by-step instructions and pictures. Competency-Based Training and Performance Check-offs: 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. A revised curriculum (6/30/14) appeared to be comprehensive in content. Class time included five hours only to address general communication, deaf awareness, and AAC. 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 as, strategies for use as an effective communication partner. This included: • 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	

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		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 an 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. 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. The training materials should address the minimum foundational content areas below: • Identification of nonverbal means of communication. • Strategies to enhance individual participation in routines throughout the day • How to be an effective communication partner • Methods to enhance communication • Implementation of communication plans and programs • Benefits and use of AAC • 100% of the 180 new employees required to attend communication training from 2/1/14 through the time of this review had completed NEO core foundational skill training and passed performance check-offs based on the participation reports submitted. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs. • 100% of the 249 staff required to take the Annual Refresher class related to communication successfully passed the competency check-offs based on the participation reports submitted. • There was a system to establish and maintain competency for staff who provided the training.	

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		Individual-Specific Competency-Based Training The facility had established a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. 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 training curriculum (red dot system). This type of training required competency check-offs in order that staff could implement that element. There were no individuals identified with non-foundational components related to communication at the time of this review. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though improvements continued, there was insufficient integration of communication supports and services into the ISP and inconsistencies related to the provision and documentation of direct therapy. 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 consistent with the individual's communication function and methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Address the consistency and necessary elements of documentation of direct interventions. 4. Refine the system of effectiveness monitoring to address inconsistencies related to review of communication supports.	
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	Compliance Monitoring of Implementation of Communication Supports A system of compliance monitoring was established at SGSSLC using the Communication-Home Competency/Compliance tool. This form addressed the interactions between the staff and individual, but did not address whether communication supports were available, in good working condition, and implemented as intended. The following were implied, but not directly addressed: • Plan was current and available. • When equipment was used, staff responded. Completed forms for communication-related compliance monitoring conducted in the last month were requested (CC.900) for the individuals in Sample R.1 with communication supports (14 individuals). There were 11 forms for six individuals. Also,	Noncompliance

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	and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	monitoring forms completed in the last month were requested (XV.12). Only 14 forms for 12 individuals, including three duplicates for two individuals from sample R.1 (Individual #251 and Individual #288) were submitted. For one additional form completed on 5/31/14, the individual was not identified. Each of these was marked as a staff compliance skill drill. Though it was reported that monthly equipment checks were conducted by the home manager and PNMPCs, it was of significant concern that equipment could be missing or not working for three months or more. Upon review of the forms submitted, the following was noted: • Nearly half of the completed forms reported that staff were not able to demonstrate how to use basic AAC devices, yet in only two of these did the staff score less than 80%, the established standard for compliance at the facility. • In at least three cases, AAC equipment was recorded as missing, but follow-up was not indicated on the form. 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. The intended frequency for staff compliance monitoring was at least annually. Additional monitoring was conducted, selected randomly throughout the year. Each skill area had a set sample size (16) to be conducted monthly plus additional based on identified individual need. The frequency of compliance monitoring was staff based rather than per individual and only a random sample of was monitored each month and as such did not include all individuals provided a communication device.–Effectiveness monitoring also did not appear to routinely include all individuals who were provided a communication system. Neither method appeared to be entirely effective due to identified concerns for implementation and availability of equipment. All equipment should be effectively monitored routinely (at least monthly) for availability, condition, and working order with routine general check-offs that the systems were implemented as intended. Communication dictionaries should be monitored for availability, effectiveness, and whether staff understand how to use them. This did not appear to be consistent. <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	

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		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 health and functional status of the individual since the previous review, 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 of findings in the individual record (IPNs). Documentation 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 In sample R.1, effectiveness monitoring conducted in the last six months was requested for each of the 14 individuals relative to PNM/Communication plans. This was consistently noted in each of the individual records, but the focus appeared to be primarily on the PNMP with limited reference to communication supports. In most cases, it referred primarily to the presence and working condition of all PNM/Communication equipment. Effectiveness monitoring was completed by all Rehabilitation Therapists and, as such, OTs and PTs would be unlikely to appropriately assess the effectiveness of communication plans and the actual use of communication systems, beyond the presence of equipment. This process consisted of the completion of a worksheet, then documentation of findings and recommendations in an IPN. In some cases, problems identified were not addressed in a timely manner. For example, Individual #180's communication board was reported to be missing on 11/11/14 and the recommendation was that a referral be made to the SLP. In reviews on 1/14/14 and 2/3/14, the board was still reported to be missing. His PNMP identified that he used a communication book. No further monitoring conducted after 2/3/14 documented whether this issue had been resolved. Individual #104's Communication Dictionary was out of date on 4/30/14, 5/7/14, and 6/30/14. It was documented that this would be updated as of 7/8/14. There was no documentation that this had been resolved as of 7/30/14. As reported above, Individual #104's talking photo album was reported to be in the home manager's office and clearly not readily accessible to him. His plan could not be deemed effective if he did not have ready access to his communication supports. In addition, he had not been provided a communication assessment since 8/17/12.	

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		The facility concluded that they were not in compliance with this provision of section R, and the monitoring team concurred 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. Review the consistency and accuracy of communication monitoring. 2. Continue to track findings of both effectiveness and compliance monitoring and timeliness of follow-up when issues are identified. 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. 3. Clearly document timely follow-up of issues identified in all monitoring conducted	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: ○ Individual Support Plans (ISPs) for: • Individual #9, Individual #86, Individual #295, Individual #237, Individual #104, Individual #365, Individual #37, Individual #277, Individual #134, Individual #24, Individual #280, Individual #349, Individual #201 ○ Skill Acquisition Plans (SAPs) for: • Individual #37, Individual #280, Individual #349, Individual #201, Individual #104, Individual #196, Individual #365, Individual #9, Individual #117, Individual #329, Individual #165, Individual #77 ○ Monthly review of SAP progress for: • Individual #37, Individual #349 ○ Functional Skills Assessment (FSA) for: • Individual #37, Individual #280, Individual #349, Individual #201, Individual #104 ○ Personal Strengths Inventory (PSI) for: • Individual #280, Individual #349, Individual #201, Individual #37, Individual #104 ○ Vocational assessments for: • Individual #37, Individual #280, Individual #349, Individual #201, Individual #104 ○ Section S Presentation Book, undated ○ Section S Self-Assessment, 7/24/14 ○ Section S Action plans, 7/21/14 ○ A list of employees that have gone through the ATSAP refresher from 9/6/13-7/25/14 ○ Home observation active treatment/engagement form, 3/14 ○ List of assessments submitted at least 10 days prior to ISP for June 2014 ○ Monthly summary review form, 9/13 ○ Program developer competency tool, 10/12 ○ Skill acquisition program competency review form, 1/14 ○ List of all instances of skill training provided in the community from 12/14-5/14 ○ Summary of community outings per residence from 12/14-5/14 ○ List of individuals employed on- and off-campus, undated ○ Description of on-campus and off-campus work programs, undated ○ List of individuals who were under age 22 and their public school educational status ○ ISPs, IEPs, and public school report cards for • (none) ○ Documentation of review of public school report cards for • (none)

- Minutes from one meeting with Water Valley ISD public school, April 2014

Interviews and Meetings Held:
- Vanessa Barrientez, QIDP Coordinator; Trisha Trout, Unit 1 Director; Billy Walker, Program Resource Supervisor; John Church, Assistant Director of Behavioral Health Services; Lynn Zaruba, BCBA, Clinical Supervisor
- Billy Walker, Program Resource Supervisor
- Vicki Hinojos, Vanessa Barrientez, and Chris Sandoval, public school liaisons

Observations Conducted:
- SAP implementation for:
  - Individual #365
- SAP integrity session for:
  - Individual #365
- SAP peer review committee meeting
- Pre ISP meeting for:
  - Individual #148
- Pretreatment Sedation meeting
- 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 self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be based on the monitoring team's report. SGSSLC's self-assessment consistently included a review for each provision item, a list of 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 allowed the facility and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues.

The monitoring team wants to acknowledge the efforts of the facility in completing the self-assessment, and believes that they continued to proceed in the right direction.

SGSSLC's self-assessment indicated that S3b was in substantial compliance, and all other items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was that all items in this provision were in noncompliance. The reasons for this discrepancy are discussed below.

	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: • Improvement in the quality of skill acquisition programs (SAPs) (S1) • Addition of SAM/HIP to the new SAP format (S1) • New monitoring tool to improve SAP documentation (S1) • Added engagement monitoring to the program areas (S1) • New monitoring tool was developed to ensure that SAPs were based on assessment results (S2) • New monitoring tool and new procedures to ensure that SAPs are implemented as written (S3) • Improvement in the percentage of community trips that include a SAP training opportunity (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that instructions following an incorrect response are specific and tailored to individual (S1) • Ensure that SAP data are accurately recorded (S1) • Ensure that SAP objectives and SAP data sheets are consistent (S1) • Ensure that SAP task analyses are consistently complete (S1) • Ensure that training instructions are consistently clear (S1) • Increase the percentage of individuals that attend day programming (S1) • Improve individual engagement in the residences (S1) • Document that functional skills assessments, and preference and strengths inventories 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) • Ensure that all individuals have monthly SAP summaries (S3) • Establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3)

#	Provision	Assessment of Status	Compliance
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,	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. Skill Acquisition Programming Individual Support Plans (ISPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition programs (SAPs). These plans were written by three 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

#	Provision	Assessment of Status	Compliance
	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.	An important component of effective skill acquisition programs 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. Twenty-six SAPs across 12 individuals were reviewed to determine if they were functional and practical. In 25 of the 26 SAPs reviewed (96%), the rationale appeared to be based on a clear need and/or preference. This represented a dramatic improvement in the percentage of SAPs judged to be practical and functional from the review (82%). Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology All of the SAPs reviewed contained all of the above components. Additionally, the quality of some of these components was improved. For example, 96% of all SAPs reviewed had acceptable generalizations plans and 100% of the maintenance plans reviewed were judged to be complete. One common shortcoming of the SAPs reviewed, however, was unclear training instructions following an incorrect response. The majority of SAPs reviewed contained the same statement that reinforcement should be withheld and trainers should follow the next levels of training prompts. Including specific training prompts tailored to each individual is important because it is likely that some prompts with some individuals (e.g.,	

#	Provision	Assessment of Status	Compliance
		hand-over-hand guidance) could lead to behavioral issues that would interfere with learning. Additionally, "taking a break" following a refusal may be the most effective training strategy with other individuals. As discussed in more detail in S3, it is recommended that specific and individualized training instructions following a refusal or in correct response be included in all SAPs. As noted in the last review, some of the task analyses were unclear. Some of the steps in the task analyses appeared to be out of order. For example, the steps of the task analysis appeared to be out of order for the bathing SAP for Individual #349 (i.e., exiting the tub was step 1, and using soap was step 4). The task analysis for Individual #201's SAP to learn to tolerate routine dental procedures included both individual behavior (e.g., sit in the dental chair) and staff behavior (offer encouragement). Additionally, some of the general instructions were unclear. For example the general instructions for Individual #201's SAP of brushing teeth instructed staff to ensure he brushed his teeth for no more than two to three minutes or as long as he tolerates. If he only tolerated three seconds of brushing, would that be recorded as complete? The monitoring team also found examples of the behavioral objective or the general instructions not being consistent with the data sheet. For example, Individual #201's eat safely SAP objective was to eat safely with two to three verbal prompts. The data sheet, however, listed a prompt level of 2, another prompt level as more than two verbal prompts. If that level of prompt was recorded, it is impossible to determine if Individual #201 achieved the objective (e.g., he required three prompts) or did not achieve the objective (e.g., he required four prompts). Finally, the facility continued to struggle with the documentation of SAPs. Six of the 17 data sheets reviewed (35%), for example, contained errors in the recording of the data. This is consistent with SGSSLC's data that indicated from 12/13 to 5/14 there were documentation errors on 36% of the data sheets they reviewed. It is very important that the facility ensure that SAP data are consistently recorded accurately. The monitoring team was encouraged by the continued progress in the quality of the SAPs at SGSSLC. Additionally, several of the issues discussed above were being addressed at the SAP peer review observed by the monitoring team, and/or by the use of new monitoring tools (e.g., revised competency reviews requiring the demonstration of documentation skills, see S3). It is recommended that the facility ensure that all DSPs are trained in the recording of SAP data, and that all SAPs contain accurate examples of all of the above components.	

#	Provision	Assessment of Status	Compliance
		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 had been working cooperatively with them to ensure that individuals were getting the necessary routine dental care, however there had been no formal method to document if necessary follow-up occurred. The dental and behavioral health services departments will begin to meet regularly to track individual progress/needs. The overall use of sedating medications continues to be reviewed (see section Q2) and will be used as measure of the success of these plans/strategies. 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. 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 (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 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	

#	Provision	Assessment of Status	Compliance
		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. The monitoring team observed individual engagement in both the residences and the day programs. As found in past reviews the ability to maintain individuals' attention and participation in the activities varied widely across the residential settings, while engagement continued to be consistently good in the day programs (it averaged 92%). The facility recently extended their monitoring of engagement to include the day programs. As discussed in past reviews the major concern with the day programs was attendance. Despite developing a performance improvement plan to improve day program attendance, it continued to be poor. Attendance during the month of May 2014 was 40%, which compared to the last review when it was 38%. It is recommended that SGSSLC continue to work to increase day program attendance. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 72%, an improvement from the last review when 64% of individuals were found to be engaged. The self-assessment indicated that individual engagement in the residences was 77% in May 2014, and 94% in the day program. At the last review the facility established 70% as the goal level of engagement in the residences. It is recommended that SGSSLC now establish a goal level of individual engagement in the day programs, and ensure that they achieve those goals. Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
511	1/2	1:2
Building Imagination	2/2	1:2
Building Imagination	2/2	1:2
Suzy Crawford Center	5/5	5:5
Vocational Building	1/2	2:2
Vocational Building	2/2	0:2
Vocational Building	2/2	1:2
Vocational Building	9/11	3:11
Vocational Building	9/9	2:9

#	Provision	Assessment of Status	Compliance

504 B	4/5	2:5
508 A	1/3	2:3
508 A	1/2	1:2
508 B	1/1	1:1
501 B	4/4	2:4
510 A	0/4	2:4
510 A	1/4	2:4
510 B	1/2	1:2

Educational Services
SGSSLC continued to maintain an excellent working relationship with the Water Valley Independent School District. The school principal and superintendent remained the same. Six students received educational services since the last onsite review. All six attended school at the WVISD campus, an improvement since the last review. The new school year was to begin the Monday following this onsite review.

The QIDP coordinator Vanessa Barrientez and the QIDP educator Chris Sandoval (who was also the QIDP for the students for four of the six) remained 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 April 2014. Relevant topics were discussed.

SGSSLC QIDPs and other staff (e.g., house manager, behavioral health specialist, RN) attended every ARD/IEP meeting.

Overall, students were attending school, graduating, and receiving their diplomas. The students were fully included for art, music, and physical education. There was discussion with the school about other classes, but the students' academics were far behind and they needed the more intensive instruction provided in their special education classrooms.

Students were given vocational training opportunities within the school. Individual #99 worked as a teacher assistant and Individual #70 worked as an office assistant. These were the types of experiences in which general education students also participated.

Four students attended prom and participated in graduation ceremonies with other students. Individual #43 went to a special awards banquet, and received an award for being a member of football team.

#	Provision	Assessment of Status	Compliance
		The facility's classroom observation tool was reinstated. WVISD progress notes were given to QIDPs for IDT review. These were included in the monthly reviews done by the QIDPs. The monitoring team was unable to review any ISPs or ARD/IEPs because, of the six students, all ISPs and ARD/IEPs either occurred prior to the previous monitoring review or hadn't yet occurred (for the new students). Extended school year was reviewed for each student and determined not required. This occurred during ARD/IEP meetings and during the facility's meeting with WVISD administration in April 2014. The monitoring team does not have any additional recommendations for the facility's support of educational services for students at SGSSLC.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	There were improvements in this area. This item was rated as noncompliance, however, because only 68% of SAPs reviewed were clearly based on assessments, and functional skills assessments and preference and strengths inventories were not consistently available to team members at least 10 days prior to each individual's team meeting. 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. Tracking data from 5/14 indicated that an average of 60% of FSAs, 73% of the PSIs, and 88% of vocational assessments were completed 10 days prior to the ISP. This was an improvement from the last review when only 56% of FSAs were completed at least 10 days prior to the ISP, and vocational assessment tracking data were not available. This is comparable to the last review for the PSIs, when 75% were completed at least 10 days prior to the ISP. FSA and PSI assessments need to be more consistently completed 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. Overall, these five individuals had a total of 19 SAPs, and 13 of those (68%) had documentation that assessments were used to develop them. This is comparable to the last review when 67% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #104's ISP and SAP rationale indicated that he was at high risk for aspiration/respiratory comprise. Therefore, a SAP was developed for him to learn to operate a medical device to improve his lung function and increase his oxygen levels. • Individual #37's FSA summary and ISP indicated that he had dry and itchy skin. A SAP to learn to apply lotion to address his dry skin was developed. • Individual #280's PSI and ISP documented that she wanted to learn new types of exercise. Therefore, a SAP to teach her to use the Wii to exercise was developed. • Individual #349's ISP stated that his rehabilitation evaluation indicated that he had unsafe eating habits. Therefore, a SAP to teach him safe eating was implemented. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #280 had SAP to learn deep breathing. There was, however, nothing in her ISP, FSA, or PSI that suggested that this was a practical SAP for her, or that it was based on any assessment data. • Individual #201 had a SAP to learn to brush his teeth using physical guidance, however, his FSA indicated that he did brush his teeth using gestural prompts. SGSSLC recently introduced a new monitoring tool to ensure that SAPs were based on assessment results. The monitoring team looks forward to seeing the improvements in this area in subsequent reviews.	

#	Provision	Assessment of Status	Compliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	SGSSLC made progress on this provision item, however, more work is necessary before it will be in substantial compliance. Program trainers at SGSSLC summarized monthly SAP data. These reviews included graphed SAP data that lent itself to data based decisions concerning the continuation, discontinuation, or modification of SAPs. Monthly SAP summaries were requested for five individuals, however, three (Individual #201, Individual #280, and Individual #104) were missing. It is recommended that the facility ensure that all individuals have monthly SAP reviews that contain graphed data used to make data-based decisions concerning their continuation, discontinuation, or modification. SGSSLC continued to conduct SAP integrity monitoring to ensure that SAPs were implemented as written. The facility initiated several new procedures, since the last review, to ensure that SAPs are implemented with integrity. First, the SAP integrity monitoring form was modified to add a focus on the documentation of SAPs (a problem area discussed in S1). Another improvement was the development of a SAP refresher class, which was mandatory for all DSPs that scored less than 80% on two consecutive SAP integrity observations. The implementation of a SAP was observed by the monitoring team to evaluate if it was implemented as written, and to evaluate the treatment integrity procedure. For the SAP observed (Individual #365's SAP of reading), the DSP did not follow the SAP procedure following an incorrect response. As discussed in S1, however, the generic instructions following an incorrect response were unclear. Additionally, the DSP did not appear to understand when to move to the next step. Finally, the SAP was prematurely discontinued after 45 minutes (he was on page two of a five page worksheet) because Individual #365 was remarking that he was tired and appeared to be getting very distracted. The DSP did an excellent job of engaging and encouraging Individual #365, however, the SAP was clearly too complex for him. The program trainer, DSP, and unit supervisor all agreed that the reading SAP and worksheet needed to be modified.	Noncompliance

#	Provision	Assessment of Status	Compliance
		SGSSLC reported that their goal was that every individual would have a SAP integrity session at least annually. There were, however, no data available at the time of the onsite review indicating this frequency of SAP integrity goal was achieved. Additionally, available SAP integrity data indicated that during the month of May 2014, overall SAP integrity was 85%. The monitoring team was encouraged by the SGSSLC's commitment to ensure that SAPs are consistently implemented as written. At this point it is recommended that the facility ensure that goal SAP integrity frequency (i.e., how often it is assessed) and levels (i.e., SAP scores) are achieved.	
	(b) Include to the degree practicable training opportunities in community settings.	SGSSLC's self-assessment indicated that this provision item was in substantial compliance. Although there have been improvements, this item has been rated as noncompliance because community leisure and training goals have not been established. 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 tracked 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, from 12/13 to 5/14, 50% of community trips included SAPs. This represented a dramatic improvement from the last review when 18% 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, no individuals at SGSSLC had supported employment in the community. This is a decrease from the last review when two individuals had supported employment in the community.	Noncompliance

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	

	Steps Taken to Assess Compliance:
	
	<u>Documents Reviewed</u>:
	○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments
	    • State office guidance documents regarding special review process (November 2013) and potentially disrupted community transitions (December 2013)
	○ SGSSLC facility-specific policies regarding most integrated setting practices
	    • Continuity of Services, 2.1.01, updated 4/19/12
	    • Most Integrated Services, 2.1.31, 6/12/14
	○ SGSSLC organizational chart, June 2014
	○ SGSSLC policy lists, 6/25/14
	○ List of typical meetings that occurred at SGSSLC (not provided)
	○ SGSSLC Self-Assessment, 7/24/14
	○ SGSSLC Action Plans, 7/21/14
	○ SGSSLC Provision Action Information, 6/9/14
	○ SGSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book
	○ Presentation materials from opening remarks made to the monitoring team, 8/18/14
	○ Admissions Placement Department meeting minutes, 2/24/14-8/18/14 (16 meetings)
	○ Community Placement Report, last six+ months, 12/1/13 through 8/15/14
	○ List of individuals who were placed since last onsite review (14 individuals)
	○ List of individuals who were referred for placement since the last review (13 individuals)
	○ List of individuals who were referred <u>and</u> placed since the last review (1 individual)
	○ List of total active referrals (16 individuals)
	○ List of individuals who requested placement, but weren't referred (17 individuals)
	    • Documentation of activities taken for those who did not have an LAR (17 individuals)
	    • Those who requested placement, but not referred due to LAR preference (0 individuals)
	○ List of individuals who were not referred solely due to LAR preference (3 individuals))
	○ List of rescinded referrals (4 individuals)
	    • Blank updated SRT document, 4/14/14
	    • ISPA notes regarding each rescinding (4 of the 4)
	    • Special Review ISPA Team minutes for each rescinding (4 of the 4)
	○ List of individuals returned to facility after community placement (4 individuals)
	    • Related ISPA documentation (4 of the 4)
	    • Root cause analysis (somewhat)
	○ List of individuals placed in the past year, who experienced serious placement problems <u>since the last review</u>, 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 • 7 of 24 individuals who moved since 8/1/13, data as of 8/22/14 ○ Completed Potentially Disrupted Community Transition forms for many of the above events ○ Blank updated PDCT form, 4/14/14 ○ List of individuals who died after moving from the facility to the community since 7/1/09 (4, 0 since the last review) ○ List of individuals discharged from SSLC under alternate discharge procedures and related documentation (4 individuals) ○ APC weekly reports • Detailed referral and placement report for senior management, (0) • Statewide one page weekly enrollment report (4) ○ Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair • Community tours • Work with local LA • Work with local providers • Facility-wide staff trainings/activities • For individuals • For families ○ Description of how the facility assessed an individual for placement ○ 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) ○ List of individuals who had a CLDP completed since last review (14, including Individual #53) ○ Description of how CLDP discharge assessments were tracked/managed ○ Mock discharge assessment examples for behavioral health and medical departments ○ Documentation of day of move items (1) ○ SGSSLC APC CLDP self-assessment tool, April 2014-June 2014 (6) ○ QA related activities and documents • QA reports for last six months (2 quarterly reports, May 2014 and August 2014 [August was the handout presented in the August 2014 QI Council meeting) • QI Council presentations (2, May 2014 and August 2014) • Completed self-monitoring tools for CLDP (2), post move monitoring (2), and alternate T4 transitions (1) • QA data listing inventory, 7/16/14 ○ State obstacles report and SSLC addendum, March 2014 ○ SGSSLC obstacles databases, one for referral (8/20/14) and one for transition (8/26/14) ○ PMM tracking sheet, 7/14/14 ○ PMM response to the four bulleted items in the previous monitoring report, 8/22/14 ○ Transition T4 materials for: • Individual #34, Individual #79, Individual #378 ○ ISPs for:

	- Individual #134, Individual #200, Individual #365 ○ Draft ISP used during the ISP meeting: - Individual #50, Individual #130, Individual #57 ○ CLDPs for: - Individual #53, Individual #182, Individual #35, Individual #316, Individual #208, Individual #170 ○ Draft CLDP for: - (none) ○ 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 #220: 90 - Individual #162: 7, 45 - Individual #310: P, 7, 45, 90 - Individual #194: P, 7, 45 - Individual #108: P, 7, 45 - Individual #205: P, 7, 45 - Individual #163: P, 7, 45 - Individual #244: P, 7 - Individual #47: P, 7 - Individual #170: P, 7 - Individual #394: P, 7 - Individual #208: P, 7, 45 - Individual #316: P, 90 - Individual #35: P, 45 - Individual #182: P, 45 Interviews and Meetings Held: ○ Tim Welch, Admissions and Placement Coordinator ○ Denise Copeland, Post Move Monitor; James Reid, Janet Jordan, Facility Transition Specialists; Donnie Varela, Transition Specialist Observations Conducted: ○ CLDP meeting for: - (none) ○ ISP and pre-ISP meetings for: - Individual #50, Individual #130, Individual #57 ○ Living options discussion meeting for: - (none) ○ Community group home and day program office visit for post move monitoring for: - (none)

	○ Admissions and Placement Department meeting, 8/18/14
	Facility Self-Assessment The self-assessment was in the same format as used during previous compliance reviews. Therefore, the activities engaged in by the APC and his staff did not look at the same items looked at by the monitoring team. Thus, the results were not valid or comparable to the monitoring team's report. The monitoring report now contains metrics within each provision. Each metric is preceded by a letter. The APC should use these to develop her next version of the self-assessment.
	Summary of Monitor's Assessment The SGSSLC admissions and placement department (APD) made progress in many areas of section T, however, a high rate of returns and behavior problems in the community continued to occur. The number of individuals placed was at an annual rate of about 13%, an increase since the last review and more consistent with the rate of placements seen over the past few years. 14 individuals were placed in the community since the last onsite review. Sixteen individuals were on the active referral list. Seventeen individuals were described as having requested placement, but were not referred. All had an appropriate review, appeal, and or lack of consensus review (or one was in process). Obstacles to referral were identified for some, but not all, individuals who were not referred. Most individuals did not have action plans developed to address the specific reasons for why they were not referred. During annual ISP meetings, the verbal presentation by each IDT member of his or her determination and opinion about community living and referral helped set the stage for a more robust living options discussion than would have otherwise likely occurred. Once referred, reasonable activity and actions occurred related to the transition and placement for most individuals. There were problems with the availability of providers competent to support individuals with challenging psychiatric and behavior problems in many geographic areas of the state. In some geographic areas, there were very few providers at all, and those that were available were not competent to support the types of individuals who were on the referral list. As a result, IDTs (and LARs) made poor choices and individuals suffered (e.g., psychiatric hospitalization, return to the facility). CLDPs were initiated within 14 calendar days of referral and included documentation to show that they were updated throughout the transition planning process. IDT members actively participated in the transition planning process.

	The APC developed a checklist to self-assess each of the CLDPs for the items in T1c1, T1d, and T1e. Overall, there was good agreement between the APC's self-ratings and the monitoring team's findings. The facility continued to struggle with providing discharge assessments that addressed how preferences, supports, and services could be provided in the community in the individual's specific new home, day, work, and community settings. The APC and the facility took a number of actions over the past few months to improve the quality and usefulness of the discharge assessments. There were 4 re-admissions. There were now 22 returns since monitoring began in 2010. At least three other individuals continued to display serious problem behaviors that made it likely they would also return to the facility. Quality assurance activities were improved. Some analysis of the many problems that occurred with individuals' placements was done, but little useful information was gleaned by the facility. Given the high rate of returns to the facility and the seriousness of each case, the APC should involve more members of the QI Council in identifying trends and themes and developing actions to make improvements. For instance, the monitoring team identified a number of variables that should be explored further, such as the occurrence of behavior problems in the first week of placement, housemate problems, cigarette and tobacco issues, lack of spending money, absence of crisis intervention plans, and many problems with psychiatric services and medication management/changes in the community. Post move monitoring occurred as required, however, the occurrences of behavior problems within the first week of moving (i.e., identified at the 7-day reviews) were not acted upon. Discharge summaries for alternative discharges (T4) were adequately prepared prior to the individual's move.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	<u>Placement Department Staff</u> The SGSSLC admissions and placement department (APD) made progress in many areas of section T. This was due, in part, to more attention being paid to the comments and suggestions made in previous monitoring reports. For instance, actions were taken in response to the need for quality improvement activities (T1a, T1f) and engaging in self-assessment of the detail of CLDP support lists (T1c1, T1e). The entire APD staff remained the same since the last review. Moreover, many of the staff had been working for a number of years in their current positions. This stability contributed to the progress made. The department was led by Tim Welch, the Admissions and Placement Coordinator (APC). The other four staff were the Post Move Monitor (PMM) Denise Copeland, Placement Coordinators James Reid and Janet Jordan, and Transition Specialist Donnie Varela. 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. A brief root cause analysis type topic was described in about a third of the meetings. The facility's transition committee continued to meet almost weekly, too. The APC reported that they were nearing initiation of the long-talked-about transition home and the oft-hoped-for QIDP assigned to the AP department. The QIDP was to focus upon referral- and transition-related ISPAs and living option discussions. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 13%, an increase since the last review and more consistent with the rate of placements seen over the past few years. 14 individuals were placed in the community since the last onsite review. This compared with 8, 19, 18, 12, 13, 10, 10, and 17 individuals who had been placed at the time of the previous monitoring reviews. Referrals: • 13 individuals were referred for placement since the last onsite review. This compared with 18, 28, 18, 12, and 23 individuals who were newly referred at the time of the previous reviews. ○ 5 of the 13 individuals were referred and placed since the last review. This compared with 2 at the time of the last review. • 16 individuals were on the active referral list. This compared with 18, 19, 23, 27, 33, 27, 21, and 19 individuals at the time of the previous reviews.	Noncompliance

		- 5 of the 16 individuals were referred for more than 180 days. This compared to 1 at the time of previous review. - 2 of these 17 individuals were referred for more than one year. This compared to 0, 2, and 1 at the time of previous reviews. <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 6 CLDPs and 1 ISP for individuals who had been placed or who were on the referral list, 7 (100%) individuals and/or LARs did not oppose transition to the community. <u>Responding to individual requests and rescinded referrals</u> There were 4 rescinded referrals since the last review. This compared to 7, 9, 4, 9, 2, 3, 5, and 4 at the time of the previous reviews. Documentation (ISPA notes, ISPs, and/or SRT) was provided for 4 of the 4 individuals regarding the reasons for the rescinding. b. Of these 4, the reasons for the rescinding appeared to be reasonable for 4 (100%). • All were related to serious behavior outbursts or psychiatric symptom manifestation. Examples included tantrum behavior and social-sexual problem behaviors, such as following women and soliciting sexual activity while on site visits to potential providers. An adequate review to determine if changes in the referral and transition planning processes at the facility was conducted for 2 (50%) of the rescinded referrals. Of these reviews, actions were recommended in 2 (50%) cases. Of these, actions were implemented for 0 (0%). • It was good to see the facility engaging in discussion of process improvement based upon these rescindings. Examples included paying extra attention to an individual when there was a delay between referral and initiation of site visits to potential providers, IDT alertness to an individual's refusal to attend therapy and work sessions after being referred, and having an LSOTP present at transition discussions for individuals who were receiving this type of therapy or had an alleged sexual offending history. • A next step is to demonstrate implementation/incorporation of these quality improvement suggestions.	

		c. 17 individuals were described as having requested placement, but were not referred. This compared with 8, 14, 17, 13, 27, 21, 44, and 80 individuals at the time of the previous reviews. Of the 17 individuals who requested placement, but were not referred, 0 individuals had an LAR who made this decision. Of the remaining 17 individuals, an appropriate review, appeal, and or lack of consensus review was conducted (or was in process) for 17 (100%). The list of individuals not being referred solely due to LAR preference contained 3 names. This compared to 6, 6, 67, 1, 12, 5, and 8 individuals at the time of the previous reviews. This appeared to continue to be an accurate count. Systemic issues 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 existing and/or potential systemic issues delaying transitions (at the state and/or facility level). One issue was the availability of providers competent to support individuals with challenging psychiatric and behavior problems in many geographic areas of the state. In some geographic areas, there were very few providers at all, and those that were available were not competent to support the types of individuals who were on the referral list. As a result, IDTs (and LARs) made poor choices and individuals suffered (e.g., psychiatric hospitalization, return to the facility). In some of these cases, these transitions were not labeled as "delayed" because the transition occurred in less than 180 days. However, in practice, transitions to appropriate competent providers were delayed (i.e., never occurred) and as a result individuals, LARs, and IDTs ended up choosing the wrong provider. A second issue was the availability of accessible housing. Some providers appeared willing to develop/build new homes, but delays in construction delayed individuals' transitions. The APC had a database that listed individuals referred for more than 180 days and each individual's obstacle(s) to transition. This was a good start. The data would be more useful if it included all individuals who are referred and whether there is an obstacle to transition, even if it had not yet been 180 days since referral. Further, the database would be more useful if it indicated the criteria for determining if there was an obstacle to transition, if-when-how the obstacle was overcome, and a summarization of data. This would mean that the database should include all individuals, even those who have been placed (for perhaps the previous 12 month period). This information then could be very useful for the APD staff's planning for future transitions, using APD resources, and working with state office and facility	

		administration. 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. <u>Pace of transitions</u> h. Transitions were occurring at a reasonable pace. To make this determination, the monitoring team reviewed CLDPs, ISPs, ISPAs, 180 day meeting notes, any APD meeting minutes or reports, the APC's weekly enrollment report, and various emails and meeting minutes. 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 sample of 13 individuals placed since the time of the last onsite review, 11 (85%) were placed within 180 days of their referral (i.e., 2 were not). ○ 1 of the 13 was placed within 10 days of having passed the 180 day marker. The other's transition was delayed due to guardianship changes that occurred following her referral. • At the time of the review, 16 individuals were referred for community transition. 11 of these 16 (69%) had not exceeded the 180-day timeframe (i.e., 5 had exceeded 180 days). ○ Of the 5, 2 individuals had exceeded one year. One of the two individuals who were placed after more than 180 days, and all 5 of the individuals on the referral list for more than 180 days (i.e., a total of 6 individuals) were chosen for determining the ratings of metrics i., j., and k. i. Reasonable activity and actions had occurred related to the transition and placement for 6 of the 6 (100%) individuals. IDTs met most months for the individuals who were past 180 days on the referral list. • Of the sample of 5 individuals referred for more than 180 days, reasonable activity was taken for 5: ○ Two individuals were highly involved in their transition planning, and made decisions regarding their preferred type of living. Both individuals, however, changed their community option preference (i.e., group home versus foster care) and changed their preferred	

		location numerous times. Moreover, both disliked every provider after completing site visits. This slowed their transitions. • Of the sample of 1 individual who was placed after being on the referral list for more than 180 days, reasonable activity and actions were taken for 1. Guardianship changes following referral slowed her transition. • The transition specialists engaged in numerous activities each month regarding the individuals on their caseload. This seemed to have a positive effect on the pace of transitions. o Even so, the obstacles to transition cited above were ones that were unable to solve on their own. They will require the assistance of facility administration and state office. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 4 of the 6 (67%) individuals. Little activity appeared to occur in the months following referral for Individual #189 and Individual #127. At this time, however, providers and homes were identified for both of these individuals. k. Adequate justification was provided for the lengthier transition process for 4 of the 6 (67%) individuals.	
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:	State policy a. The state policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to	Noncompliance

		transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. • There was no mention of need for the IDT to use CLDP to ensure supports are in place. • The policy listed two reviews of CLDPs to be undertaken, one at the facility and one at state office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. ○ The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. Facility policy b. There were not facility policies that supported the state policy for most integrated setting practices. • The facility had updated its facility policy by adding some facility-specific activities to the state's policy. This was good to see, however, the APC should have policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. Training of facility staff on policies is addressed in T1b2 below. 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.	This section relates to the activities of the IDT, QIDP, and the ISP process. The APC and QIDP coordinator should work together to address these topics. They should be able to adequately address the metrics in this provision (T1b1) as well as the other ISP-related provisions of section T, which include T1b2 item#1, and all of T1b3. The monitoring team recommends that the APC and QIDP coordinator begin to collect data on these same metrics, as does the monitoring team. <u>Protections, services, and supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted in section F, substantial compliance was not found for F1d, F2a1, and F2a3. For the sample of 6 individuals who's CLDPs were reviewed, 0 individuals had SAPs developed and implemented to help prepare the individual for his or her transition during the period between referral and placement. <u>Obstacles to movement</u> The monitoring team reviewed a sample of 3 ISPs and observed the conduct of 3 annual ISP meetings for monitoring of this provision. ISPs were submitted by the facility and included individuals from each of the units. The facility submitted 8 ISPs, however, 5 of the 8 were conducted during the week of the previous monitoring review and, therefore, were not included in this review. Regarding referral at the individual level: b. Of the 3 ISPs reviewed, 2 should have had obstacles <u>to referral</u> defined (1 was referred for transition to the community). Of these 2 ISPs, 1 (50%) included an adequate list of obstacles to referral. This was a set of behavior problems (Individual #200). For Individual #134, falls were noted, but it was unclear how falls were an obstacle to referral. c. Of the 3 annual ISP meeting observed, an adequate list of obstacles <u>to referral</u> was identified for 1 (33%). This was for Individual #50. His team identified intense pica (cigarette butt) searching and ingestion behaviors, the preferences of his brother/LAR, and the individual's lack of understanding about community living for which he would need sign language interpretation. On the other hand, Individual #130's team presented only general comments, such as "she's never indicated that she wants to live in the community," "I think her quality of life would not be good," and "she would need significant modifications to her environment." A plan to address obstacles at the individual level: d. Of the 2 ISPs, 1 (50%) included an action plan to address/overcome obstacles	Noncompliance

		identified. Of these 1, 1 (100%) was adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). This was discussion regarding action plans for Individual #200 to implement his PBSP, attend counseling, and implement his positive reinforcement program. There were not, however, any actions specifically related to behavior improvement and community. e. Of the 3 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 0 (0%). Of these, n.a. was adequate. The IDT discussed what they might do for Individual #50, but specific action plans to address the specific obstacles (listed in metric c.) were not created. Overall, there was an absence of action plans that directly lined up with the actual obstacles or the reasons behind the obstacles (e.g., the reasons for LAR preference). The ISPs stated broad generic activities (CLOIP, tour, provider fair). Regarding transition at the individual level: f. Of the 6 CLDPs (and related ISPAs) reviewed, 0 should have had obstacles to transition defined. Of these CLDPs, n.a. (n.a.%) included an adequate list of obstacles to transition. • Although all individuals in the sample transitioned in less than 180 days, it seems that appropriate psychiatric care should have been identified as an obstacle to transition. g. Obstacles to transition were defined for n.a. individuals. Of these, n.a. (n.a.%) had action plans to address the obstacle to transition. Preferences of individuals and LARs Preferences of individuals are determined and described: h. Of the 3 ISPs, 2 (67%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). • For 1, the LAR requested that the facility and LA not have any conversations or presentations about community living to the individual. i. Of the 3 annual ISP meetings observed, the individual's preference for where to live was adequately described in 1 (33%) (Individual #57), and this preference appeared to have been determined in an adequate manner for 0 (0%). Preferences of LARs are determined and described: j. Of the 3 ISPs, an LAR was appointed for 1. Of these, 1 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT. k. Of the 3 annual ISP meetings observed, the LAR's preference for living setting was adequately described in 3 (100%), and this preference appeared to have been	

		determined in an adequate manner for 3 (100%).	
	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.	<u>1. Individualized plan</u>: a. In reviewing 3 recently completed ISPs, 1 individual was referred for placement and was engaged in the CLDP process. For the remaining 2, 0 (0%) had a plan that addressed education about community options. Therefore, the following metric could not be assessed: Of these, n.a. (n.a.%) were adequate. Regarding the plans for education in this set of 3 ISPs: • 0 of the 2 (0%) had a list of activities that was individualized and specified what will be done over the upcoming year. To meet criteria with this metric, 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. ○ In the 3 ISP meetings observed during the onsite review, an individualized plan was not created for any, however, individualized activities were discussed for Individual #50. • 0 of the 3 (0%) were in measurable terms and provided for the team's follow-up to determine the individual's reaction to the activities offered. • 1 of the 3 individuals had an LAR. 0 of the 1 (0%) included the LAR, as appropriate, based upon the content of the ISP. The actions were not individualized for the individual or the LAR. • 0 of the 3 (0%) adequately described how/if the previous year's plan was completed. It may be helpful to: 1. Add some prompts or headers to the ISP shell to help the IDT address each of the above four bullets. 2. Have the transition specialist who attends the ISP meeting ensure that the IDT always adequately addresses these four bulleted items. 3. Review this, with data, with the APC and QIDP coordinator. <u>2. Provider fair</u>: b. The facility did not hold a provider fair within the past 12 months. A provider fair, however, was scheduled for September 2014. There was documentation of a provider fair planning group, led by the APC, on 7/30/14. Some good ideas were presented for improving the outcomes of the fair. <u>3. Local MRA/LA</u>: c. The facility did appear to maintain good communication and a working relationship with the LA. The facility did participate in quarterly meetings with the LA. Relevant topics were on the agenda for the LA meeting, including presentation of the APC's	Noncompliance

		data graphs. <u>4. Tours of community providers</u>: 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). Since the last review, there were 10 tours, one to two each month. The APC planned for the soon-to-be-hired transition QIDP to focus on managing the system of tours in a better manner. • To meet this aspect of T1b2, the facility needs to demonstrate that: ○ All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). ○ Places chosen to visit are based on individual's specific preferences, needs, etc. ○ Tours are for individuals or no more than four people. ○ Individual's response to the tour is assessed. e. The facility did not have data for the following metric: Based on the facility's own report, of the n.a. individuals at the facility for whom a tour was appropriate, n.a. (n.a.%) went on a tour appropriate to their needs within the past year. f. Of the n.a. individuals in the sample for whom their teams had determined a tour was appropriate, n.a. (n.a.%) went on a tour tailored to their needs within the past year. To meet the standard for this item of T1b2, at least 90% of the individuals for whom a tour was appropriate should have attended a tour. <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 not occur during self-advocacy meetings, did not occur during house meetings for individuals, did not occur during family association meetings, and did occur during any other situations or locations (monthly coffee house/provider meet and greet gatherings). <u>7. Education activities for direct support professionals (DSPs), clinicians, and managers</u>: i. More than 75% of DSPs were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour).	

		j. More than 75% of clinicians were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. More than 75% of managers and administrators were not 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. • The facility did not have a process for this to occur.	
	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 monitoring team requested a set of recent ISPs, attachments, and assessments. Three were selected for review by the monitoring team (see above under Documents Reviewed and description in T1a). 1. Professionals provided recommendation in assessments: a. Assessments were reviewed for 3 of the 3 ISPs. Of the 3 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines. • The ISPs sampled were for some individuals who were referred and some who were not referred. • Assessments were completed for some, but not all disciplines. • The state office new standardized statement/requirement was not being used by all disciplines all the time. • Below are some data for these 3 ISPs: Discipline / # assessments / # with a statement / # w/ state statement Medical / 3 of 3 / 2 of 3 / 2 of 2 Nursing / 3 of 3 / 1 of 3 / 1 of 1 Dental / 3 of 3 / 0 of 3 / Psychiatry / 1 of 3 / 0 of 1 / Psychology / 3 of 3 / 3 of 3 / 2 of 3 Pharmacy / 2 of 3 / 0 of 2 / SLP / 1 of 3 / 1 of 3 / 0 of 1 OTPT / 3 of 3 / 3 of 3 / 0 of 3 Nutrition / 3 of 3 / 3 of 3 / 3 of 3 Aud./Vision / 2 of 3 / 0 of 2 / Cultural/day / 3 of 3 / 3 of 3 / 3 of 3 Vocational / 3 of 3 / 3 of 3 / 3 of 3 2. Professional determinations presented/discussed at ISP meeting: b. In 2 of the 3 (67%) written ISPs reviewed, and during 2 of the 3 (67%) annual ISP meetings observed, independent recommendations from each of the professionals	Noncompliance

<table>
<tr><td></td><td></td><td>on the team to the individual and LAR were included.
• Statements were copied from the assessments and inserted into the written ISP for all of the assessments.
o In two of the ISPs, there was also description of each discipline's recommendation that occurred during the meeting.
• The verbal presentation by each IDT member of his or her determination and opinion about community living and referral helped set the stage for a more robust living options discussion than would have otherwise likely occurred.

<u>3. Thorough discussion of living options at ISP or other IDT meeting</u>:
c. In 2 of the 3 (67%) written ISPs reviewed, and during 1 of the 3 (33%) annual ISP meetings observed, a thorough discussion of living options did occur.
• Living options discussions were not adequate. Although there was some discussion regarding different types of living options, there was no discussion of barriers to referral and action plans to address those barriers.

<u>4. IDT determination in written ISP</u>:
d. In 3 of the 3 (100%) 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 3 of the 3 (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included.</td><td></td></tr>
<tr><td>T1c</td><td>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:</td><td>The APC submitted 11 CLDPs completed since the last review. This was 79% of the 14 CLDPs completed since the last review. The monitoring team reviewed 6 of the 14 (43%) CLDPs in depth. One of the CLDPs was for an individual who was due to move the week following the onsite review. The APC requested that the monitoring team include this CLDP because he felt it represented their best work to date.

<u>Timeliness of CLDP</u>
Initiation of CLDP
a. 6 of the 6 (100%) CLDPs were initiated within 14 calendar days of referral. The monitoring team based this finding by reviewing documentation of CLDP-related activity occurring within 14 days of referral, including the actual 14-day meeting minutes or indication on the CLDP cover/first page.

Ongoing development of CLDP
b. 6 of the 6 (100%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. Evidence was found within the CLDP section IV., in ISPA notes, and/or in the APD meeting notes.</td><td>Substantial Compliance</td></tr>
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		<u>IDT member participation in placement process</u> c. 6 of the 6 (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). The SGSSLC IDTs were highly involved in transition planning. Examples included supporting individuals as they visited providers, chose day and residential providers, and changed their minds regarding locations and service models. <u>Coordination of CLDP with LA</u> d. 6 of the 6 (100%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. The placement coordinators included a paragraph in the CLDP section IV that described the LA's activities in the transition process.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. Some progress was made in this area. The monitoring team talked with the APC at length about ways to ensure these activities are done and documented in a simple manner, such as by including six short paragraphs/bulleted paragraphs within section IV of the CLDP. The APC developed a checklist to self-assess each of the CLDPs for the items below as well as for items in T1d and T1e. Completed self-checklists were submitted for five of the six CLDPs (all but Individual #53). Overall, there was good agreement between the self-ratings and the monitoring team's findings. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 6 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all 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. The monitoring team understands that not all six of these bulleted items will apply to every individual, however, there should be some indication that all six were at least considered by the IDT and placement coordinator in the development of every CLDP. The absence of any comment in the CLDP indicates that these important aspects of transition were most likely overlooked. • 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	Noncompliance

		professionals, management staff, clinicians, day and vocational staff), 6 of 6 (100%). This varied as appropriate per individual and per topic of training. 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), 0 of 6 (0%). The trainings said competency based, but did not describe how the staff would be trained. The APC reported that a new component of training utilizing DVD video was to begin soon. iii. a competency demonstration component, when appropriate, 6 of 6 (100%). It would be better if the support described what type of competency demonstration was to be completed so that the reader and the PMM are informed (e.g., paper quiz, role play). • Collaboration with community clinicians (e.g., psychologist, behavior health specialist, psychiatrist, PCP, nurse, SLP). This was noted in 2 of the 6 CLDPs, but applied to all six (33%). These were for psychologist to psychologist prior to the move and again after the move for Individual #53. This was great to see and appeared to be an important pre and post move support for him. For Individual #170, the SGSSLC psychiatrist spoke with the community psychiatrist prior to the CLDP meeting (therefore, it did not need to be a pre or post move support). For the other individuals, this type of contact would have been important to do, such as for Individual #182, who had serious psychiatric and neurologic/seizure issues only a few months before his move. o If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. o Further, for the CLDPs that indicated one type of clinician (e.g., the two above), the CLDP should indicate that the IDT determined it was not necessary for other clinicians. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 0 of the 6 CLDPs (0%). At least one IDT member visited each setting, but there was no notation regarding clinical assessment of the sites. • Collaboration between provider day and residential staff. This was not evident in any of the CLDPs (0%). The CLDP described how the day and residential provider for Individual #182 were going to work together on transportation and daytime supervision, which was good to see, but there was no indication of the way day and residential programs would work together to meet the needs of the individual. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was evident in 1 of the CLDPs (17%). This was for Individual #53. SGSSLC staff were going to stay	

		with him for a few days when he moved, and members of his IDT were to visit him a month after he moved. The CLDP did not indicate if provider staff were to visit with him at SGSSLC prior to his move. For all individuals, if this is not needed, it should be indicated in the CLDP. • Collaboration between Post-Move Monitor and Local Authority staff. This was not noted in any of the CLDPs, but the PMM and APC reported that every post move monitoring report was sent to the LA for all individuals (100%). For this aspect of this provision, the CLDP should indicate how the PMM and LA were, or were going to, collaborate regarding the individual's transition to the community. <u>Documentation of day of move activities</u> b. 6 of the 6 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. Documentation for 1 of the 6 (17%) indicated that the activities did indeed occur (Individual #182). The APC reported that this was now a regular part of the transition day activities. <u>CLDP meeting prior to moving</u> A CLDP meeting occurred for 6 of the 6 individuals (100%). It was described in each of the CLDPs. c. A CLDP meeting did not occur during the onsite review. The following are the components of a CLDP meeting. The APC self-recorded these as part of his new self-checklist tool. • 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.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Staff names provided for all pre- and post-move supports a. For 6 of 6 CLDPs (100%), the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and title for each pre-/post-move support. Completion timeframes/dates for all pre-/post-move supports: b. For 6 of 6 CLDPs (100%), the facility identified specific timeframes/specific dates for completion and/or implementation for each pre-/post-move support.	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.	Evidence of individual/LAR participation: a. Based on review of 6 CLDPs, 6 (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by: • signatures on CLDP • narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were updated and summarized prior to the CLDP meeting. At SGSSLC, special pre-CLDP meetings were held to review these assessments a few days prior to the actual CLDP meeting. The facility continued to struggle with providing discharge assessments that addressed how preferences, supports, and services could be provided in the community in the individual's specific new home, day, work, and community settings (see APD meeting notes). That being said, the APC and the facility took a number of actions over the past few months to improve the quality and usefulness of the discharge assessments. The results of these actions were not yet evident in the discharge assessments. These activities were: • All assessments were reviewed by the APC prior to the pre-CLDP meeting and sent back to the writer if they were not done correctly. • James Reid, placement coordinator, met with the professionals who wrote discharge assessments. • Mr. Reid also created mock sample assessments for two of the disciplines. He shared these as examples that clinicians could use. • The QA director formed a performance improvement team to work on all assessments, including discharge assessments. • The new integrated clinical services review board was focusing on assessment quality as one of their first tasks. Overall, the current assessments provided a lot of information about the individual's history and current status at the facility, but they were more like annual assessments than discharge assessments. For instance, many of the assessments recommended transition to the community, which made no sense because the individual was moving to the community and a specific provider, home, and day site were already identified and known to the IDT. The following review was based on the discharge assessments from the 6 CLDPs reviewed by the monitoring team.	Noncompliance

		<u>The assessments selected for completion are appropriate and none are left out</u> a. For 0 of the 6 CLDPs reviewed (0%), all necessary assessments were completed. • All of the individuals should have had a discharge assessment from psychiatry. This was especially important given each individual's unique and complex psychiatric history and medication regimen (e.g., multiple anti-psychotics) <u>Assessments done within 45 days of move date</u> b. For 6 of the 6 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. • The APC did a good job of monitoring this variable. <u>Assessments are available for use by the APC and IDT</u> c. For 6 of the 6 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 6 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. ○ The content of the assessments for most of the assessments for all 6 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. ○ The assessments for all 6 individuals were thorough enough to assist teams in developing a list of supports, but would have been much more useful if they'd focused upon the new community locations. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. ○ The set of assessments for 0 of the 6 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. ○ The assessments for 0 of the 6 individuals specifically focused upon how the necessary supports might need to be provided in these new settings.	

T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The lists of pre-move and post-move supports were in the CLDPs. There was a lot of improvement in the lists of supports, even though more work was needed. The APC, as noted in T1c1, initiated a self-check of the content of the list of pre and post move supports. This was a good addition to his program and likely played a role in the improvements seen in this section. The competence of the two placement coordinators also contributed to these improvements. In addition, good information was included in section IV of the CLDP (though more was needed as described below and in T1c1). <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 6 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. Similar to section T1c1 above, not all of these items will apply to every individual, but each should be considered in the development of every CLDP. If this was being done, more of the items below would be present in the list of pre and post move supports, or some indication of their consideration by the IDT would be written in the deliberations/discussion paragraph for the corresponding clinical area. 1) The list is comprehensive and inclusive, demonstrated by the following eight open bullets: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 6 of the 6 individuals, and was demonstrated in 1 of the 6 (17%). • This was for Individual #53. His supports included staff training and staff implementation of various aspects of his PBSP, including how to respond to behavior problems and how to teach and support alternative behaviors. It was an individualized set of post move supports that included use of reinforcement, skill acquisition plans, and context-specific responding to behavior problem occurrences. o His behavioral health assessment, however, noted five inappropriate sexual behavior occurrences in April 2014 to May 2014, with no explanation of their severity and/or their implications for his upcoming move. ▪ Merely saying to "continue the PBSP as written" was insufficient. Further, the CLDPs and PBSPs detailed many aspects about interaction style, communication, preferences, clothing, food, music, schedules, and so forth that were critical to each of these individual's success. This was the case for the other 5 CLDPs.	Noncompliance

			• Individual #182's supports correctly included staff training on his psychiatric history and signs of psychiatric decompensation. On the other hand, very important supports were omitted, such as no medication refusals and no changes to his medication regimen. This was particularly important given that he had a history of refusing medications (sometimes even cheeking them to avoid detection), and medication refusals and medication changes recently resulted in hospitalization. • Individual #35's supports regarding her psychiatric and behavioral history were individualized and included teaching replacement behaviors, skill acquisition plans, and having opportunities to go on the swings and to make hot sauce. On the other hand, merely stating to continue to medications was insufficient, especially given the facility's history with community provider changes to psychiatric medications resulting in hospitalization, police contact, and returns to the facility. Individual #35 received two different anti-psychotics. This type of regimen was often targeted for change in the community, sometimes within a very short time of transition. Also, her record indicated the use of a weighted vest. This was not explored in her CLDP. • Individual #316 had a history of serious behavior problems and psychiatric disorders. A single support to continue her PBSP and a single support for one replacement behavior (to gain attention) were insufficient given her history. • Individual #170's list of supports did not address the importance of not making medication changes. Further, her CLDP contained different diagnoses in different places (chronic paranoid schizophrenia versus chronic undifferentiated schizophrenia) • Individual #208's PBSP contained many suggestions for how to best interact with her. These were not included in the CLDP supports list. ▪ More should be garnered from psychiatry. ▪ As appropriate, crisis intervention plans should be developed, 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. This was not in any of the CLDPs, but should have been for anyone with a history of behavioral and/or psychiatric issues. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 6 individuals and was adequately done for 5 of the 6 (83%). Examples included weight monitoring, no grapefruit juice (as a separate support), diet, constipation treatment, and use of adaptive equipment. Aspects not addressed sufficiently were chronic kidney disease issues (Individual #316), tardive dyskinesia (Individual #208), and diet (Individual #170). ▪ For Individual #35, the placement coordinator did an excellent job of taking the content of the medical and nursing assessments and transforming them into more measurable outcome oriented pre and/or post move supports. o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 6 and was adequately addressed for 2 of 6 (33%) (Individual #35, Individual #208). For many, multiple preferred activities were grouped into a single support, making it impossible for the PMM to determine if a certain level of variety was what the IDT was looking for. There were no at-home preferred activities or items for Individual #53, no preferred activities at all for Individual #182, only a single item for Individual #316, and only one (regarding outings once per week) for Individual #170. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment or day supports applied to 6 of the 6 individuals and was adequately addressed for 5 (83%). The single support regarding DARS referral for Individual #316 seemed insufficient given her preferences, skills, and needs. On the other hand, a referral to DARS for Individual #35 made total sense given her skills, self-initiation, work history, and likelihood of not needing a job coach for an extended period of time. 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 addressed in 1 of the CLDPs (17%), for Individual #53. Positive reinforcement applied to all individuals and probably	

		played a considerable role in their success at the facility. ○ 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 3 of the 6 (50%), for Individual #53, Individual #35, and Individual #208. ○ There were pre-/post-move supports for the provider's implementation of supports. This refers to the components of the PBSP, 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. ○ All recommendations from assessments are included; or if not, there is a rationale provided. This occurred for 6 of the 6 CLDPs (100%). ▪ For the most part, recommendations were included. ▪ The APC or placement coordinator wrote very detailed narratives of the IDT's discussion and deliberation that occurred for each of the disciplines regarding their recommendations. This occurred (a) during the pre-CLDP meeting in great depth, and (b) again at the CLDP meeting. ▪ At SGSSLC, the pre-CLDP discussion/deliberation and "final" recommendations were entered into the CLDP document and brought to the CLDP meeting. Any additional discussion that resulted in addition, deletions, or edits to the pre-CLDP final recommendations were thoroughly described in a CLDP meeting paragraph in the CLDP. Although different than done at other facilities, the monitoring team found this system to be easy to understand and seemed to work well for SGSSLC. ○ Examples included discussion about there not being need for an OT, and for the individual to not start off in a sheltered workshop. 2) The wording of every pre-/post-move support is in measurable, and observable terms. ○ Most were in measurable terms. 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. ○ This was much improved and included more references to logs, checklists, and interviews. Essential supports were in place on the day of the move The following metrics applied to 5 of the 6 individuals who's CLDPs were reviewed because Individual #53 had not yet moved.	

		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. 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).	
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.	Policy/Procedure a. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. • The state recently developed and disseminated the beginnings of a section T/most integrated setting practices QA program to each of the facilities. It included three tools to assess: the written completed CLDP document, written completed post move monitoring forms, and the written completed transition document for alternate transitions (section T4). ○ The content of the three tools lined up better than ever before with the content of the monitoring team's metrics and reports. The CLDP tool contained many of the items in the monitoring team's report; this was good to see. The post move monitoring tool, however, would be improved if it included all of the items reviewed by the monitoring team in T2a and T2b. • The APC created his own CLDP self-check tool. This tool was very good and lined up with the items in the monitoring team's report sections T1c1, T1d, and T1e. • The old state tool to assess living options discussions continued to be used. As noted in previous reports, it was not likely providing the APC with relevant information for the ISP-related components of section T (T1a, T1b1, T1b2, T1b3). Moreover, it was implemented only for individuals who were referred whereas these sections apply to all individuals at the facility. It is impossible to assess the IDT's identification and addressing of obstacles to referral if the sample chosen doesn't include some individuals who were not referred. • The facility should have its own facility-specific policy/procedure for quality assurance to meet what is required by this provision T1f. Collection of data b. Data/information were being collected. The data that were being collected were relevant and valid. The data appeared to being collected reliably. • The monitoring team has, for some time now, suggested the following set of	Noncompliance

			data to contribute to the APC's QA program and to set the occasion for summation, review, and analysis of data. These are simple data to collect and graph. Some time might be required for the initial set up of data charts and graphs, but once done, will only require a monthly entry of a data point that the APC should be collecting and reporting on anyway. Six of these items were being reported (indicated with check marks). 1. Number of individuals placed each month or monitoring period 2. Number of new referrals each month or six-month period 3. Number of individuals on the active referral list as of the last day of each month 4. Number of individuals on the active referral list for more than 180 days, as of the last day of each month 5. Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). 6. Number of individuals who have requested placement, but have not been referred, as of the last day of each month 7. √ Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month 8. Number of individuals not referred solely due to LAR preference as of the last day of each month 9. √ Number of individuals who had any untoward event happen after community placement each month (including return to the facility or death) ▪ √ Cumulative number of each type of untoward event for all placements (returns, deaths) ▪ number that had a root cause type review 10. √ Number of rescinded referrals each month or each six-month period ▪ √ number that had a root cause type review 11. Number of alternative discharges (T4) 12. √ Number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles (from T1b1) ▪ The APC had two sets of data, one regarding obstacles to referral and one for obstacles to transition. The obstacles to transition was only for those on the referral list for more than 180 days. 13. Number of individuals who went on a community provider tour each month and total number/percentage of individuals who went on a tour in the past 12 months (from T1b2)	

In addition, the APC reported on the following:

14. Living options discussion monitoring tool
15. CLDP monitoring tool
16. Post move monitoring tool
17. For current referral list: number of days since referral
18. For those placed: number of days from referral to move date

The APC submitted his data list inventory and QA matrix (see section E for a description). These lined up with what was in his QA report (except for item #18, which wasn't in the data inventory).

The monitoring team acknowledges the work done by the QA and SAC departments regarding development of data list inventories. This included discussion and thoughtful review of those data items that would be most relevant and useful to the APC and to QI Council. Therefore, the APC should consider the above list of 13 data/graph items as a suggestion.

Summarization/analysis of data and actions taken

c. Data were reviewed, summarized, and somewhat, but not thoroughly, analyzed. Beginning with the August 2014 QA report, the QA department provided five headings (i.e., prompts) to be applied to each data component summary/analysis section in the report. The APC (and all discipline heads) were required to write about each of these. The purpose was to set the occasion for more thoughtful narrative analyses of the data. The five sections were summary, identify trends, explain the data, describe actions to be taken, and make predictions. The APC completed this for six sets of data (living options discussions, CLDP tool data, post move monitoring data, transition length, obstacles to transition, and PDCTs).

   Based on his findings, the APC was going to work to improve the LODs that occurred outside of ISP meetings because these were not as good quality as those occurring during the ISP meetings. The review of the CLDP, post move monitoring, transition length, and obstacles to transition provided good explanations of the data.

   Descriptive detail was provided regarding three of the four individuals whose placements failed and returned to live at SGSSLC. The APC looked to see if there were any trends regarding the types of problems that occurred in the community, and whether there were certain SGSSLC homes from which these individuals had moved. He did not identify any relevant information or trends, but it was good to see him exploring data to try to better understand these cases. As noted immediately below in metric d., however, more analysis was needed given the importance and seriousness of these outcomes.

		Re-admissions: There were 4 re-admissions. This compared with 4, 3, 4, 4, 0, 2, 0, and 1 re-admissions at the time of all of the previous reviews. This is a total of 22 returns since monitoring began in 2010. d. For 0 of the 4 (0%) who returned to the facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the facility should be made. Note that a good description of what occurred for each of these cases was written, an ISPA meeting was held, and there was much discussion about what happened with each of these returns. In fact, the APC had a very good understanding of what went wrong in each case. Using this information to identify trends or themes and then implementing actions to improve services was the next step. Thus, of these 4 reviews, actions were recommended in 3 (75%). Of these 3 cases, actions were implemented for 0 (0%). Given the high rate of returns to the facility and the seriousness of each case, the APC should involve more members of the QI Council in identifying trends and themes and in developing actions to make improvements. For instance, the APC identified issues with the way the IDTs chose providers as well as examples of IDT and APD failures to include proper supports in the CLDPs (also see the content of T1c1 and T1e above). In addition, problems with medication changes, psychiatrist availability, cigarettes and tobacco, problems with housemates, and crisis intervention planning were identified by the monitoring team. In addition, the monitoring team noted that many individuals exhibited problem behaviors almost immediately after their moves (i.e., reported at the 7-day post move monitoring). SGSSLC should consider taking action when a behavior problem occurs at anytime during the 90 day post move monitoring period, including problems that might occur in the first few days. Due to the history of failed placements from this facility (and the others that were fragile, such as Individual #208 and Individual #316). It may be that earlier and more intensive involvement with providers early, at the first sign of problems, may be one way to reduce failed placements. Deaths Following Community Placement: There were 0 deaths of any individuals who had moved to the community. This compared with 1, 0, 0, and 1 at the time of previous reviews. A total of 4 individuals had died since 7/1/09. e. O individuals who transitioned to the community passed away since the last onsite review. Therefore, this metric did not apply: Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the facility should be made for n.a. (n.a. %) of the cases. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for (%).	

		Other Adverse Outcomes: f. Over the past six months, 9 of the 24 individuals placed in the past year (38%) experienced one or more potentially negative outcomes since placement. Two of these 9 were not included in the facility's report of these adverse outcomes, but were found in the post move monitoring report. These were for Individual #108 and Individual #316 for hospitalizations. Moreover, the PDCT for Individual #316 indicated her move to a different home was due to her desire to have a pet (not an adverse outcome), but the monitoring team learned that she was also having serious behavior problems with her housemates (an adverse outcome). (There was one other change that was included in the facility's PDCT data; it was a change to a foster care arrangement. This was not included in the 9 count because it was not an adverse outcome.) Of the 9, there was an adequate review conducted for 3 (33%) of the cases to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in all 3 cases. Of these 3 cases, actions were implemented for (0) (0%). The monitoring team reviewed ISPAs, completed PDCT forms, and the ADP meeting minutes. The APC had added a prompt to the PDCT form regarding what might be changed to improve overall transition planning services. Examples were given, but no plan was in place to implement these proposed improvements. Overall, very good progress was made in the APC's QA program, including better data summation and analysis, and more discussion of possible quality improvement based upon data and based upon discussion of problem cases.	
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	Annual narrative by facility a. The facility did not have an adequate system to collect information about obstacles to transition. • The facility's annual narrative was one year old. The facility, in the February 2014 compliance review self-reported that their data collection system was inadequate and that, therefore, their annual report did not meet the standard for this provision. The monitoring team agreed. • Even so, the APC and facility continued to develop their data collection system for obstacles to referral and to transition. ○ For referral, data through 8/20/14 showed that the primary obstacle to referral for 137 individuals was their behavioral/psychiatric status. The APC was working with the unit directors and QIDP coordinator to make sure that these data were correct. ○ For those referred, obstacles to transition were identified for four individuals. For two of these, the obstacles were related to provider capacity. For the other two, it was due to the individuals repeatedly	Noncompliance

	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.	changing their preferences for providers and service models. • The facility's data system, when completed, should also indicate if any "compromises" of the individual's needs, preferences, and/or supports were required in order for the transition to occur. An example of a compromise would be if the individual "settled" for a day habilitation program because the vocational program that the team recommended (or that the individual preferred) was not available in the part of the state in which the individual/guardian wanted to live. Another example would be if the individual moved to an area of the state that was not the original preference because clinical services were not available there. b. The facility did not have an annual narrative that showed it had (a) conducted a comprehensive assessment of obstacles, and (b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. • Again, the facility's annual narrative was one year old. The facility, in the February 2014 compliance review self-reported that their assessment of obstacles and plans to address the obstacles were inadequate and that, therefore, their annual report did not meet the standard for this provision. The monitoring team agreed. Annual narrative by DADS state office c. The State did not present an annual narrative that showed it had (a) conducted an analysis of the Facilities' data, (b) taken 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, and (c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles.	

		The following concerns were noted with regard to the report:
		• Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles).
		  ○ State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report.
		• DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report.
		  ○ During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition).	

		• Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). ○ The monitoring team was unable to determine this because there was no information in the report addressing it.	

T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review (12/1/13-8/15/14) 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 (this was an attachment that will need to be added to the body of this report for the next onsite review)
			Substantial Compliance

T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		

T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SGSSLC maintained substantial compliance with this provision item. Overall, post move monitoring was done thoroughly and competently. The post move monitor's reports were easy to read. They contained descriptions of what she examined to determine if supports were being provided. Since the last review, 42 post move monitorings for 16 individuals were completed. This compared with 39 post move monitorings for 14 individuals, 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. Thus, the amount of post move monitoring was relatively stable over the past few years. The monitoring team reviewed completed documentation for 23 of the 42 post move monitorings 15 different individuals. Of the 23 post move monitorings, 21 were completed by the post move monitor, Denise Copeland. She was very experienced, having worked as the PMM for about five years. The other 2 were completed by the transition specialist, Donnie Varela. Ms. Copeland was (as always) responsive to the comments in the previous monitoring report and, thereby, continued improvement in her reports was seen by the monitoring team. <u>Timeliness of Visits</u> For the 16 individuals, 42 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 42 required visits, 42 (100%) were conducted and 42 (100%) were completed on time. Of the 23 post move monitoring forms reviewed by the monitoring team, all 23 (100%) included dates showing that they were completed on time. <u>Locations visited</u> For the 23 post move monitorings reviewed, 23 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. <u>Content of Review Tool</u> 23 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 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 12 of the 12 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 23 of the 23.	Substantial Compliance

		- The PMM provided 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. This was an improvement since the last review. - Each post move monitoring report (100%) included a review of all pre move supports (as it should). The yes/no boxes were marked in each post move monitoring report. - There was adequate justification for findings for each support in 23 of the 23 (100%). - Detail/comment was included in 23 of the 23 (100%) reports for every support. - LAR/family satisfaction with the placement and the individual's satisfaction was explicitly stated in 23 of 23 (100%). Or, the PMM wrote about her attempts to contact the LAR or family. - 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 23 of the 23 (100%). - The PMM tended to put in general comments within the paragraph about the individual's satisfaction with his or her home and day programs. - To repeat from the last report, the monitoring team recommends that a separate final paragraph be added at the end of the report. 23 of 23 reports (100%) indicated the specific name and title of each person interviewed by the PMM. The monitoring team has the following additional comments: - The PMM monitored for the presence and use of daily checklists to document the provision of many of the supports for which this type of checklist made sense to use. This was good to see. - The PMM was now, for the most part, reporting on three general categories of evidence for each support: what she <u>observed</u>, what <u>documentation</u> she looked at, and the result of her staff <u>interview</u>. This was an improvement from the last review. - Some single supports continued to include a list of many preferred activities or items. The PMM was now reporting on the occurrence of each activity or item even though the support grouped them. This was another improvement. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 15 individuals who received post move monitoring who were reviewed by the monitoring team, 9 (60%) ultimately transitioned very well and appeared to be having good lives.	

		The placements for the other 6 individuals (40%) did not go well. The placements of 3 individuals failed and they returned to the facility. The other 3 continued to have difficulties, including the exhibition of serious problem behaviors. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 15 of the 23 post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 11 of the 15 individuals. For the most part, the PMM referred the problem to the IDT and then (a) did whatever follow-up was determined by the IDT, and/or (b) followed up at the next post move monitoring visit. Some of the problems were of a relatively minor nature and were ultimately corrected. These included checklist documentation not being done, minor injuries, and lack of implementation of SAPs. This was for 3 of the 15 post move monitorings. The majority of the issues (i.e., the other 12), however, were more serious: • Transportation, money availability, care of baby, living environment, arrests of family members (Individual #162) • Problems with a male housemate (Individual #310) • Psychiatric hospitalization (Individual #194) • Problems with housemate within first few days of move, aggressive outbursts, changes to PBSP, discontinuation of psychiatric medication (Individual #205) • Serious behavior outburst within first few days, continued violent behavior at 45-day review (Individual #163) • Behavior problems at the 7-day review (Individual #170) • Argument with housemate, aggression, pulling fire alarm first few days after move, more and more aggression (Individual #208) • Serious aggressive behavior, including pulling a knife on a staff member (Individual #316) There was appropriate follow-up and correction for 3 of the 3 minor issues, but only for 7 of the 12 more serious issues (for a total of 10 of 15, 67%). Four of the 5 more serious issues that did not receive follow-up were the occurrences of behavior problems that were identified at the 7-day post move monitoring. It may be that the PMM did not deem it necessary to notify the IDT (to conduct immediate follow-up) because the providers reported that they dealt with the behavior problems. • It seems clear that for individuals who transition from SGSSLC, <u>any occurrence</u> of problem behavior that occurs, especially if it occurs within the first week of moving, should result in swift and intense action from the facility. Consider that of these five individuals, three had returned to the facility and the other two continued to have problems that threatened their continued placement in the	

		community. The PMM will need to work closely with the APC and placement coordinators to ensure that behavioral problems are thoroughly responded to by the facility in order to maintain substantial compliance with this provision at the next review.	
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.	This item was not rated because a post move monitoring was not observed by the monitoring team due to post move monitoring not occurring within a reasonable driving distance from the facility during the week of the onsite review. The PMM traveled to the Houston area during the week of the onsite review to conduct post move monitoring. Note that the facility received substantial compliance ratings for a number of consecutive monitoring reviews. Moreover, the PMM reported on the status of the four bulleted items noted in the previous report in section T2b. All four were addressed adequately and fully.	Not Rated
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	Four individuals were listed as being discharged as per section T4. Thus, their discharges were required to meet this provision's discharge and transfer requirements. A sample of all 3 of these 4 individuals was reviewed. One was discharged to another SSLC. The other three were discharged because they were found competent to proceed with legal charges via the court system. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summary completed for the individuals listed above under Documents Reviewed, 3 out of 3 (100%) did contain the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. These include a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. A review was conducted to determine whether or not the facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • In 3 out of 3 records reviewed (100%), good cause was identified in the discharge summaries. • The facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies) for 3 out of 3 individuals (100%). • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 3 out of 3 individuals (100%). • For 3 out of 3 individuals (100%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. • Based on the narratives provided in the discharge reports, the report for 3 out of 3 individuals (100%) adequately described the key supports that the individual would need in the new setting.	Substantial Compliance

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) ○ SGSSLC Prioritized Need for Guardianship List ○ SGSSLC Self-Assessment and Provision Action Information for section U ○ SGSSLC Section U Presentation Book ○ Documentation of activities the facility had taken to obtain LARs or advocates for individuals ○ ISP, Rights Assessment (for a subsample): • Individual #201, Individual #273, Individual #134, Individual #381, Individual #362, Individual #365, and Individual #200. Interviews and Meetings Held: ○ Informal interviews with various individuals, direct support professionals, and program supervisors in homes and day programs; ○ Roy Smith, Human Rights Officer Zula White, Administrative Assistant Observations Conducted: ○ Observations at residences and day programs ○ ISP preparation meeting for Individual #118 ○ Annual IDT Meeting for Individual #130, Individual #50, and Individual #57 ○ Incident Management Review Team Meeting 8/19/14 and 8/21/14 ○ Human Rights Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment, updated on 7/24/14. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. Activities that the facility engaged in to assess compliance with section U included: • Reviewed guardianship policies. • Reviewed priority list for individuals determined to need guardians. • Monitored 30% of the ISPs completed in the past six months using the section U Monitoring tool. • Observed 25% of the annual ISP meetings held in the past six months to determine if the IDTs engaged in adequate discussion of each individual's ability to provide informed consent. The facility self-rated U1 and U2 as not in compliance. The facility self-assessment found that IDTs were

	generally holding a much better discussion regarding individual's ability to give informed consent, however, QIDPs were still not adequately reflecting that discussion in the ISP. The monitoring team agreed with the facility's noncompliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The following action had been taken in regards to section U: • Guardianship had been obtained for 10 individuals. • The HRO continued to assess compliance with section U using the Section U Monitoring Tool. • The HRO and QIDPs continued to provide information and support to families regarding obtaining guardianship. • The HRO continued to explore community resources for guardianship. • Met with local attorneys to discuss barriers to pursuing guardianship. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions and develop training to address any barriers to making decisions when possible. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with provision U1 as a prerequisite. A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: 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 parties agreed the monitoring team would complete a reduced review of this provision because the facility had reportedly made little progress on this provision. On 3/7/12, DADS State Office issued Policy #019: Guardianship. A statewide standardized assessment to determine each individual's capacity to make informed decisions was still in draft form. The state is encouraged to finalize this assessment because it should assist the facilities in moving forward with regard to the Implementation of the Section U Settlement Agreement requirements. The facility continued using the rights assessment tool to evaluate each individual's ability to give informed consent in a number of areas. IDTs were continuing to refer individuals to the Human Rights Officer when the team identified a need for guardianship. While this was a good start to identifying individuals that may have priority needs, the facility needs to ensure that the IDTs engage in adequate discussion regarding whether	Noncompliance

#	Provision	Assessment of Status	Compliance
	the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	or not the individual has the ability to give informed consent and, if not, determine if appropriate training (e.g., money management training, training on living options) or supports (e.g., communication supports) could improve the individual's ability to give consent. Two annual ISP meetings were observed, for Individual #130 and Individual #57. Individual #130's IDT agreed that she should be referred for guardianship. The QIDP reviewed her rights assessment. The team acknowledged that she did not have the ability to provide informed consent in any key area of her life, however, there was no discussion regarding developing outcomes for training that might have offered her at least some opportunity to make decisions and have minimal control over her day. Individual #57 participated in his ISP meeting and gave input into decisions that the team made regarding living and day programming options. The need for guardianship was not discussed. A sample of ISPs was reviewed by the monitoring team to determine if IDTs were adequately addressing each individual's ability to give informed consent. It was not yet evident that an adequate discussion was routinely taking place at annual ISP meetings. It will be important for QIDPs to document recommendations from the assessment process and ensure that outcomes are developed to address any barriers to each individual's ability to make decisions when deemed applicable. Teams did not develop adequate training opportunities to improve decision making skills, particularly in regards to expanding each individual's knowledge of options available to them. IDTs also failed to discuss supports necessary to assist individuals in making decisions. To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that the facility's priority list for guardianship is accurate based on information gathered at annual IDT meetings.	
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	The parties agreed the monitoring team would complete a reduced review of this provision because the facility had reportedly made little progress on this provision. New guardianships had been obtained for 10 individuals at the facility in the past six months. The Human Rights Officer and QIDPs continued working with many current guardians to renew guardianship on an annual basis. The facility had some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	through the self-advocacy group at the facility. The HRO and the assistant HRO were strong advocates for individuals at the facility and a valuable resource to IDTs Although not a requirement for substantial compliance for this provision, the monitoring team wants to highlight the self-advocacy group's activities at SGSSLC. Attending and participating in the monthly meeting continued to be a preferred activity for more than 70 individuals at the facility. The HRO, his staff, and the leadership of the self-advocacy group regularly worked to make the gatherings meaningful and educational. Compliance with U2 will be contingent on ensuring that all individuals have been assessed using an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: ○ Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 ○ SGSSLC recordkeeping-related policies: • Active Record Guidelines, updated 9/27/12 • All About Me Shared Drive, 2.1.26, 6/12/14 ○ SGSSLC organizational chart, June 2014 ○ SGSSLC policy lists, 6/25/14 ○ List of typical meetings that occurred at SGSSLC (not provided) ○ SGSSLC Self-Assessment, 8/20/14 (new) ○ SGSSLC Action Plans, 7/21/14 ○ SGSSLC Provision Action Information, 6/9/14 ○ SGSSLC Recordkeeping Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 8/18/14 ○ List of all staff responsible for management of unified records, 6/3/14 ○ Description of flow of documents/materials (no changes made) ○ Monthly home secretary meeting minutes, February 2014 to May 2014 (4 meetings) ○ Description of changes since the last onsite review (there were some) ○ List of other binders or books used by staff to record data, and a description of how these were incorporated into the recordkeeping practices of the facility and into the V3 audits ○ Description of the SGSSLC shared drive and All About Me folder, one page ○ Tables of contents for the active records (updated 1/22/14), individual notebooks (updated 1/22/14), and master records (January 2014), no changes for this review ○ List of all individuals and checks to indicate if each aspect of unified record was updated, 3/21/14 ○ Home secretary audit data graphs, February 2014 to May 2014 ○ Various emails regarding status of records, June 2014 ○ Home secretary meeting minutes and attachments, February 2014 to May 2014 ○ Gap report, February 2014 to May 2014 ○ Updated QA data listing inventory, February 2014 to May 2014 ○ New employee orientation and refresher trainings, February 2014 to May 2014 ○ Description of the unified record audit process ○ Instruction packet for completing audits ○ List of individuals whose unified record was audited by the URC, February 2014 to July 2014 ○ Completed audits for 10 individuals, March 2014 and Mary 2014 • 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 ○ Data regarding inter-rater agreement ○ Description of the actions that occurred following an audit ○ Monthly audit recommendations list and tracking of status, including a set of graphs for the month, February 2014 to May 2014 ○ Monthly summary data and graphs for all audits, February 2014 to May 2014 ○ Individual information for medical tracking of off-campus consultations, injury reports, and psychiatric consultations, March 2014 and May 2014 ○ URC QA data summary, monthly, February 2014 to May 2014, and the data summary presented at QI Council during the onsite review, with data through July 2014 ○ Six packets of documents for each of the six components of V4, including ○ URC's written responses to documents found missing by the monitoring team while onsite ○ Active records and/or individual notebooks of: - Individual #101, Individual #31, Individual #383, Individual #42, Individual #279, Individual #199, Individual #200, Individual #37, Individual #300, Individual #398, Individual #340 ○ Master records of: - (none) Interviews and Meetings Held: ○ Cary Lovelace, Unified Records Coordinator ○ Leticia Williams, QA Program Compliance Auditor ○ Various DSP and clinical staff Observations Conducted: ○ Records storage areas in residences ○ PPAR meeting, 8/21/14 ○ Various other meetings
	Facility Self-Assessment: The self-assessment was the same format as during the previous onsite review. In general, it looked at items more in line with what the monitoring team looked at. The self-assessment required data to be added each month. 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 maintained performance in recordkeeping practices, and maintained substantial compliance with provisions V1 and V3. There was turnover in the URC position since the last review. For the most part, the activities described in the last report were still in place and were occurring at about the same level. Some minor changes were made in some aspects of recordkeeping practices. Given these leadership changes in the last six months, the monitoring team was pleased that the facility was able to maintain the recordkeeping practices observed at the last onsite review. Eleven of 11 (100%) individuals' 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. Individual notebooks continued to be used for all individuals and as per state policies. Quality assurance procedures (audits) continued in the same manner as during the last review. Five (or more) were conducted in five of the previous six months. The URC summarized, analyzed, and reported on her data. She actively participated in all QA program activities at SGSSLC. The facility was in substantial compliance with four of the six items (67%) in V4. Provision V2 information had not been updated since the last review. For the most part, the QA director was only tracking training when a policy was revised, not the current status at particular points in time.

#	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 maintained performance in recordkeeping practices, and maintained substantial compliance with provisions V1. There was turnover in the URC position since the last review. The previous URC, Cary Lovelace, changed jobs in April 2014 (about a month after the previous onsite review and at about the time the monitoring team's report was issued). The facility appointed a new URC, but she only remained in the position for about a month. The QA program compliance auditor, Leticia Williams, stepped in to manage recordkeeping at the facility. Then, Ms. Lovelace returned to the URC position, her first day coinciding with the first day of the monitoring team's onsite review. Thus, for the most part, the activities described in the last report were still in place and were occurring at about the same level. Some minor changes were made in some aspects of recordkeeping practices. Given these leadership changes in the last six months, the monitoring team was pleased that the facility was able to maintain the recordkeeping practices observed at the last onsite review. To conduct this review, the monitoring team examined aspects of the unified record for	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. State policy and facility-specific policies remained the same as in previous review with the exception of one new policy that specified how the All About Me Shared Drive folder was to be used. The URC actively participated in the facility's QA program. This included participating in QA department face to face meetings, completing QA reports, and making presentations to the QI Council. Other activities continued, including new employee orientation, monthly home secretary meetings, and the URC's spreadsheet indicating the status/presence of each of the three components of each individual's unified record. Eleven of 11 (100%) individuals' records reviewed included an active record, individual notebook, and master record. Active records 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 (range was 0-7). This was slightly lower than what was reported in the recordkeeping department's August 2014 QI Council presentation. 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., CLOIP for a new admission). The remaining missing items were to be corrected by the home secretaries by their obtaining the missing documents from the clinical departments. The monitoring team continued to be impressed by the consistent format, contents, and presentation of the active records across the 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.	

#	Provision	Assessment of Status	Compliance
		Numerous activities initiated at the time of previous reviews maintained: • Home secretary targeted audits • Recording the date that documents were given to the home secretary • Gap tracking feedback to unit directors Individual notebooks Individual notebooks continued to be used for all individuals and as per state policies. Other binders/logs: Data kept in other binders or logs continued to be used to record data regarding the individuals. The URC continued to use pointer pages in the individual notebook to refer the staff to these other locations and she continued to include these other logs in her monthly audits. Master records A master record existed for every individual at SGSSLC. The monitoring team did not review master records for this report. Shared drive 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. The URC continued to assess this correspondence during her monthly audits. Overflow files 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. It had not been updated since the last review. For the most part, the QA director was only tracking training when a policy was revised, not the current status at particular points in time. During the onsite review, the monitoring team and the QA director reviewed the requirements and expectations for this provision. The monitoring team attended the Policy and Procedure Approval and Review committee meeting. There was lively discussion regarding the review of some updated policies.	Noncompliance

#	Provision	Assessment of Status	Compliance
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. Quality assurance procedures (audits) continued in the same manner as during the last review. Five (or more) quality assurance reviews (audits) were conducted in five of the previous six months. Nine were conducted in February 2014 and March 2014. During the URC transition month of April 2014, none were done. Five were done in May 2014, June 2014, and July 2014. Thus, 34 audits were completed in the past six months. Given the facility's history of meeting the requirements of this provision and given the reasonable rationale for there being no audits in April 2014, the monitoring team considered this aspect of V3 to remain in substantial compliance. The review consisted of these parts: • The active record and individual notebook audit tool. • Assessing gaps in data entries on a variety of documents. • Checking for documentation of medical consultations for the past 12 months. • A direct comparison of the SAPs with what was in the ISP action plans. • Comparing client injury reports and the psychiatry department's scheduler to see if there were corresponding entries in the IPNs. • Comparing the active record contents with what was in the All About Me electronic shared drive folder. • The master record audit tool. Inter-rater agreement reliability checks continued to occur quarterly. Findings were not calculated (but should be). Even so, it appeared that most items were in agreement when looking at the raters' scores side by side. 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), and documenting the V4 interview continued in the same manner as described in some detail in previous monitoring reports. The URC summarized, analyzed, and reported on her data. She actively participated in all QA program activities at SGSSLC. The URC continued to summarize and track her data in three reports. • One was a monthly audit recommendations database spreadsheet. • 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The monthly QA report was now about 16 pages 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.	
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. Most of the activities related to V4 remained the same as described in the previous monitoring report. Any changes are described below. The facility was in substantial compliance with four of the six items (67%). 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 log. During direct observations in homes 505A, 508B, and 509B, the monitoring team examined these check out/in logs and found all three to be 100% correct. The following two activities continued: the home secretaries conducted a daily active record check, and campus administrators did a daily check on their overnight shift. Campus administrator checks, due to data being consistently high for many months, were being discontinued. 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 when needed for making care and treatment decisions. All records requested by the monitoring team, with the exception of missing pages of one nursing assessment, were made available. • 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 15 (100%) of 15 individual notebooks in the sample.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual notebooks (which contained PBSP data sheets) were generally accessible to DSPs. • 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. 2. Data are filed in the record timely and accurately 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). The same two activities as last reported continued: First, home secretary focused monthly audits indicated whether a document was in the record, up to date, and in the right place. As noted in V1, the monitoring team found that more than 90% of the documents met these criteria. Second, the facility compared what was in the electronic shared drive (called the All About Me folder) with what was in the active record to determine. This, however, was being discontinued. 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. • During medication administration observation, data were recorded timely and accurately. • Habilitation therapies documents were filed in a timely manner. • The facility had begun gathering data on the submission of completed ISPs. A list provided by facility reported that 137 of 217 (63%) ISPs developed in the past year were not filed within 30 days after the annual ISP was held. Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to be in substantial compliance. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The two activities described in the previous report continued. First, the URC looked to see if SAP data and observation notes in the active record were fully completed. She did this while conducting her audits. Second, the Gap Tracking tool continued to be used, primarily for data in the individual notebook. The findings showed that some aspects of	

#	Provision	Assessment of Status	Compliance
		data collection were not occurring in a timely manner. The monitoring team also found that: • Late entries by nursing make following the records difficult. Many were squeezed into small spaces in the IPNs. • Some data were not consistently documented, such as the intake and output records for the 24 hour totals, and aspiration data sheets (which contained blanks for daily monitoring). • The clinicians consistently documented direct therapy interventions per session and when review of indirect supports were required. Monthly summaries were not noted consistently by the therapists, however. • QIDP monthly reviews indicated that data on progress towards ISP outcomes was usually available at the time of review, however, monthly reviews were not always completed, so it was difficult to assess if data were consistently gathered and reviewed. 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. 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 monthly audited records, she looked at a list of 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. • Psychiatry entries had improved since the last report. Injury-related entries had decreased. To address this, a new specialized IPN for injuries was created. • The facility was not yet addressing the use of IPNs by other clinical disciplines. In addition, the monitoring team observed that: • One medical provider's IPN documentation was consistently illegible and incomplete. • Nursing IPNs did not consistently document a review of the individual's history and or associated health antecedents/triggers pertinent to the acute illness or injury, as a part of their initial and follow-up assessments. More comments regarding nursing IPNs are in section M1.	

#	Provision	Assessment of Status	Compliance
		• The psychiatrists documented findings in the comprehensive psychiatric evaluation according to Appendix B, or in the form for psychiatry clinic including a psychiatric interim note, and Quarterly Psychiatric Medical Review. • Habilitation therapy staff documented consistently related to many supports, services, and interventions in the IPNs. In some cases, direct therapy interventions were documented in a working folder, but not appropriately translated to an IPN for use by other team members. 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. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The V4 interview tool, used for many years, was no longer providing the facility with any relevant or useful information. The section of the daily AOD interview tool described in the previous report was solely used now. Competency checks following NEO training were also used. In addition, the monitoring team observed that: • Nurses, when queried, noted the unified record was utilized for completing the required 24 hour chart checks (verification of MARS, physician orders, and reported as part of their assessments). Even so, this was not consistently found. For example, an individual identified with a head injury requiring a neurological assessment did not refer to the individual's baseline from his or her previous exams (e.g., vision). • The unified record was used during psychiatry clinic to obtain the results of EKG, labs, etc. Based on the above observations, data, and systems in place at SGSSLC, the monitoring team rated this item to 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.	

#	Provision	Assessment of Status	Compliance
		The URC continued to draw 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. Since the last review, data were also drawn from the transition committee. No other facility meetings were assessed. The monitoring team found the following: • The QIDP provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #50, Individual #57, and Individual #50. Data from assessments were entered into these two forms so that team members could reference current assessments when developing necessary supports. • The active record was available at these ISP meetings and was used by the team when additional information was needed. • Pre ISP meetings was observed for Individual #118. 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. • The monitoring team observed nurses executing the implementation of physician orders, found the nurses consistently referenced the unified record and the Medication Administration Record. • Psychiatry rounds included the use of the active record. • Active records were readily available during the PNMT meeting, and the PNMT RN, IDT members, and other clinicians conducted a record review prior to the meeting in order to report various elements of the individual's current status. • 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 of V4 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
ADS	Annual Dental Summary
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AHA	American Heart Association
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
BHS	Behavioral Health Services
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
CI	Clinical Intervention
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
ICGSB	Integrated Clinical Services Governing Body
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
NHLBI	National Heart, Lung, and Blood Institute
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
PD	Program Developer
PDD	Pervasive Developmental Disorder
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PEMA	Psychiatric Emergency Medication Administration
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
POC	Polypharmacy Oversight Committee
POT	Post Operative Treatment
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor

PPSV	Pneumococcal polysaccharide vaccine
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
RBBB	Right Bundle Brach Block
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