United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: August 16-20, 2010

Date of Report: October 8, 2010

Submitted By: Alan Harchik, Ph.D., BCBA-D
Monitor

Monitoring Team: Helen Badie, M.D., M.S.
Carly Crawford, M.S., OTR/L
Daphne Glindmeyer, M.D.
Gary Pace, Ph.D., BCBA-D
Carolyn Smith, R.N., CDDN
Teri Towe

Table of Contents

I. Background - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement (SA) covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him or her every six months, and detailing his or her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 were considered baseline reviews. Compliance reviews began in July 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of the San Antonio State Supported Living Center.

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this status review, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, and consent; Carolyn Smith

reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Daphne Glindmeyer reviewed psychiatry services; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, record keeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

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

(a) **Onsite review** – During the week of July 19 through July 23, 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports, and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living discharge plans, and consent forms; incident reports and investigations; restraint

documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. The following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, PSP team meetings, discipline meetings, incident management meetings, and shift change.

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

III. Organization of Report – The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA, the report includes the following sub-sections:

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

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SASSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring tour. Moreover, the facility made a number of staff members available to

the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The facility director, Ralph Henry, set the tone for the week of the onsite tour. He was readily available, ensured that all requested information was obtained, and directed all of his staff to work cooperatively and openly with the monitoring team.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Unfortunately, there were many problems with the preparation and management of documents prior to and during this monitoring tour. As is typical, prior to the onsite tour, the monitoring team submitted a request for numerous documents to the facility (e.g., reports, assessments, policies, lists of individuals who met certain criteria). The facility then sends these documents to the Monitor two weeks prior to the first day of the onsite tour. For San Antonio SSLC, many of the requested documents were not included, and many of the documents that were sent turned out to not be the document that was requested (i.e., the wrong document was sent). Document management continued to be a problem during the week of the onsite tour. The Monitor had numerous conversations with central office and facility staff and hopes that these difficulties can be addressed for future tours.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at SASSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist SASSLC in meeting the many requirements of the Settlement Agreement.

Third, this was the first post-baseline tour of SASSLC. These tours are called compliance tours and this is a report of the compliance tour, that is, of the facility's status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement requires the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite tour. In the monitoring report, the Monitor is to describe and comment upon the self-assessment steps the facility undertook to assess compliance and the results of this self-assessment. At SASSLC, the self-assessment consisted of two documents called the Plan of Improvement (POI) and Supplemental Plan of

Improvement (SPOI). These were submitted to the Monitor within the required timeframes. The POI described the many actions the facility had taken, or planned to take regarding each provision of the Settlement Agreement. The SPOI described the facility's response to each of the recommendations in the baseline report. The Monitoring Panel and the parties have had a number of discussions regarding the POI and SPOI. As a result, a number of revisions and additions are going to be put in place for future POIs and SPOIs because in its current version, the documents did not provide the Monitor with sufficient detail regarding the facility's actions (e.g., number of cases reviewed, criterion used).

The SASSLC POI contained hundreds of items in the lengthy document of more than 300 pages. All of the items were marked as being in noncompliance (except for about a dozen scattered throughout the document, most of them in nursing). Little information was provided other than the noncompliance rating (e.g., sections J, S, and T), though some sections included some commentary for some of the items (e.g., sections K, N, O, P, and R). The document did not provide the monitoring team with information regarding the activities in which the facility engaged to conduct the self-assessment for each provision. Therefore, the monitoring team has not commented upon the self-assessment in each of the report sections to follow below. It is hoped that subsequent self-assessments will provide the monitoring team with enough information to adequately comment on the processes and findings of the self-assessment. Then, future monitoring reports will contain commentary from the monitoring team regarding the self-assessment processes for each of the provisions of the Settlement Agreement.

Fourth, a summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and an understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

<u>Restraints</u>

- SASSLC continued to make the reduction of restraints used for crisis intervention a priority at the facility. Continued positive outcomes had been achieved. There had only been one incident of physical restraint for crisis intervention in the past 488 days. This was a great achievement. The facility, however, reported 10 incidents of chemical restraints in 2010. These restraints appeared to be used as a last resort intervention during behavioral crises. A review of documentation from these restraint incidents indicated that documentation was not completed as required, making it impossible to confirm that monitoring and review of restraint incidents were occurring according to state policy requirements. There was considerable focus by the facility on tracking and trending restraints used for crisis intervention, however, there was less information and data available on the use of protective and medical restraints. The facility was in the beginning stages of addressing reduction of medical restraints. It appeared that chemical, physical, and mechanical restraints were routinely used for medical and dental interventions without consideration of alternative treatments and desensitization plans. A total of 308 medical or dental restraints had been documented since October 2009. The

facility did not include this information in quarterly trend analysis reports. A Restraint Reduction Committee met in June 2010, but formal minutes and a roster of committee members were not available. The facility needs to formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop action steps to further reduce the use of medical and dental restraints at the facility.

Abuse, Neglect, and Incident Management

- All staff interviewed were familiar with the policies regarding abuse, neglect, and mandated reporting. They had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory. Overall, it was found that incidents were investigated quickly and consistently and the facility was quick to safeguard individuals from further harm. According to a log of investigations provided to the monitoring team, there had been 82 cases of alleged abuse or neglect involving 142 allegations at the facility from 1/1/10 through 6/30/10. Of the 142 allegations, 75 were for physical abuse, 47 for neglect, 17 for verbal/emotional abuse, and 3 for sexual abuse. This included six confirmed cases of abuse and eight confirmed cases of neglect. Approximately 10% of the total allegations were confirmed over this six-month period. The monitoring team reviewed 25 of the 53 cases completed by DFPS from 3/1/10 through 6/30/10, plus an additional five cases completed in July 2010. The facility's trend analysis summary for FY10 3rd quarter indicated that there had been 43 cases opened by DFPS with a total of 62 allegations. This was the lowest quarter for the past two years, according to the report. There were a total of 613 injuries reported during the third quarter of FY10 involving 213 individuals. Fifty-one of those injuries were abuse or neglect allegations. Eleven of the injuries were serious injuries, four involved fractures. Non-serious injuries accounted for 446 of the injuries, 124 did not require treatment, and in 30 cases, no injury was apparent. The top causes of all injuries were scratches (105), other (93), slips/trips/falls (39), and bites (37). Injuries caused by lifting/transfers accounted for 31 of the injuries.

Quality Assurance

- An adequate, comprehensive quality enhancement plan did not exist. Facility-wide data were not directed to the QE department. Regular reports were not completed by the QE department for use by senior management. Even so, a number of QE-related activities were occurring at SASSLC, including the observation and monitoring of various areas by QE program auditors, and by department staff. Moreover, the monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. The PIC was not functioning as intended by state policy. Corrective action plans were not developed correctly, and they were not tracked or managed in any organized manner. It is expected that the quality enhancement program will develop and mature over the next few years at SASSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the QE department's data

collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report.

Integrated Protections, Services, Treatment, and Support

- A sample of 14 Personal Support Plans (PSPs) was reviewed, and one annual Personal Support Team (PST) meeting and one interim PST meetings were observed during the onsite monitoring visit. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. All information gathered was reviewed at the team meeting. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision, nor did they focus on moving the individual into a less restrictive setting. It was observed at annual PST meetings and in observation of day programs, that information from assessments was not used to prioritize outcomes for the individual. Throughout the monitoring visit, it was noted that there was a low level of engagement in activities based on individual's preferences in many homes and areas of the day program, although there were some exceptions where individuals were engaged in interesting and meaningful activities. In the PSP meeting observed, a majority of the time was spent reading over assessment information that was written in the draft plan. The individual and most of the meeting participants clearly lost interest in the discussion. There was no real discussion around what the individual liked to do and how he could be supported to participate in new activities. Outcomes were general and represented no more than a continuation of things he was already doing.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, however, little activity had occurred regarding this provision item. Clinicians across the facility were not familiar with this provision. Moreover, examples of efforts to create and ensure the integration of clinical services were not evident at SASSLC and this provision was found to be in noncompliance. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

At-Risk Individuals

- The state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other

overwhelming concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk even with a plan in place. Note that, for the most part, the population served at SASSLC were admitted due to their high risk for health and/or behavioral issues. Risk levels often conflicted with information included in the PSP by specific disciplines. SASSLC's Health Status Team (HST) was reported and documented to be an interdisciplinary review of risk factors. Risk levels were also assigned by the Nutritional Management Team (NMT) and there were future plans by DADS for another team that would be involved in targeting and managing certain areas of risk. There was a need for integration and the identification and analysis of overlapping team functions.

Psychiatric Care and Services

- The psychiatry department at the SASSLC was in need of a strong leader. The facility has managed to recruit a quality full time psychiatrist, however, this physician did not have experience in the field of developmental disabilities, and although bright, energetic, and ambitious, will need administrative support and mentoring. The psychiatric physicians, though recently better integrated with primary care and neurology services, were otherwise not integrated into the overall treatment program at the facility. The psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate data in order for them to make data informed decisions regarding pharmacology in an objective manner, and, per a review of records, frequently made medication additions or adjustments in absence of data regarding specific target symptoms. Additionally, while staff from nursing and psychology attended psychiatry clinic, these clinic encounters were rapid and, per observation during this onsite monitoring tour, were not thorough with respect to a review of available records or interaction with the individual. Interviews with psychiatry staff revealed that, in most cases, they were aware of the challenges and need for increased structure and integration with respect to psychiatry, however, some resistance was verbalized by staff, specifically due to increased documentation requirements, and increased need for clinical contact time (which affects disciplines other than psychiatry). In order for psychiatric services to improve to the level of generally accepted practices, the facility will need to make a cultural shift, which will require leadership and integration among all the necessary disciplines.

Psychological Care and Services

- A number of psychology staff were enrolled in training towards certification as a behavior analyst. The facility was working to develop Positive Behavior Support Plans (PBSPs) that promoted growth, development, and independence while ensuring the safety, security and freedom from undue restraints of the individuals they served. The PBSPs reviewed, however, did not contain all of the components necessary for an effective plan, and the quality of the content of some of the components included did not meet the generally accepted professional standard of care. The majority of PBSPs reviewed demonstrated no change in target behaviors, and the PBSP

data from four individuals demonstrated an increase in SIB or aggression without evidence of PBSP modifications, retraining of staff, change in an antecedent procedure, and/or additional data collection. The facility had recently added internal peer review to the Behavior Therapy Committee meeting, but there was no evidence that the facility was conducting external peer review. The data collection methodology used at SASSLC did not conform to ABA generally accepted professional standards, but had made some improvements, such as introducing individual data books (that included each individual's PBSP and data sheets) that followed each individual throughout the day. Only fifteen of the 283 individuals at SASSLC had a psychological assessment. All individuals whose records indicated a behavioral disturbance had a functional assessment of the variable or variables affecting the individual's target behaviors. At the time of the onsite review, 16 individuals participated in "Circles." Discussions with the director of psychology revealed that the facility planned to expand psychological services offered to social skills classes, relaxation classes, and communication groups.

Medical Care

- Medical care was provided by a staff that included a full time medical director and two primary care physicians. All of these physicians were long-term employees of the facility. Psychiatric services were provided onsite as well as several subspecialty clinics. Acute care was provided by several local hospitals. There was no formal medical quality program in place. The medical director had started some quality initiatives. The mortality review process was in place. Clinical death reviews were completed for all deaths reviewed, but this process appeared inadequate as it resulted in zero recommendations. Overall, individuals received a wide variety of healthcare services. Policies and procedures were needed to guide the medical staff in the delivery of those services. SASSLC was found to be in noncompliance with this provision of the Settlement Agreement because a number of areas of weakness existed in the medical services practice at the facility as indicated below in section L of this report.

Nursing Care

- The nursing staff members were dedicated to providing quality care and individualized supports and services. During the conduct of this review, 23 individuals were visited, and their records were reviewed. In general, recordkeeping practices were improved from the baseline monitoring review. There was ample evidence across the 23 individuals reviewed that the individuals' physician was generally notified of significant changes in their health status and needs, and/or when they needed to be seen. Regarding medication administration, omissions (i.e., holes or blanks) on the MARs were greatly reduced from baseline, however, there were several areas of medication administration practice that did not meet acceptable professional standards, such as timely administration and appropriate follow-up for response to treatment with PRN medications. All 23 individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner. Notwithstanding these positive findings,

problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. All 23 individuals reviewed had some of their health needs and risks referenced by Health Management Plans (HMP) and Acute Health Care Plans (ACP). These plans were established by their RN case manager in response to identified health needs, risks, and/or significant changes in health status. The plans were generally generic and more appropriate for acute episodes than for individualized long term management of a health risk or problem. The forms, processes, and plans in place at the time of the review, however, had problems, and they were in dire need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. It was clear that a large part of the problems noted in the HMPs and ACPs were associated with the inadequate and incomplete nursing assessments and nurses' identification and follow-up to significant changes in individuals' health status and needs.

Pharmacy Services and Safe Medication Practices

- The facility had implemented several processes to ensure safe medication use. Several of the processes were either newly, or incompletely, implemented. Other requirements of the provision had not been addressed. Medication orders for individuals supported by the facility were dispensed from the San Antonio State Hospital and delivered directly to the residences. Prospective reviews of medications were, therefore, completed at the state hospital. The facility did not maintain a policy and procedure manual. At the time of the onsite review, the sole employee of the SASSLC pharmacy department was the clinical pharmacist who reported that a second clinical pharmacist was scheduled to start 9/1/10. The clinical pharmacist reported to the chief nurse executive and was responsible for administration of the medication error system. The clinical pharmacist also appeared to be involved in duties that normally do not fall under the purview of the pharmacy department, such as responsibility for programming all of the facilities defibrillators. Systems were in place for tracking medication errors, but not all errors were being recorded. Adverse drug reactions were reported over the past six months through the use of the WORx software. The ADRs reported were detected during the process of completing the drug regimen reviews. The facility had not developed a comprehensive ADR reporting and monitoring system. The facility had not completed any drug use evaluations. The function of the facility's Pharmacy and Therapeutics Committee (P&T) was integrated into the P&T Committee of the San Antonio State Hospital. A review of the last five committee meeting minutes indicated that participation by facility staff was cursory and information was frequently reported as not available. The facility recently formed a Pharmacy and Therapeutics Committee that met for the first time in July 2010. The composition and function of this committee was not defined in policy and procedure.

Physical and Nutritional Management, and Physical and Occupational Therapy

- SASSLC continued to implement a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. This team (NMC), however, still did not include critical team members, such as the physician, physician assistant, nurse practitioner, or PT. The Habilitation Therapies team members had attended PNM-related continuing education, but no evidence of further clinical instruction for other team members was submitted. A group of clinicians and the Medical Director met to discuss the recently developed policy (draft) for a new Physical Nutritional Management Team process that was to be implemented in the upcoming months. Concerns for the continued lack of a strong health risk assessment and the continued lack of integration between the NMC and the HST systems were also discussed. Mealtime observations in a number of homes demonstrated that great effort and attention had been directed toward improvement of staff training, monitoring, and support for home managers and direct support staff. Fewer errors in implementation were noted, though issues related to liquid consistencies continued to pose challenges for staff. Positioning continued to be inconsistently implemented by staff with limited attention to detail for alignment and support of those in wheelchairs. In a number of cases, pictures with the PNMP to assist staff with this were missing from the individual books. The PNMP coordinators had been trained and, though there had been some turnover in these staff, they had stood out as leaders during mealtimes. Direct support staff and home managers looked to them for information and validation.

Dental Services

- Individuals did not receive care in compliance with the requirement for annual evaluations. There was frequent use of sedating medications and restraints with little documentation from the Personal Support Teams (PST) on strategies to prevent use. In most instances, the personal support plans documented team agreement with the dental plan, including the use of restraints. Desensitization plans were not noted in any of the records reviewed. In the case of individuals who refused, the PSTs did not have a clear strategy to overcome barriers. Policies and procedures for the provision of dental services had not been implemented. The policy and procedure manual provided was a draft version that had not been approved. The majority of the records reviewed indicated that the individuals had a hygiene status of poor or fair. The facility had not implemented a dental quality improvement program and data for key dental process and outcome indicators was lacking.

Communication

- As was the case during the baseline monitoring tour, there were still only two speech clinicians to provide supports and services in the area of communication. Each of them also had responsibilities in the area of mealtimes and dysphagia assessment. Of the 32 assessments reviewed, approximately 82% identified individuals with significant expressive and/or receptive language deficits. There were 14 of these individuals who were recommended for some type of AAC system beyond the communication dictionary provided. It

continued to be a concern that so few individuals were actually receiving communication supports. Much time and energy were focused on two individuals with higher tech devices, as they were receiving direct therapy with communication-related SPOs. Many others, however, continued to wait for these supports. Collaboration with other disciplines outside of the Habilitation Therapies department continued to be limited and impacted the relevance and integration of communication supports across environments. The foundation of communication skills must be well integrated within the home, work, and leisure settings. SLPs must be able to lend their expertise to others in order to ensure that staff can capitalize on communication opportunities, appropriately reinforce communicative intent in a timely and effective manner, and promote communication-based skill acquisition integrated into all activities throughout the day. During an interview with the SLP clinicians, they discussed that they had made an error regarding the development of a plan for completion of comprehensive assessments (assessments for those who had been identified with highest needs for AAC had in fact been deferred until the next PSP year due to the existing staff's inability complete them). The therapists indicated that these assessments could be completed by the end of this calendar year. A number of individuals were determined not to be candidates for AAC systems based on a very limited assessment of their potentials to benefit from this supports.

Habilitation, Training, Education, and Skill Acquisition Programs

- The skill acquisition plans at SASSLC were not adequate to promote growth, development, and independence. The facility needs to better document that individual skill acquisition plans are chosen to address individual needs and preference. Additionally, the methodology used to teach individual SPOs was found to be inadequate to maximize learning. Finally, although skill acquisition plan progress was monitored, the DCPs implementation of plans was not monitored. Nevertheless, meetings with staff responsible for skill acquisition plans indicated that they recognized the need for an effective and improved process to determine and document how skill acquisition objectives were chosen. Additionally, they expressed a desire to incorporate evidence-based training procedures for training skills, and acknowledged the need for enhanced monitoring of progress. Despite staffs clear enthusiasm and shared goal for skill acquisition at SASSLC, it is not obvious that these changes can be effectively accomplished without an organizational change that would allow more time and focus for writing skill acquisition goals and monitoring implementation and progress. A good working relationship was described between SASSLC and the local public school district, however, the monitoring team raised questions regarding the adequacy of provision of an extended year educational program that included summer school. The monitoring team continues to be encouraged by the progress SASSLC demonstrates in the area of active treatment. The activities were well planned and some individual staff members were excellent at engaging groups of individuals in meaningful activities.

Most Integrated Setting Practices

- SASSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Very few individuals were in the referral process, however, progress was occurring. Individuals who were on the referral list during the time of the baseline tour had been placed, and new individuals had been referred for placement. Typical procedures for educating individuals and LARs were being conducted at SASSLC, but the effectiveness of these activities was in question. The facility should determine measureable outcomes for these activities (e.g., provider fair, CLOIP action). Further, An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. SASSLC had two staff who were dedicated to providing most integrated setting options to individuals. The Admissions and Placement Coordinator had many years of experience at the facility. The Post Move Monitor had many years of experience working with community providers and was knowledgeable about the community provider network. The process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. This was evident in the three CLDPs that were reviewed and during the group home visit conducted by the monitoring team. The local area had a large number of community residential providers. The monitoring team had the opportunity to attend the provider fair and to talk with representatives from more than two dozen providers. These conversations, as well as reports from facility staff indicated that the providers appeared committed to providing quality service. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. All of the discussions appeared to be brief and/or done in a rote manner and only had minimal individualization. They did not refer to optimistic visions for the individual. All four annual PSP meetings held during the week of the onsite monitoring tour were observed by the monitoring team. The LOD occurred towards the end of these meetings. The LODs were brief, rote, and not all meaningful. There was little discussion among PST members. The CLOIP was implemented for every individual reviewed. It is possible that the CLOIP activities were not meeting their intended purpose, that is, educating individuals and LARs about relevant community options. This is discussed in section T of this report. The facility recently appointed a new facilitator of the self-advocacy group and meetings were going to be re-instated. This will provide the opportunity to add to the content of the self-advocacy group meetings to include community placement, decision-making, and problem solving as regular topics for discussion. Comments in one individual's PSP document indicated that funding might be an obstacle to his placement. The facility should examine this case to determine if funding was an obstacle and if so, a plan should be put into place to address this obstacle.

Consent

- The facility had not begun to formalize a process for identifying individuals in need of LARs or identifying resources for finding guardians. A self-advocacy meeting was observed during the monitoring visit. The

meeting was well attended and the individuals in attendance appeared to enjoy participating in the meeting. The staff person that assisted with facilitation of past meetings was no longer working at the facility and officers of the group had been recently elected, so the meeting had little focus. The new facility Rights Officer had just been appointed and planned to continue to assist the group.

Recordkeeping and General Plan Implementation

- SASSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented in for some, but not all, individuals in every one of the homes. The new records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and a checklist of required/typical documents was used to ensure consistency across individuals. The Coordinator of Consumer Records and the Unified Records Coordinator were both committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records and were interested in improving the records as implementation of this new system moved forward. SASSLC should ensure that record keeping is tied into the facility's quality enhancement program and that quality assurance activities occur related to record keeping. Moreover, it will be important for SASSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. Management of the individual notebooks may become a challenge, especially regarding whether the size of the notebooks competes with the goal of having information readily available to direct support professionals. A system for auditing a sample of records every month was in place beginning in July 2010. The reviews were conducted by the URC and appeared to be thorough. The auditing process should be coordinated with the QE department so that the checklists used are the same. A system for ensuring that problems identified by the URC's audit are corrected.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of SASSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team continues to look forward to continuing to work with DADS, DOJ, and SASSLC.
Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Use of Restraint Policy #001 dated 8/31/09 o DADS Administration of Chemical Restraint Consult Form o DADS Physical Restraint Tracking Form for Dental o DADS Emergency Restrictive Practice HRC Review Form o DADS Restraint Checklist Form, numbered 06032010R o DADS Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint o DADS Restraint Documentation Guidelines for State Supported Living Centers November 2008 o List of all restraints used for crisis intervention, since 9/09 o List of all medical and dental restraints, since 10/09-6/10 o SASSLC Restraint Trend Analysis Report FY10 o PBSP Assessment – Guided Staff Training o HRC Referral Form and PSP Addendum (3/18/10) for Individual #107 o Structural and Functional Assessment, BSP, and Safety Plan for Crisis Intervention for • Individual #306 o Documentation of restraint used for crisis intervention : • Individual #107 3/18/10 Chemical • Individual #127 3/2/10 Chemical • Individual #211 3/30/10 Chemical • Individual #324 6/8/10 Chemical • Individual #218 6/10/10 Chemical • Individual #272 7/25/10 Chemical • Individual #188 7/29/10 Chemical/Physical • Individual #272 8/6/10 Chemical • Individual #272 8/13/10 Chemical o PSPs for Individuals #201 and #219 o PSPs listed in Section F Interviews and Meetings Held: o Interviews with various direct support professionals in homes and day programs o Ralph Henry, Director o Daisy Ellison, Psychological Services Director Observations Conducted:

	o Observations at all residences o Observations at the onsite workshop, prevocational program, and Forever Young Program o Unit #1 Morning Meeting 8/18/10 o Unit #3 Morning Meeting 8/17/10 o Incident Management Meetings 8/17/10 and 8/18/10
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: SASSLC continued to make the reduction of restraints used for crisis intervention a priority at the facility. Continued positive outcomes had been achieved. There had only been one incident of physical restraint for crisis intervention in the past 488 days. The facility reported 10 incidents of chemical restraints in 2010. It was obvious from documentation and interviews throughout the facility, that restraints were used as a last resort intervention during behavioral crises. A review of documentation from these restraint incidents indicated that documentation was not completed as required, making it impossible to confirm that monitoring and review of restraint incidents were occurring according to state policy requirements. Therefore, provision items addressing documentation were rated as being in noncompliance. While there was considerable focus by the facility on tracking and trending restraints used for crisis intervention, there was less information and data available on the use of protective and medical restraints. The facility was in the beginning stages of addressing reduction of medical restraints. It appeared that chemical, physical, and mechanical restraints were routinely used for medical and dental interventions without consideration of alternative treatments and desensitization plans. A total of 308 medical or dental restraints had been documented since October 2009. The facility did not include this information in quarterly trend analysis reports. A Restraint Reduction Committee met in June 2010, but formal minutes and a roster of committee members were not available. The facility needs to formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop action steps to further reduce the use of medical and dental restraints at the facility.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately	There was only one incident of physical restraint at the facility since the last monitoring visit. Documentation indicated that it was a horizontal hold lasting one minute, due to aggression towards staff and the exhibition of self-injurious behaviors. The restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
	and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	checklist indicated that the restraint was implemented following unsuccessful attempts to implement less restrictive strategies listed in the individual's PBSP, including verbal prompts, redirection, removing dangerous objects, and switching out staff. A list provided to the monitoring team indicated that there had been 10 incidents of chemical restraints used for behavioral intervention implemented at the facility since January 2010. Restraint checklists were completed for seven of the 10 incidents. Each of the seven checklist indicated that the restraint was used after less restrictive measures to deescalate the behavior were unsuccessful. It did not appear that any of the restraints were used for punishment, convenience of staff, or as an alternative to other treatment. For example, • The restraint checklist completed for Individual #272 on 7/25/10 indicated that staff attempted to engage the individual in replacement behaviors; and used verbal prompts, redirection, moved others away, and moved furniture away in an attempt to stop aggression towards staff and self injurious behaviors. • The restraint checklist completed for Individual #127 on 3/2/10 indicated that staff attempted verbal and gestural redirection in an attempt to stop the individual's self injurious behavior (removing colostomy bag and picking at stoma) prior to the administration of chemical restraints. • The restraint checklist completed for Individual #107 on 3/18/10 indicated that staff prompted replacement behaviors, redirected the individual, removed dangerous objects, moved others away, and traded out staff in attempts to stop aggression towards peers prior to administering chemical restraints. There was no indication that any restraint had been used at the facility that was not approved by the facility's policies. It was noted that there were posters in some common areas at the facility that reminded staff to use restraint as a last resort measure. The facility reported two individuals (Individual #306 and Individual #141) with protective restraints as a result of self injurious behavior (SIB). The monitoring team encountered other individuals, however, that staff indicated wore protective equipment to present injury from SIB. One, Individual #199, was reportedly to have had his protective helmet removed, but still had it on his wheelchair when he met with the monitoring team. After his helmet was reported to the director of psychology, his helmet was removed during the monitoring team's onsite tour. Two other individuals (#23 and #349) were also observed wearing protective equipment (i.e., mitts) that DCPs reported were for protection from SIB. These need to be addressed in order for this item to be rated as being in substantial compliance.	
C2	Effective immediately, restraints	There were no incidents of mechanical restraint use at the facility and only one	Substantial

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>shall be terminated as soon as the individual is no longer a danger to him/herself or others.</td><td>documented physical restraint since January 2010. The physical restraint only lasted one minute indicating that restraints were terminated in a timely manner.

The facility was rated as being in substantial compliance with this provision item.</td><td>Compliance</td></tr>
<tr><td>C3</td><td>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.</td><td>The facility had adopted the state policy governing the use of restraints. There was no indication that restraint had been used at the facility that was not approved in the state policy.

Training records were reviewed for the last three employees completing training at SASSLC and three experienced long-term direct support staff. All six had completed Use of Restraint and PMAB training prior to working with individuals as required by state policy. One of these staff had not completed PMAB training within 365 days as required by state policy. Both trainings were competency based with competency demonstration testing required.

In many cases, restraints were not documented according to methods included in current training. See section C4 for specific details regarding documentation.

The facility needs to ensure that correct forms are available for use to all staff and staff are trained to complete documentation as required by state policy.

The facility was rated as being in noncompliance with this provision item.</td><td>Noncompliance</td></tr>
<tr><td>C4</td><td>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</td><td>A log of medical and dental restraints used between 10/09 and 6/10 indicated there had been 308 incidents of medical or dental restraints used with individuals residing at SASSLC during this time period. The following is a breakdown of the types of restraints used:

<table><tr><td>Type of Restraint</td><td>Number of incidents</td></tr><tr><td>Mechanical</td><td>17</td></tr><tr><td>Physical</td><td>5</td></tr><tr><td>Chemical – IV sedation</td><td>40</td></tr><tr><td>Chemical – Oral sedation</td><td>64</td></tr><tr><td>Chemical with mechanical</td><td>165</td></tr><tr><td>Chemical with physical</td><td>17</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	or strategies to minimize or eliminate the need for restraint.	Mechanical restraints included the use of wristlets, soft ties, belts, and papoose boards. The log of medical and dental restraints provided to the monitoring team indicated that wristlets, soft ties, belts, and papoose boards had been used as restraints. The facility was not in compliance with state policy regarding the use of mechanical restraints because papoose boards are not an approved method of restraint. The following instances of the use of a papoose board were included on the log provided to the monitoring team: • 10/21/09 with Individual #181, 10/19/09 with Individual #34, 10/21/09 with Individual #180, 10/15/09 with Individual #238, 1/20/10 with Individual #127, 10/22/09 with Individual #66, and 2/22/10 with Individual #40. At the time of the onsite tour, the facility was only just beginning to focus on medical and dental restraint reduction. Dental services were currently provided outside the facility, but an onsite dental clinic was being developed and a dentist had recently been hired by the facility. The monitoring team was informed that the facility planned to look at the use of dental restraints when the clinic had been established. Notes from the Restraint Reduction Committee meeting on 6/25/10 indicated that the facility was taking "baby steps" in regards to reducing the number of medical and dental restraints. The facility did not have a formal plan in place to reduce the use of these restraints. Minutes from the Human Rights Committee (HRC) meetings indicated that the committee reviewed medical and dental restraints and, more recently, requested additional information regarding the nature of the restraints being used, and discussed the need for desensitization plans. For example, on 3/18/10, the HRC suggested a desensitization plan for Individual #240 and on 3/25/10 suggested a desensitization plan for Individual #294. Desensitization plans were not being routinely developed for individuals who required restraints for medical and dental treatment. Some examples are provided below. • The PST for Individual #201 discussed strategies to reduce the use of dental restraints and strategies that were included in her PBSP. • Individual #219's Rights Assessment indicated that mechanical restraints were used for dental procedures. He did not have a desensitization plan in place, nor did the PST indicate that the team had discussed the need for restraints. • Both chemical and mechanical restraints were used on Individual #199 for a routine dental visit on 1/11/10. His PSP indicated team and HRC approval of the restraints, but did not include a desensitization plan to reduce the need for restraint. .	

#	Provision	Assessment of Status	Compliance
		A focus on the reduction of medical and dental restraints should be the next priority for the facility in regards to restraint use. The facility was rated as being in noncompliance with this provision item.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the 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.	The monitoring team reviewed the 10 restraint incidents reported by the facility since January 2010. Monitoring and assessment of restraint incidents were not documented consistently by the facility. It was not evident that restraint use was being monitored as required by state policy. Some details are provided below. • For Individual #272 on 7/25/10, the nurse only indicated one attempt to monitor vital signs. Time of the attempt was not documented. The form was not reviewed by the restraint monitor. Neither form documented review of the restraint by the unit, psychologist, psychiatrist, or Incident Management Team. • For Individual #272 on 8/13/10, the restraint checklist indicated the restraint was a medical restraint, however, the restraint was administered for crisis intervention. That is, it was misreported by staff. The form did not indicate that a restraint monitor was notified or reviewed the restraint. A Face-to-Face Assessment form was not completed. There was no documentation of enhanced supervision following the restraint. • For Individual #272 on 8/6/10, the nurse only documented one attempt to monitor vital signs and mental status. Time of the attempt was not documented. Neither the Restraint Checklist nor Face-To Face Assessment Form indicated review by the psychologist, psychiatrist, unit, or Incident Management Team. • For Individual #127 on 3/2/10, the restraint was documented on incorrect forms. There was no indication that a nurse continued to monitor the individual following the initial review completed 15 minutes after administration of IM sedation. A Face-to-Face Assessment Form was not completed. • For Individual #107 on 3/18/10, the restraint checklist indicated that the restraint was a medical restraint, though the restraint was administered for crisis intervention. The form did not indicate who had applied the restraint, if a restraint monitor was notified, or the level of supervision during the restraint. There was no indication that the restraint incident was reviewed by the unit or Incident Management Team. • For Individual #211 on 3/30/10, a restraint checklist was not completed. The Face-to-Face Assessment did not indicate that the restraint was monitored as required or was reviewed by the unit or the Incident Management Team. • For Individual #218 on 6/10/10, the Restraint Checklist indicated that the nurse did not assess the individual within 15 minutes of the restraint application. The restraint was administered at 7:50 pm and the first assessment was documented	Noncompliance

#	Provision	Assessment of Status	Compliance
		at 8:35 pm. The review of the restraint by the restraint monitor, psychologist, unit, or Incident Management Committee was not indicated on the Restraint Checklist. The review section of the Face-To-Face Assessment Form was not completed. • For Individual #188 on 7/29/10 (physical restraint followed by chemical restraint), the restraint checklist and Face-To-Face Assessment did not indicate review of the incident by the unit, psychologist, or Incident Management Team. • A Restraint Checklist and Face-To-Face Assessment was not completed for Individual #324 following a chemical restraint on 6/8/10. Only two (20%) of the restraint checklists reviewed documented a face-to-face assessment of the individual within 15 within of the start of the restraint. The facility needs to ensure that all restraints are monitored as required by state policy and provisions of the Settlement Agreement. Monitoring and post restraint review should be consistently documented on the correct forms.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with	Restraints were not documented consistently. Of the 10 restraints reviewed, only seven (70%) were documented on a restraint checklist mandated by state policy. Staff did not complete all areas of the restraint checklists. Documentation did not always indicate that required supervision levels were implemented. See comments in section C5 above regarding restraint monitoring and supervision. Restraints were being documented on restraint checklists with revision dates of 4/1/08 and 7/30/08. The state revised the restraint checklist on 6/1/10. The facility needs to ensure that all future restraints are documented on the current restraint checklist and checklists are completed accurately. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Appendix A.		
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:	According to documentation provided by the facility, there were only two individuals (Individual #113 and Individual #306) at the facility who required the use of restraints more than three times in any rolling thirty-day period. Mechanical restraint was utilized with both individuals for self-abusive behaviors. Individual #306 had a plan in place that met the requirements (a-g), but individual #113 did not have a plan in place. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	A comprehensive assessment was completed for Individual #306 that included information regarding her adaptive skills, biological, medical, and psychosocial factors that may be contributing to the self abusive behaviors. According to information provided to the monitoring team, a plan was being developed Individual for #113. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(b) review possibly contributing environmental conditions;	The assessment for Individual #306 addressed environmental conditions that may contribute to self-abusive behaviors. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	A structural assessment was completed for Individual #306 on 2/11/2010. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	A functional assessment of behaviors was completed for Individual #306 on 2/11/10. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint,	A PBSP plan dated 2/13/09 was in place for Individual #306 that addressed use of restraints to prevent self injurious behaviors. The plan was updated and reviewed by the PST on 2/11/10. The plan summarized attempts to reduce the use of mechanical restraints and offers alternative strategies to reduce the behaviors targeted by restraint use. The facility was rated as being in noncompliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;		
	(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	Data on behavioral incidents was collected and analyzed for Individual #306 in a structural and functional assessment report dated 2/11/10. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	For individual #306, her team met annually and reviewed her BSP. Behavioral data was reviewed quarterly by the psychologist. The facility was rated as being in noncompliance with this provision item.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Restraint documentation did not indicate that reviews of restraint incidents were completed by the unit, psychologist, and incident management team as required by state policy in all instances. See findings in Section C5. The facility was rated as being in noncompliance with this provision item.	Noncompliance

Recommendations:

1. Formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop action steps to further reduce the use of medical and dental restraints at the facility.

2. Ensure that all restraints are monitored in accordance with state policy.

3. Ensure that all restraints are documented in accordance with state policy.

4. The facility needs to better define the uses of protective equipment, and ensure that all staff understand why an individual wears the equipment.

5. For those individuals who are wearing protective equipment for behavioral problems, the facility should have a fading procedure written into the PBSP.

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 SASSLC Draft Policy: Levels of Supervision and Adaptive Equipment, Revised 9/1/09 o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o List of most recent incidents of peer to peer aggression o Training transcript for last three employees hired o Background check for last 10 employees hired o Training transcript for three experienced employees o Background check for three experienced employees o Background check for the last three volunteers o Background check for all facility investigators o Log of Injuries by Individual (1/1/10-6/30/10) o Sample of 33 Client Injury Reports involving: • Individuals #47, #146, #347, and #56 o Sample of seven Client Injury Investigations completed by the facility for: • Individuals #47, #146, #347, and #65 o Client Injury Trending Report FY10 3rd quarter o Unusual Incidents Trend Analysis FY10 3rd quarter o Allegations of A/N/E Trend Report FY10 3rd quarter o Documentation of employee disciplinary action taken with regard to the last three incidents of confirmed abuse or neglect o Sample of unusual incident reports completed by each Campus Administrator o Log of employees reassigned due to ANE allegations (1/1/10-6/30/10) o Documentation of training for five DFPS investigators o Documentation from 30 completed, closed DFPS investigations:

Case #	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Date/Time Of alleged incident**	**Date Closed**
35578809	Physical Abuse	Unconfirmed	3/15/10 12:31pm	3/9/10 8:00 am	3/29/10
35578949	Physical Abuse	Unconfirmed	3/15/10 12:31 pm	3/11/10	3/29/10
35579251	Physical Abuse	Unconfirmed	3/15/10 12:31 pm	3/09/10	3/29/10

		35586629	Neglect Physical Abuse (2)	Unconfirmed	3/16/10 5:01am	3/16/10 5:00 am	3/30/10	
		35601669	Sexual Abuse	Unconfirmed	3/17/10* 8:51 am	3/17/10 8:00 am	4/7/10 Extension 3/31/10	
		36192949	Physical Abuse (3)	Unconfirmed	5/4/10 10:44 am	5/4/10 10:44 am	5/12/10	
		36239589	Emot/Verbal Abuse	Unconfirmed	5/7/10 10:45 pm	5/7/10 10:00 pm	5/21/10	
		36275949	Neglect Neglect	Unconfirmed Inconclusive	5/11/10 4:50 pm *	5/4/10	5/25/10	
		36370809	Neglect (4) Physical Abuse (3)	All allegations Confirmed	5/19/10 12:33	5/18/10 5:17 pm	7/19/10	
		36379670	Emot/verbal Abuse Physical Abuse	Unconfirmed	5/19/10 8:55 pm *	5/19/10 6:30 pm	6/16/10 Extension	
		36370729	Physical Abuse	Confirmed	5/19/10 12:33 pm	5/19/10 7:50 am	6/11/10 Extension	
		36414570	Emot/verbal abuse	Unconfirmed	5/23/10 12:31 pm	5/21/10 and 5/22/10	6/2/10	
		36430569	Physical Abuse (2)	Unconfirmed	5/24/10 6:41 pm	Unknown	6/7/10	
		36420369	Neglect	Unconfirmed	5/24/10 10:51 am	Unknown	6/4/10	
		36499950	Neglect Physical Abuse	Unconfirmed Confirmed	5/29/10 4:00 pm*	5/29/10	6/14/10	
		36500803	Sexual abuse (2)	Unconfirmed	5/30/10 6:13am*	5/30/10 6:08am	6/14/10	
		36607829	Neglect (2) Physical Abuse (2)	Other Unconfirmed	6/9/10 10:30 am*	6/7/10	6/18/10	
		36606970	Neglect (2) Physical Abuse	Confirmed Inconclusive	6/9/10 10:38 am	6/9/10	7/6/10	

36607769	Neglect	Confirmed	6/9/10 11:14 am	6/4/10 1:30 pm	6/18/10
36638651	Physical Abuse	Unconfirmed	6/11/10 12:27 pm*	6/10/10 10:30 pm	6/18/10
36696989	Emot/Verbal Abuse	Unconfirmed	6/16/10 4:18 pm	unknown	6/25/10
36706209	Neglect	Unconfirmed	6/17/10 12:18 pm	Unknown	6/25/10
36708289	Physical Abuse	Unconfirmed	6/17/10 1:40pm	Unknown	6/25/10
36816051	Neglect (2)	Confirmed Other	6/27/10 12:42 pm	6/27/10 12:42pm	7/7/10
36852890	Physical Abuse	Unconfirmed	6/30/10 9:33 am	6/30/10 9:33 am	7/9/10
36879229	Neglect (3)	All confirmed	7/1/10 3:27pm	6/29/10 5:45pm	7/9/10
36896431	Emot/verbal abuse Physical Abuse	Unconfirmed Unconfirmed	7/3/10 1:23 pm	7/2/10 8:00 pm	7/8/10
36929669	Emot/Verbal Abuse Neglect Physical Abuse	Inconclusive Unconfirmed Confirmed	7/7/10 9:15am	7/7/10 Unknown	7/7/10
36950789	Emot/Verbal Abuse	Inconclusive	7/8/10 12:47 pm	7/8/10 12:30 pm	7/16/10
37079169	Emot/Verbal Abuse	Referred back to facility	7/19/10 5:32 pm	Unknown	7/22/10

* law enforcement was notified by DFPS (#) indicates multiple allegations

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

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs;
- Three Direct Support Professionals
- Ralph Henry, Director
- Daisy Ellison, Psychological Services Director
- Gina Dobberstein, Leisure/Recreation Program Therapist
- Martin Garcia, Vocational Director
- Patrick Haas, Vocational Rehab Counselor

	o Jane Dahlke, QMRP Coordinator o Geral Rhoder, Assistant Director of Administration o Yolanda Nious o Leticia Jaloma, Abuse and Neglect Coordinator o Laurence Alqueseva, Rights Officer <u>Observations Conducted</u>: o Observations at all residences o Observations at the onsite workshop, prevocational program, and Forever Young program o PSPA Meeting for Individual #276 o PSP Meeting for Individual #212 o Self Advocacy Meeting 8/16/10 o Unit #1 Morning Meeting 8/18/10 o Unit #3 Morning Meeting 8/17/10 o Incident Management Meetings 8/17/10 and 8/18/10 o Meeting to organize volunteer group at Cyber Cafe
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: SASSLC had adopted the state policy without revision to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory. Overall, it was found that incidents were investigated quickly and consistently and the facility was quick to safeguard individuals from further harm. According to a log of investigations provided to the monitoring team, there had been 82 cases of alleged abuse or neglect involving 142 allegations at the facility from 1/1/10 through 6/30/10. Of the 142 allegations, 75 were for physical abuse, 47 for neglect, 17 for verbal/emotional abuse, and 3 for sexual abuse. This included six confirmed cases of abuse and eight confirmed cases of neglect. Approximately 10% of the total allegations were confirmed over this six-month period. The monitoring team reviewed 25 of the 53 cases completed by DFPS from 3/1/10 through 6/30/10, plus an additional five cases completed in July 2010. The facility's trend analysis summary for FY10 3rd quarter indicated that there had been 43 cases opened by DFPS with a total of 62 allegations. This was the lowest quarter for the past two years, according to the report.

	The facility trended unusual incidents, including injuries, choking incidents, deaths, unauthorized departures, and allegations of abuse and neglect. Data were trended by individual, home, shift, day of the week, and injury/incident type. There were a total of 613 injuries reported during the third quarter of FY10 involving 213 individuals. Fifty-one of those injuries were abuse or neglect allegations. Eleven of the injuries were serious injuries, four involved fractures. Non-serious injuries accounted for 446 of the injuries,124 did not require treatment, and in 30 cases, no injury was apparent. The top causes of all injuries were scratches (105), other (93), slips/trips/falls (39), and bites (37). Injuries caused by lifting/transfers accounted for 31 of the injuries. Some of the items in this provision were found to be in substantial compliance, others were found to be in noncompliance.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Assessment of this item required review of policies and an examination of implementation of those policies. The state had recently updated policies regarding Incident Management and Protection from Harm. SASSLC had adopted both state policies without revision. The Incident Management Policy numbered 002.2, and was dated 6/18/10. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and client injury reporting procedures. The Protection for Harm - Abuse, Neglect, and Exploitation policy was also Revised 6/18/10 and numbered 021. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility location visited and all staff interviewed were able to relay this information. The facility had developed reporting information posters with pictures of individuals living at the facility on them. This was a good way to ensure that the posters would receive a little more attention from individuals at the facility.	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		

#	Provision	Assessment of Status	Compliance
	policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The state policy specified reporting requirements for all serious incidents and was in line with this provision item. The facility policy included a section on incident reporting responsibilities for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Unusual Incident Reports documented notification to the facility director, After-Hours Duty Officer, DFPS, Law Enforcement, State Office, OIG, and DADS Regulatory. A sample of unusual incident reports, investigations, and injury reports was reviewed and indicated that notifications were made as required in most, but not all cases, to the facility director, DFPS, law enforcement, the state office and DADS regulatory. DFPS was responsible for notifying local law enforcement or OIG. Of the 30 investigations completed by DFPS for abuse or neglect allegations, five were reported to law enforcement for investigation. OIG notified the facility of outcomes of investigations by email. There were posters located throughout each facility site that provided basic instructions on intervening to stop abuse, as well as reporting abuse. It was not evident; however, that staff always reported suspected abuse and neglect. In DFPS case #36370809, the investigator noted the following concerns: • A concern has been raised that multiple staff provided consistent statements that were all found to be in direct contradiction to what was recorded on the surveillance tapes. • It is a concern that administrators from SASSLC viewed the surveillance tape, but did not report the additional allegations of abuse/neglect.	Noncompliance
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with	A review of Incident Management Team meeting minutes, observation of Incident Management Team meetings, and observation of morning Unit meetings confirmed that the facility took immediate and appropriate action to protect individuals involved in serious incidents. Alleged perpetrators were immediately removed from direct contact with individuals and reassigned to other duties until investigations were completed. This was confirmed by a list of employees reassigned due to ANE investigations provided to the monitoring team. According to interviews conducted with direct care professionals, staff were required to complete individual specific training prior to resuming work if released back	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	to a direct care position. Nursing staff completed injury assessments on individuals involved in all serious incidents. Levels of supervision were routinely increased when individuals were involved in any type of serious incident until team members could determine that the increased level of supervision was no longer necessary. A review of individuals on one-to-one supervision at the time of the onsite monitoring visit indicated that individuals were place on heightened supervision for medical monitoring, to minimize the risk of aggression towards others, to minimize the risk of self-injury, and to minimize the risk of injury. Additional recommendations for protections were routinely made at Incident Management meetings and Unit morning meetings. The facility was rated as being in substantial compliance with this provision item.	
	(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 facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. Documentation of training was kept by the facility and a small sample of seven staff records was reviewed. A Training transcripts for the employees reviewed showed that all had received required training on abuse and neglect within the past year this included ABU0100 Abuse and Neglect and UNU0100 Unusual Incidents. During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents. A larger sample of training records will be reviewed for compliance of this provision item during future monitoring visits. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate	The policy addressed mandatory reporters. Initial staff training provided during orientation included information on recognizing and reporting abuse and neglect. All staff who were interviewed were aware of their obligation to report. In all facility buildings toured during the review, posters stating the obligations of mandatory reporters were posted in common areas. The facility policy required staff to sign a statement acknowledging their responsibility to report abuse, neglect, and exploitation. A sample of staff personnel records was not reviewed during this monitoring visit to verify the existence of the signed statements.	Not rated

#	Provision	Assessment of Status	Compliance
	personnel action in response to any mandatory reporter's failure to report abuse or neglect.		
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. Clear reporting information was posted in each building in the facility. PSPs indicated that information regarding reporting of abuse and neglect was shared with families. A review of abuse and neglect investigations indicated that at least some of the individual's family members were aware of reporting procedures and had reported suspected abuse and neglect incidents to DFPS. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	Posters were found posted in common areas throughout the facility with a statement of individuals' rights. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The state policies included procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. DFPS was responsible for making the determination of when it was appropriate and following through with reporting. Five of the 30 investigations completed by DFPS correctly indicated that either local law enforcement or OIG was notified regarding the allegations. The Incident Management Coordinator confirmed that DFPS routinely referred cases and she verified that cases were referred as required. The facility was found to be 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	Policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	mistreatment should be reported. No cases of retaliatory action or allegations of retaliatory action were found by the monitoring team. Recommendations from the FY10 Trend Analysis Report on abuse and neglect included the recommendation to revise the agency policy to mandate that staff notify the facility director when they report an allegation of abuse or neglect. While in some cases this would be beneficial to the facility (e.g., so that management may begin taking steps to safeguard the individual), it may also inhibit staff from reporting as well as be counter to state regulations. The facility needs to ensure that failure to report abuse or neglect to the facility director is not grounds for disciplinary action. This was a recommendation and had not been implemented and, therefore, did not affect the rating for this provision item. The facility was found to be in substantial compliance with this provision item.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There was no evidence that formal audits were conducted to determine whether significant resident injuries were reported for investigation, though it was evident that the facility did routinely investigate significant injuries. Streamlined investigations were also completed on minor injuries of unknown cause by Campus Administrators. The investigation included a document review and statement of physical evidence. These investigations usually included recommendations for team members. Some examples of investigations conducted for serious injuries included: • UIR10-073 involving Individual #41 indicated that an investigation was completed for a serious injury even though it was a witnessed fall. • UIR10-072 involving Individual #47 indicated that an investigation was completed for a witnessed serious injury. • UIR10-060 involving Individual #146 was also an investigation involving a witnessed serious injury. • UIR10-058 was another investigation involving a witnessed serious injury for Individual #218. • DFPS investigation #36841069 was reported for investigation following a serious injury due to alleged staff neglect/abuse. • DFPS investigation #36499950 was reported for investigation regarding an injury of unknown cause for Individual #256. Client injury reports were consistently filled out by nursing staff or direct care professionals and reviewed by the Home Supervisor, the QMRP, and the Safety Officer.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Follow up action was noted on the report. For example, • One injury report completed on Individual #65 indicated that a PST was held to address aggression from the individual causing the injury and that individual was placed on 15-minute checks and referred to the next psychiatric clinic for review of psychiatric meds. • Another injury report completed on Individual #65 when he cut his toe, note the Safety Officer's recommendation for staff to verbally redirect the individual and keep his socks and shoes on, especially during transfers. When he was having a behavior during transfer, staff needed to ensure safety and let him down easy while holding his gait belt. Also, staff needed to follow his PNMP instructions for transfers and recommended referring him to Podiatry Clinic. • For Individual #47, an injury report was completed after she reopened an injury from SIB. The recommendation for follow up included the statement, "recent change in seizure medications may be contributing to increased agitation. MD and Psychiatrist will be notified." It was noted that injuries that were often discovered were documented as witnessed injures. Some examples include: • In an injury report regarding a fractured clavicle to Individual #65, the original injury report was completed on a bruise discovered by staff, but marked as witnessed. The report indicated a probable fall, not known how it happened. • Another injury report for Individual #65 was completed by staff after noticing a bruise on his lower back. The form indicated that the bruise was witnessed. • An injury report for Individual #146 was completed when staff reported that they heard a loud noise, when they went to investigate, they found the individual served sitting in the hallway with his head against the wall. He had a laceration to the top of his head. • Another injury report for Individual #146 was marked as witnessed by the person completing the form, but indicated that staff heard an individual yelling and saw the individual laying in his bedroom doorway. He had a laceration to the side of his head. Any injury that is not witnessed by staff completing the form should be marked discovered. The facility needs to develop a process to ensure that all significant injuries are investigated. The facility was found to be in noncompliance with this provision item.	
D3	Commencing within six months of the Effective Date hereof and with		

#	Provision	Assessment of Status	Compliance
	full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated that all investigators who were responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100) within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. Additionally, the Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternatives (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. Training documentation for facility investigators was not provided to the monitoring team even though it was requested and, therefore, this item was rated as being in noncompliance. This will be reviewed at future monitoring visits. According to interviews, there were several trained investigators at the facility, including the Unit Directors and all of the Campus Coordinators. Having numerous trained investigators on campus ensured that investigations could begin promptly. The facility policy also stated that the investigator would not be in the direct line of supervision of the alleged perpetrator and must be trained in working with people with intellectual disabilities. There was no evidence that this was not the case. Training records were reviewed for five of the seven DFPS investigators completing investigations in the sample of 30 completed investigations reviewed. Four of the five had completed MH & MR Overview and MH & MR Investigations. Facility investigator training transcripts will be reviewed during future monitoring visits.	Noncompliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff cooperate with all investigations at the facility. The Abuse and Neglect Coordinator reported a good working relationship with DFPS, local law enforcement, and OIG. There was no evidence that the facility had not cooperated with outside investigations. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	There was no evidence of interference with investigations completed by law enforcement agencies. Note, however, that there was little evidence of law enforcement's involvement in investigations at the facility. As noted in other sections of this report, cases were referred to local law enforcement or OIG, but details of those investigations were not included in investigation files. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The state policy mandates that the facility investigator should prioritize the collection of evidence that is at most risk of contamination. It was evident that facility staff were quick to react to incidents and begin preliminary investigations. As noted in (e) below, there were some concerns over the ability of the facility to safeguard evidence when DFPS investigations do not always commence in a timely manner. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 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.	The state policy addressed timelines for investigations. While DFPS policy allowed for the initial facility notification of an allegation to be the start of an investigation, the monitoring teams viewed the first attempt to gather information at the facility as a starting point for the investigation. Several concerns that arise from this practice include, the opportunity to tamper with evidence, the opportunity for collaboration between perpetrators and staff, and the victim's inability to recall events after time has lapsed. Therefore, while investigations met DFPS requirements, many did not meet requirements of the Settlement Agreement to commence the investigation within 24 hours. Of the 30 DFPS investigations in the sample reviewed, the initial attempt to gather information did not occur within 24 hours of the initial notification to DFPS in 20 (66%) of the cases. Additionally, in some cases, days lapsed before a second contact was made following the first initial contact. The following are examples where initial attempts to gather information did not commence within 24 hours of notification: • DFPS investigation #36275949: a neglect allegation was reported on 5/11/10 at 4:50 PM. The initial face-to-face investigation did not occur until 5/13/10 at 9:50 AM. • In DFPS investigation #369296669, allegations of emotional abuse, neglect, and physical abuse were reported on 7/7/10 at 9:15 AM, and the initial face-to-face	Noncompliance

#	Provision	Assessment of Status	Compliance
		Investigation did not begin until 7/10/10 at 2:35 PM, not meeting the requirement to commence within 24 hours. The second contact was made to gather evidence on 7/13/10. • In DFPS investigation #36606970, allegations of neglect and physical abuse were reported to DFPS on 6/9/10 at 10:30 AM, and the initial face-to-face contact occurred at 5:15 PM on 6/11/10. The next contact made in the investigation did not occur until six days later on 6/17/10. • In DFPS investigation #35578809, an allegation of physical abuse was reported to DFPS on 3/15/10 at 12:31 PM. An initial attempt to gather evidence at the facility occurred at 1:45 PM on 3/18/10. The second face-to-face interview occurred on 3/24/10. Of the 30 investigations reviewed, 14 were completed within 10 days as mandated by this provision. DFPS had updated its policy to require completion within 10 days beginning 6/1/10. Of the 14 cases reported after 6/1/10, three were not completed within 10 days, and extensions were not filed in those cases. Extensions were requested in four cases that took longer than 14 days to complete prior to 6/1/10. DFPS reports included a comprehensive summary of the investigation. Some of the investigations included recommendations for follow up action by the facility based on information gathered during the review. All Unusual Incident Reports (UIR) completed by the facility indicated that internal investigations began as soon as the incident occurred or was discovered, usually within minutes. UIRs reviewed included recommendations and an action plan for following up on the incident. All were completed within 10 days. The facility needs to ensure that attempts to begin gathering evidence in each case commence within 24 hours and investigations conclude within 10 days. The facility was rated as being in noncompliance with this provision item.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. All investigations included the serious incident or allegation of wrongdoing, the name(s) of all witnesses, and the name(s) of all alleged victims and perpetrators (when known). Each report included a summary of topics discussed, a summary of all documents reviewed and all sources of evidence considered. There was no evidence that previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency were included in	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	evidence considered. Facility investigative reports were clearly and consistently written and contained all elements listed in this provision in a standardized format. The facility was rated as being in substantial compliance with this provision item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The state policy required that the Incident Management Coordinator reviewed all investigations to ensure that they were thorough and complete, and that the report was accurate, complete, and coherent. The Abuse and Neglect Coordinator at SASSLC was responsible for reviewing all DFPS investigations and the Facility Investigator reviewed all internal investigations. Additionally, all investigations remained an item for discussion on the Incident Management Team Meeting agenda until cases were closed and recommendations were completed. During IMT meetings observed, it was noted that the team members routinely asked for clarification and made recommendations. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each	The state policy required the facility to complete an Unusual Incident Report (UIR) for each incident at the facility. A sample of UIRs completed by the facility investigator was reviewed by the monitoring	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	unusual incident.	team. Each written report was written in a clear and consistent manner. Reports included a summary of investigative procedures, relevant history, personal information about the individual, a time line of notifications, and an analysis of findings and recommendations for remedial action to be taken. Each plan included corrective action taken and assigned responsibility and a timeline for each action.	
	(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.	A log of employees reassigned due to ANE allegations and observation of Unit and Incident Management Team meetings indicated that employees were routinely reassigned to duties not requiring contact with individuals immediately when named in an abuse or neglect allegation. Employees did not return to their position until investigations were complete. A review of employee disciplinary action taken as a result of allegations indicated that disciplinary action was taken promptly following completed investigations. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
	(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.	All investigations requested by the monitoring team were quickly accessed by the facility. Data were available by individual and/or staff person involved. The facility was found to be in substantial compliance with this provision item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents and allegations were trended by individual, home, location, date and time, staff involved, cause, incident type and results of any related investigations.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall 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 Monitoring Panel has had discussions with the state regarding how this provision of the Settlement Agreement will be assessed. This is necessary due to the confidentiality of the information, and the limited documentation that the state is allowed to maintain regarding the findings of the background checks, especially regarding applicants who are denied employment, and active employees who are terminated due to findings during their employment. To address this, the state will provide the Monitoring Teams with names of staff responsible for the process, so that they can be interviewed, and spreadsheets for each facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available, this indicator will be rated as being in noncompliance. Even so, SASSLC provided the monitoring team with some information, including a log indicating that the facility completed background checks prior to employment for the last 10 employees hired, as well as for three experienced staff, and all facility investigators. A fingerprint check for the last three volunteers at the facility was also reviewed. The facility received approval from fingerprint checks before allowing volunteers to work at the facility.	Noncompliance

Recommendations:

1. Implement an audit process to ensure all serious injuries are investigated.
2. The facility needs to further review incidents of falls for trends and develop a corrective action plan to address fall/trips and slips.
3. The facility needs to further review trends regarding injuries during lifts and transfer and develop a corrective action plan.
4. Ensure that staff completing injury reports identify injuries as discovered if they did not witness the injury.
5. Timeliness of initiation of investigations needs to be addressed.
6. More information, as indicated in D5 above, is needed in order for the monitoring team to assess the facility's rating for that 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:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o Organizational chart, dated January 2010 o SASSLC POI, 7/28/10 o SASSLC POI Supplement, 7/28/10 o SASSLC QE Department Settlement Agreement Presentation Book o SASSLC QE Plan, undated, but reported to have been completed recently o SASSLC Quarterly Trend Analysis for unusual incidents, abuse and neglect allegations, injuries, and restraints, for third quarter, FY10, through 5/31/10 o Trend Analysis Summary, third quarter, FY10, through 5/31/10 o Corrective Action Plan Tracking Spreadsheet, 8/10 o 19 documents, some of which were called CAPs o Variety of tools used by program auditors o List of meetings scheduled for the week of 7/19/10 o PIC meeting notes and agendas, eight meetings, January 2010 through July 2010 o SASSLC executive committee meeting notes, nine meetings, January 2010 through July 2010 o Attendance at monthly self-advocacy meetings, January 2010 through July 2010 <u>Interviews and Meetings Held</u>: o Ralph Henry, Facility Director o Larrie Collier, Director of Quality Enhancement o Moneke Tyner, Settlement Agreement Coordinator o QE Department staff: Laurence Alqueseva, Joshua Castro, Mandy Pena o Residential Unit Directors: Greg Vela, David Ptomey, Juan Villalobos o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. o Discussions with family members of: • Individual #205, Individual #37 <u>Observations Conducted</u>: o Many residences, day program, and vocational program o PIC Meeting, 8/19/10 o Self-advocacy meeting
	Facility Self-Assessment: Please see the Executive Summary section of this report.

	Summary of Monitor's Assessment: SASSLC was not in compliance with this provision. An adequate, comprehensive quality enhancement plan did not exist. Facility-wide data were not directed to the QE department. Regular reports were not completed by the QE department for use by senior management. Even so, a number of QE-related activities were occurring at SASSLC, including the observation and monitoring of various areas by QE program auditors, and by department staff. Moreover, the monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. The PIC was not functioning as intended by state policy. Corrective action plans were not developed correctly, and they were not tracked or managed in any organized manner. A self-advocacy group had been assigned a new facilitator. It is expected that the quality enhancement program will develop and mature over the next few years at SASSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the QE department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report. The monitoring team looks forward to continued development of SASSLC's quality assurance program.

#	Provision	Assessment of Status	Compliance
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.	Based upon a review of documents, interviews with facility staff, and observations at the facility, SASSLC was not in compliance with this provision item. A review of this section of the Settlement Agreement required the monitoring team to look at policy, processes, and outcomes related to quality assurance activities at SASSLC (these are referred to as quality enhancement (QE) in this report). A policy was developed by the state DADS regarding quality assurance titled "Quality Enhancement." It was labeled policy #003 and was dated 11/13/09. The facility had adopted this policy in full. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the Quality Enhancement plan, corrective action plans, tracking of these plans, and operation of the performance	Noncompliance

#	Provision	Assessment of Status	Compliance
		improvement council. SASSLC, however, was not implementing or following the components of this policy at the time of the onsite monitoring tour. It did not have a comprehensive, organized, or systematic quality enhancement process in place. There were, however, a number of quality enhancement-related activities going on at the facility. Nevertheless, as a result of the absence of any quality assurance system or quality enhancement plan, SASSLC was not meeting the requirement of this provision, that is, that data be tracked to identify trends across, among, within, and/or regarding, program areas, living units, areas of care, staff, and/or individuals. Further, there was no trending regarding overall protections, supports, and services as required by this Settlement Agreement provision. This was further supported by the facility's self-assessment (POI) that indicated that all items in this section of the Settlement Agreement were in noncompliance and would be addressed in the future. In addition, all items in the facility's Supplemental POI were noted as going to be addressed in the future via the POI. Further, discussions with the Director of Quality Enhancement also indicated that the facility was not yet implementing quality enhancement activities as required by the Settlement Agreement. The monitoring team expects to see a more formal and comprehensive quality assurance and quality enhancement program initiated and in place at SASSLC when it returns for the next onsite tour. <u>Policies</u> The Director of Quality Enhancement told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. At SASSLC, there were no policies or processes related to quality enhancement that were specific to the facility or that referred to the state policy. SASSLC should consider whether the development of facility policies for QE might be helpful to the overall operation of a QE program at the facility. If so, SASSLC will need to ensure that its policies are in line with any state policies. Further, any facility policies related to QE should be reviewed and approved by DADS central office. <u>Quality Enhancement Plan</u> The DADS policy required the development and implementation of a quality enhancement plan (QE Plan). An adequate QE plan did not exist at SASSLC. In general, a QE plan should indicate all areas that are to be audited, the tools to be used, the frequency of audits, and the staff who are responsible for these audits. It should also describe the type of report(s) to be generated.	

#	Provision	Assessment of Status	Compliance
		The QE director submitted a Quality Enhancement Plan to the monitoring team (it was undated, but according to the director, was written recently). Unfortunately, it was woefully inadequate as a QE Plan, that is, it did not look at comprehensive quality assurance processes, goals, and outcomes; nor did it align with the state policy. It contained three general areas: the state-required trend analysis, complying with ICFMR regulations, and the Settlement Agreement. There was no detail to guide the facility and its QE department as to what to do, what to report on, how to follow up, and so forth. The QE plan should incorporate all areas of quality enhancement, data collection, and information related to quality across the entire facility. Even so, as noted below in this section of the report, numerous activities were going on at the facility (e.g., data collection, observation and feedback). Some of it was collected by the QE department staff, and some of it was collected by other departments at the facility, but almost all of it was not a part of the QE program. The QE department should play a role as a repository for all of these activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to senior management in a manner that is useful for decision making and efficient and effective management of all services and supports at SASSLC. <u>QE Department</u> Larrie Collier was the director of the QE department. He had been in this role for about a year. Before that, he was the coordinator of the QMRPs at SASSLC and had worked at the facility for about 10 years. As part of his duties as QE director at SASSLC, he was the facility's primary contact for any ICFMR DADS regulatory activities, such as coordinating surveys and investigations, and overseeing any actions and follow up required for any deficiencies and for any plans of correction. He supervised the QE department's three program auditors (one was called the QE Nurse) as well as a number of other activities at the facility, including the facility investigator, admissions and placement coordinator, record keeping department, and QMRP department. This appeared to the monitoring team to be a reasonable set of responsibilities for this department. Facility senior management, however, should ensure that this set of responsibilities do not compete with the director's ability to attend to the important needs of quality enhancement, as described throughout this section of the report. The QE director reported that there was a good working relationship between the QE department and other departments at SASSLC. He noted that the facility director was	

#	Provision	Assessment of Status	Compliance
		available and accessible if he should need him for support or direction. Moneke Tyner, the Settlement Agreement Coordinator, also played a role in quality enhancement activities. She was responsible for document preparation for the monitoring team as well as overseeing the PIC meetings. Preparation and management of documents, however, was a problem throughout this monitoring tour, including the preparation of documents for the monitoring team prior to the onsite visit, and obtaining of documents during the onsite visit. Problems included incorrect labeling and coding of the electronic files, the absence of many items that were requested by the monitoring team, the submission of the wrong documents to the monitoring team, and a failure to have documents available onsite at the start of the onsite tour. Numerous discussions occurred between the monitoring team, facility management, and the Settlement Agreement Coordinator during the week of the onsite monitoring tour, and it is expected that the document management system will be completed thoroughly and correctly for the next monitoring tour. Professional development for quality enhancement staff should also be considered, including, for example, training in quality assurance in the field of developmental disabilities and those with dual diagnoses. Further, DADS should consider ways for program auditors across the state to interact with, and learn from, each other. <u>QE Activities and Indicators</u> A number of QE activities were occurring at SASSLC. The three program auditors were involved in many different activities. The monitoring team had the opportunity to meet with the three program auditors. This group of employees appeared to be committed to operating in a professional manner and in providing a service that would be valuable to the facility. A number of performance indicators (i.e., measures) existed at SASSLC, but, as noted above and below, the choice of indicators, their design, and their management were not done in any comprehensive, thoughtful, or systematic manner. Any measures collected by other departments were not known to the QE department, and the data were not submitted to the QE department (e.g., psychology, habilitation). Further, there was no special attention paid to ensuring that quality assurance activities were occurring for the four specific provisions of the Settlement Agreement that called for quality assurance or quality improvement activities (F2g, L3, T1f, and V3). In addition, there was no special attention paid to the Health Care Guidelines or Dental Guidelines by the QE department. Below, are listed a number of the indicators being measured and/or collected and some	

#	Provision	Assessment of Status	Compliance
		of the tools being used by the QE department at SASSLC. • Consumer support observation and interview: a four page tool that included observation of individual's engagement, a staff interview, and observation of the environment that looked at dignity, interactions, informal teaching, and available materials. • Active treatment: five minute observation of interactions and activities • Levels of supervision • Physical management plan: PNMP, positioning, lifting, equipment • Mealtime: dining room, texture, positioning, equipment, dining plans, and risks • Snack time safety • Appearance of individual: clothing and grooming • PSP meeting contents • Home management team meeting • Record audit • Comprehensive nursing assessments and quarterly nursing assessments • Nursing data for central office regarding incidences of a number of different medical conditions • Use of monitoring team's checklist tools (this was implemented very recently) The program auditors reported that they collected information using the tools listed above. They reported that they provided immediate feedback to those who were observed and to their managers. This demonstrated good operating practice. Research has shown that immediate feedback regarding on the job performance can be an effective way of improving and maintaining staff performance. A number of other comments, however, are relevant regarding the program auditors' activities. • The program auditors reported to the monitoring team that they were working to communicate with all departments at the facility. This was also good practice and, once a routine part of the QE activity at SASSLC, is likely to contribute to the integration of QE into the overall operations at SASSLC. For example: o One of the program auditors reported that he attended the weekly consumer services meeting. There, he presented data (e.g., the trend analysis data), and talked about CAPs. o The program auditor who was the QE nurse reported that she had frequent communication with, and worked closely with, the facility's CNE and NOO. She reported that she attended a variety of meetings, including daily medical (these started just a month prior to this onsite monitoring tour), the daily incident management team (this rotated across the three program auditors), infection control, nutritional	

#	Provision	Assessment of Status	Compliance
		management, weight management, medication error, and admissions. She said that she did all clinical death reviews and followed up on all acute illnesses and post-hospitalization activities. • The QE department should ensure that the tools they are using are in line with the tools being used by the departments. For example, whether their PNMP and mealtime tools are in line with those used by the habilitation department, whether their PSP meeting tools are in line with that used by the PMM for the LOD section of the meeting, and whether their record audit is in line with that used by the Unified Records Coordinator. The monitoring team was pleased to see that SASSLC had made some efforts to incorporate the contents of many of the tools used by members of the monitoring team. As discussed at length with the QE department staff, and again at the exit session during the onsite tour, please remember that these tools were designed for use by the monitoring team and, therefore, many items will need to be adapted for use by facility staff. Additional points are listed below. • The monitoring tools do not include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of monitoring team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who had more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. • These tools should not be used to generate a cumulative score with regard to substantial compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. • Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise or who engaged in specific activities during the week of the onsite monitoring tour. • At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example,	

#	Provision	Assessment of Status	Compliance
		policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet likely would assist in this process. Again, the monitoring team also found that other departments were collecting data, conducting monitoring, and summarizing data. These, however, were not submitted to the QE department, and in most cases, surprisingly, the QE department was not even aware that these activities were occurring. The facility should ensure that all relevant data be submitted to the QE department as indicated above in this section of the report. The QE department did not appear to play any role in the organization or summarization of any of these data. The DADS policy called for: • "an integrated, reliable and valid data information system that compiles relevant individual and organizational data…" (page 2); • the facility to "review and monitor the integrity and validity of the data…" (page 6); and • that "data must be tracked 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." (page 7). The QE system at SASSLC was not meeting these requirements. These clear directives from the policy require that the QE department: • Ensure validity of the items in each tool (i.e., whether the tools actually measure what it is they are purporting to measure). This requires an examination of the definitions that the auditors used to determine if the item was present. - Experts in each discipline area should be involved in this process, both at the facility level, and at the state level (i.e., central office discipline heads). - Evidence needs to be provided that stakeholders agree that the indicators are important. - Detailed definitions are needed for auditors to determine the presence or absence of the indicator. o There was no evidence that any work had been done at SASSLC to address the validity of the indicators and measures. • Ensure the tools are reliable; that is, that there is agreement across auditors, that unintentional bias by auditors is reduced, and that observer drift does not occur (a change, over time, in what is accepted to indicate presence of the indicator). o There was no evidence that any work had been done at SASSLC to address the reliability of the data collected for each of the indicators and	

#	Provision	Assessment of Status	Compliance
		measures. SASSLC also collected and reported data on a number of areas, as was required by the DADS central office, called the Trend Analysis Report. These data were summarized for facility management and recommendations were included for each of the four areas of the Trend Analysis Report. These measures were unusual incidents, abuse and neglect allegations, injuries, and restraint usage. Although a CAPs tracking form, and a number of CAPs were submitted to the monitoring team, it appeared that CAPs did not exist for most of the recommendations and there was no way to determine if the recommendations were being implemented or met. Satisfaction surveys were recommended in the SASSLC baseline monitoring report. Satisfaction surveys had not yet been conducted at the time of this onsite tour at SASSLC. Satisfaction surveys are an important part of any quality enhancement program and usually include an assessment of the satisfaction of individuals, their families and LARs, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their satisfaction across a range of areas, some broad, some very specific. To further support the need for these type of surveys, the policy on page 3 notes that the QE program should "...assess individuals satisfaction with services and supports." The monitoring team had the opportunity to talk with family members of two of the individuals immediately following their PSP meetings (Individual #205, Individual #37). Both families expressed satisfaction with services at SASSLC. These two examples provide further reason for SASSLC to implement a formal family satisfaction measure, that is, it can provide SASSLC with relevant and important information, as well as reinforce staff and management for the work they do. Examples are below: • A family member said that, "the work the staff and everyone does here means a lot to us, and makes us feel comfortable knowing she's so well taken care of." • A family member said that she felt her family member was getting excellent care in a safe, caring environment at SASSLC. She said that she had great respect for the work that the staff has done and was continuing to do. She did not think that her family member would ever thrive like she had since she came to the SSLC. A self-advocacy group can provide one way of assessing, or learning about, individual satisfaction, opinions, and suggestions. The monitoring team was pleased to learn that one of the program auditors had been promoted to the rights officer position at SASSLC and would be taking over responsibility for facilitating and supporting the self-advocacy group. The monitoring team had the opportunity to talk at length with him about this new opportunity, especially regarding increasing the frequency of meetings (e.g., every two weeks instead of once each month) and using the meeting as an opportunity to teach	

#	Provision	Assessment of Status	Compliance
		individuals about problem solving and decision-making. The monitoring team requested minutes from the previous year's self-advocacy meetings, but only received attendance lists that indicated up to 27 individuals attending any month's meeting. Based upon a review of notes regarding the self-advocacy group, it appeared that nine individuals attended the meeting and that a number of relevant topics were discussed, such as what it means to be an advocate, the meaning of self-determination, the "Right for the Day" (to be free from abuse and neglect), and ways in which individuals can control their own lives. The monitoring team looks forward to the development of the self-advocacy group and to attending their meeting during the next onsite tour. Without notes, however, the topics, type and amount of participation, follow up actions, and so forth could not be determined. The monitoring also had the opportunity to attend a self-advocacy meeting held during the week of the onsite monitoring tour. The meeting lasted approximately 30 minutes and was attended by 17 individuals (though many came in after the meeting had started). There was little structure to the meeting, almost no participation from most attendees, and no attention to the seating spacing and auditory acoustics of the room. The rights officer who had been facilitating the self-advocacy meetings was no longer working at SASSLC and the facility's chaplain volunteered to facilitate this meeting. It was not an example of the way meetings typically occurred. Therefore, the monitoring team will make no further comments and will look forward to attending another self-advocacy meeting during the next onsite monitoring tour. In summary, and to reiterate, numerous QE activities were occurring at SASSLC even though a coordinated, comprehensive QE plan was not in place. The absence of a QE plan, however, resulted in the activities being fragmented, isolated, and, to a large extent, appearing to be random in their selection, design, application, and usefulness. <u>QE-Related Committees</u> The DADS policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation, such as pharmacy and therapeutics) at SASSLC. The policy required a program improvement council; this was in place at SASSLC and is described in section E2 below. The facility held a daily Incident Management Team meeting. This was a daily meeting during which senior management reviewed the previous day's incidents, emergency	

#	Provision	Assessment of Status	Compliance
		restrictions, restraints, injuries, and aggression between individuals. Although this meeting was not a QE meeting, it might be used by facility administration (in addition to the PIC described in section E2 below) as a way to incorporate QE activities into the daily operation of the facility (also see section D of this report). In addition, SASSLC had recently developed a consumer services meeting. This was a meeting for the day-to-day managers of the facility (e.g., unit directors, day service managers, psychology director) to review important issues at the facility. As noted above, QE staff attended this meeting, thus, this represented another way for QE activities to become an integral part of the daily operations at SASSLC. Further, the facility director held a periodic Executive Committee meeting. Based upon the minutes reviewed by the monitoring team, the committee appeared to meet irregularly; some months meeting two or three times (e.g., January 2010), and sometimes not meeting at all during the month (e.g., February 2010, May 2010). The topics were related to announcements, activities going on at the facility (e.g., surveillance camera installations), and reports from the assistant directors. All in all, it appeared to be an information sharing session. The facility director might also consider how this meeting might be integrated with the PIC as well as including topics relevant to QE, such as a review of data, actions plans, and outcomes. <u>QE Reports</u> The DADS policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report.	
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.	This provision item required the facility to analyze the data collected by the QE processes that are implemented at the facility. Based upon a review of documents, interviews with facility staff, and observations at the facility, SASSLC was not in compliance with this provision item. A quality assurance report did not exist and was not in the process of being developed or created. A quality assurance report should include data, line graphs, and narrative, at a minimum. SASSLC did not have any type of quality assurance report other than the state required trend analysis of restraint usage, injuries, unusual incidents, and allegations of abuse or neglect. SASSLC had added to this standard report by creating (just a few weeks prior to this onsite monitoring tour) a two-page summary that may be useful to facility management, and including a number of recommendations in each of the four sections of the report. As noted above in section E1, however, follow up and completion of these recommendations could not be determined.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As indicated above, little analysis of data occurred at SASSLC and should, therefore, be one of the facility's priorities as it moves forward in developing an active and functional QE system. During the time of the onsite monitoring tour, the facility program auditors reported that feedback was given to staff and managers. Copies of a few emails from the QE department supported this, however, the facility was not doing anything meaningful with the data collected by program auditors, such as trending, analyzing, summarizing, and developing action plans. SASSLC operated the PIC, but did not operate any performance improvement teams or performance evaluation teams. <u>Performance Improvement Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. There were no guidelines or policies specific to SASSLC to guide this group (other than the state policy). The state policy, however, provided a lot of information regarding the responsibilities and actions of the PIC. These included: • a definition: A group of State Center leadership staff that are required to meet and review each discipline and/or service area to discuss progress and concerns of individual's outcomes and organizational performance, • indication of responsibility for the overall quality assurance program at the facility (noted in paragraph I.E of the policy), and • a requirement to make recommendations on how to remedy or resolve problems (noted in paragraph II.D.1 of the policy). The monitoring team reviewed minutes from PIC meetings, and attended a PIC meeting held during the week of the onsite tour. The group met twice in January 2010 and not again until April 2010. It met once in April 2010, once in May 2010, twice in June 2010, once in July 2010, and once in August 2010. The August 2010 meeting occurred during the week of the onsite monitoring tour and the monitoring team attended the meeting. The minutes of the meetings indicated that the typical topics were the use of monitoring tools, preparation of the presentation books, and the preparation of the POI and SPOI. The August 2010 meeting was attended by 22 facility managers and was held in the facility director's office. The room was very crowded and did not lend itself to fostering of type of discussion that would be required for an effective PIC. Department heads made brief presentations (similar to their presentations to the monitoring team at the opening meeting of this week's onsite tour), but there was no discussion of issues, problem solving, or review of CAPs.	

#	Provision	Assessment of Status	Compliance
		Performance Evaluation Team Performance Evaluation Teams (PET) did not exist at SASSLC. Performance Improvement Team Performance Improvement Teams (PIT) did not exist at SASSLC. Corrective Action Plans There was no organized process for developing, implementing, disseminating, monitoring, documenting, or modifying corrective action plans at SASSLC. Nineteen documents were submitted to the monitoring team and were described as all of the CAPs that were at SASSLC. After inquiring, the monitoring team also learned about, and received, a two-page document called "Corrective Action Plan Tracking." The tracking form had 11 CAPs on it and all were dated 3/25/10, but it was impossible to tie together the 19 CAP documents to the listing on this tracking form, thus rendering all of this useless in terms of looking at the overall operation of CAPs and CAPs management at SASSLC. Further, it did not appear that any of this CAP-related activity was reviewed by the PIC. The 19 CAPs were in five different formats. Some were for individuals and some were for homes. Some had no dates on them. The ones with dates ranged from January 2010 through July 2010. Some were labeled PSP Addendum. Some of these documents, however, contained what appeared to be relevant information and appropriate action steps. SASSLC should develop a method to develop and manage CAPs.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement state policy on Quality Enhancement.

2. Consider whether facility-specific policies in QE might be helpful to the overall operation of the QE program at SASSLC.

3. Create a facility QE plan that is functional, meaningful, and useful to SASSLC managers, administrators, and clinicians regarding SA provisions and other areas of service provision (e.g., ICFMR regulations). The plan also needs to include:
    - all requirements of the DADS policy on Quality Enhancement,
    - a narrative,
    - all of the areas listed on page 4 of the policy, and
    - the Health Care Guidelines and Dental Guidelines

4. Provide professional development for QE department staff.

5. Ensure that the QE director's job responsibilities (in addition to QE) do not compete with his ability to manage the quality enhancement activities of the department and with meeting the requirements of this provision of the Settlement Agreement.

6. Ensure that the work of the Settlement Agreement Coordinator is incorporated, and in sync with, the activities of the QE department.

7. Ensure that documents are prepared and managed competently and completely for future monitoring tours.

8. Continue to modify and create quality enhancement tools that are in line with the monitoring team's checklist tools.

9. Ensure all relevant data are submitted to the QE department from all departments at SASSSLC in a timely and complete manner.

10. Ensure validity and reliability of data collected by program auditors.

11. Subject the QE department to quality assurance/enhancement review, feedback, and assessment.

12. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.

13. Consider ways to incorporate the teaching of problem solving and decision making into the self-advocacy group meetings.

14. Provide program improvement reports as per the policy.

15. Ensure the PIC operates as per the state policy and that the activities of the PIC are coordinated with the QE department.

16. Develop PETs and PITs as appropriate and as required by the state policy.

17. Develop a system to develop and manage CAPs, following all requirements of E1, E2, E3, E4, and E5 above.

18. Develop a QE report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

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 Training Curriculum: Personal Support Teams, PDP Process o PSPs for the following individuals • Individual #201 dated 2/16/10 • Individual #209 dated 4/22/10 • Individual #146 dated 9/22/09 • Individual #257 dated 12/3/09 • Individual #167 dated 2/11/10 • Individual #47 dated 5/3/10 • Individual #11 dated 4/3/10 • Individual #62 dated 7/28/09 o PSP, assessments used to develop the PSP, skill acquisition programs, and any PSP addendums for the following individuals: • Individual #199 dated 4/12/10 • Individual #159 dated 6/8/10 • Individual #174 dated 9/15/09 • Individual #103 dated 7/20/10 • Individual #214 dated 5/25/10 • Individual #225 dated 6/17/10 • Individual #219 dated 4/8/10 • Individual #36 dated 3/26/10 o Positive Behavior Support Plan for: • Individual #257 • Individual #225 • Individual #306 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals in homes and day programs o Three Direct Support Professionals o Ralph Henry, Director o Daisy Ellison, Psychological Services Director o Gina Dobberstein, Active Treatment Coordinator o Martin Garcia, Vocational Director o Patrick Haas, Supported Employment o Jane Dahlke, QMRP Coordinator o Rosella Kleiwer, QMRP

	o Karla Baker, QMRP o Michael Wong, QMRP o Laurence Algueseva, Rights Officer o Facility psychiatrists <u>Observations Conducted</u>: o Observations at all residences o Observations at the onsite workshop, prevocational program, and Forever Young program o PSPA Meeting for Individual #276 o PSP Meeting for Individual #212 o Self Advocacy Meeting 8/16/10 o Unit #1 Morning Meeting 8/18/10 o Unit #3 Morning Meeting 8/17/10 o Incident Management Meetings 8/17/10 and 8/18/10 o Meeting to organize volunteer group at Cyber Cafe
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet implemented. As a result, noncompliance was the rating determined for most of the items in this provision. The state policy #004 Protections, Services, Treatments, and Supports, dated 2/15/10, had just been approved, but had not yet been implemented. The facility had not yet developed a policy to address this section of the Settlement Agreement. A sample of 14 Personal Support Plans (PSPs) was reviewed, and one annual Personal Support Team (PST) meeting and one interim PST meetings were observed during the onsite monitoring visit. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. All information gathered was reviewed at the team meeting. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision, nor did they focus on moving the individual into a less restrictive setting. The cover page of each PSP reviewed using the new format included a list of "what's most important to the person?" and "how is this supported?" These lists tended to be generic lists that looked similar for most individuals. It was observed at annual PST meetings and in observation of day programs, that information from assessments was not used to prioritize outcomes for the person. Throughout the monitoring visit, it was noted that

	there was a low level of engagement in activities based on individual's preferences in many homes and areas of the day program, but in some areas, individuals were engaged in interesting and meaningful activities, as noted below. A group of individuals were meeting at the Cyber Café to organize a community volunteer group during the week of the review. The individuals at the meeting were actively participating in planning volunteer activities. During observation at home #766, some of the individuals had gone to the park, others were home preparing for an outing. It was noted that staff were engaged in meaningful, respectful conversation with individuals about their day. There was a natural rhythm to activities occurring in the home, unlike some of the other homes where activities appeared to be scheduled by staff and not necessarily related to individual's preferences. In the PSP meeting observed, a majority of the time was spent reading over assessment information that was written in the draft plan. The individual and most of the meeting participants clearly lost interest in the discussion (also see section T of this report). A way to avoid this and facilitate a more productive meeting would be to send the draft plan out before the meeting and ask team members to review the assessment information prior to the meeting. Then, use meeting time to develop meaningful outcomes and supports. There was no real discussion around what the individual liked to do and how he could be supported to participate in new activities. Outcomes were general and represented no more than a continuation of things he was already doing. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. The plan should describe who will provide and monitor each support, how the support will be provided, and a schedule of when each support will be needed. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

#	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:	The DADS policy for this section had just been approved, but not yet distributed at the time of this onsite review. SASSLC did not have facility policies in place addressing the role of Personal Support Teams (PSTs) or the development of Personal Support Plans (PSPs). QMRPs were scheduled to attend training on developing person centered plans. The facility needs to ensure that the QMRPs have support from all team members and facility administrators to change the current process used to develop PSPs and that all team members understand the underlying philosophy behind the changes. Quality Enhancement activities with regards to PSPs were in the initial stages of	Noncompliance

#	Provision	Assessment of Status	Compliance
		development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs at the facility were responsible for facilitating PST meetings, developing, monitoring and revising treatments, services, and supports. Interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. Two PST meetings were observed during the monitoring visit. Both meetings were facilitated by the individual's QMRP. • The annual meeting for Individual #212 was led by his QMRP. She kept the meeting focused and ensured that all items in the PSP were addressed by the team. • A PST meeting was called to discuss recent behavioral challenges for Individual #276 was also observed during the review week. The individual, QMRP, Psychologist, and Residential Manager attended the meeting. Surprisingly, both the QMRP and Psychologist acted frustrated with the individual over her long history of behavioral incidents. As a result, the meeting contained adversary and accusatory comments made to the individual, rather than a focus on reviewing and revising services and supports to address behavioral concerns. The facility needs to have a system in place to support team members in dealing with behavioral crisis and to replace team members when they can no longer be effective advocates for an individual (also see comments in section J below). According to interviews with QMRPs at the facility, they were often placed in direct services roles when there were staff shortages or when individuals required an increased level of supervision. They reported that this left little time for coordinating and monitoring of supports and services. This is another important area for the facility to address. It was not evident that plans were being monitored for implementation or revised when objectives were either completed or when progress was not being made. A review of PSPs and implementation data in the homes revealed many outdated or missing plans. Documentation of outcome implementation was often blank, incomplete, or inaccurate. For example, • In home 670, 14 records were reviewed, 50% did not contain a current plan. A current PSP was not found in the home for Individual #347, Individual #233, Individual #209, Individual #8, Individual #310, Individual #220, and Individual #246.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In home 766, 15 transport record books were reviewed; one did not contain a current plan. The PSP in the home for Individual #47 was dated 5/4/09. Implementation of her plan had not been documented for the month of August 2010. • In home 672, records for Individual #188, Individual #168, Individual #298, Individual #73, and Individual #128 were reviewed. There was no current PSP for Individual #188 in the home. Implementation for August 2010 was not documented for all five individuals in the sample. • In home 668, records for Individual #5, Individual #105, Individual #181, Individual #80, and Individual #309 were reviewed. Data had not been collected on employment outcomes for Individual #105 and there were no data collected on implementation of outcomes for the month of August 2010 for Individual #80 and Individual #309. QMRPs should ensure that support staff have current information needed to support each individual safely and consistently and that all plans are being implemented as written. Current PSPs should be available to all staff responsible for plan implementation and implementation should be documented. The facility was rated as being in noncompliance with this provision item.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The Annual PST meetings observed during the monitoring visit for Individual #212 confirmed that the PST was comprised of an interdisciplinary team based on the individual's strengths, preferences, and needs. Staff that provided direct support to the individual were present at the meeting and given the opportunity to contribute to discussion. Both the individual and LAR were present at the meeting. The physician, nurse case manager, therapy staff, nutritionist, and psychology staff all attended the meeting and contributed to the discussion. A review of a sample of attendance sign in sheets indicated that relevant team members were generally present at annual PST meetings with some exceptions including: • For Individual #146, psychology staff were not present at the meeting, though the PSP indicated that he had a PBSP in place to address physical aggression and inappropriate sexual behavior. Additionally, there was no indication that OT/PT staff participated in planning efforts, though he utilized adaptive equipment to move around the environment. • For Individual #225, psychology and residential support staff were not in attendance at the annual PST meeting. • For Individual #199, the attendance sheet did not indicate that the QMRP or residential staff attended the annual PST meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For Individual #201, the attendance sheet did not indicate that her LAR or residential staff attended the annual PST meeting. Direct care professionals interviewed reported that they routinely attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. All of the direct care professionals interviewed reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members and that those team members would address the issue and call the team together if needed. It was evident from a review of PSPs that documentation from a variety of relevant disciplines was reviewed in preparation of the annual PSP meeting. When direct care professionals, who know the person best, cannot attend team meetings, QMRPs should request input prior to the team meeting to include in discussion regarding the individual's preferences, routines, progress on outcomes and plan development. There was, however, no integration of psychiatry into the treatment planning process. Per interviews with psychology and psychiatry staff, psychiatrists were not attending treatment-planning meetings. A review of the PSPs for 17 individuals prescribed psychotropic medication revealed that basic information (i.e., names of medication and dosages) was included, but there were rudimentary risk/benefit ratio statements that were inadequate and rote. There were no detailed discussions of pharmacological plans or the thought processes behind the use of particular medications. For additional information regarding this issue, please see sections J10 and J13. The facility was rated as being in noncompliance with this provision item.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	A wide range of assessments were performed prior to PSP development. It was not, however, evident that these assessments were used to address barriers to each person achieving his or her individualized vision and, therefore, this provision item was rated as being in noncompliance. Positive Assessment of Living Skills (PALS) was the functional skills assessment used by the facility and specifically named in the state policy. While this assessment offered a basic checklist of functional skills, it did not include a means of prioritizing skills based on each person's individual preferences. This resulted in generic outcome development rather than individualized outcomes for each person. Additional assessments were completed for each person by specialists and clinicians. Recommendations from these assessments were often vague and not sufficient for	Noncompliance

#	Provision	Assessment of Status	Compliance
		providing support to each person throughout his or her day. For example, the PSP assessment summary section for Individual #199 only included, "Requires hand over hand assistance or complete staff assistance" under recommendations from his PALS assessment. There was no indication what areas this recommendation addressed or how the assessment would be used in planning. The PALS assessment for Individual #219 indicated many areas of need under the social skills assessment section; these needs were not addressed in his outcome "will perform a variety of social roles." Assessments were generally used to support continued placement at the facility, rather than address barriers to living in a less restrictive environment. Vocational assessments were found in many of the records reviewed, but did not address supported employment in the community. For example, documentation indicated that working was a priority for Individual #174. Her vocational assessment looked at skills applicable to the sheltered workshop where she currently worked, but did not focus on barriers to community employment. The Personal Focus Worksheet (PFW) found in most records targeted the individual's preferences and identified assessments that might be relevant to the individual's needs, however, many of these were incomplete and were not integrated into the PSP As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As noted in section F1c, it was not evident that assessment results were used to develop, implement, or revise PSP supports. The PSP included information from specific disciplines in isolated sections of the PSP, rather than integrating assessment information into one plan that staff could use to support the individual. For this reason as well as those identified in this section F1d, this provision item was rated as being in noncompliance.	Noncompliance
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	Community placement was discussed at most PST meetings according to the PSP, though the discussion was limited and little action was taken to move forward with community placement. PSPs indicated that individuals and their LARs were provided with information regarding community placement. All PSPs reviewed concluded that current placement was appropriate without any real discussion around removing barriers to living in a less restrictive environment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(1999).	At the annual PSP meeting for Individual #212, community living was discussed by the team, but quickly ruled out. The individual's sister was familiar with community placement and stated that she supported placement in the community, but did not feel that it was appropriate for her brother at this stage in his life. Her brother had lived in a community home in the past. The QMRP and CLOIP MRA agreed with her that SASSLC was the best option for the Individual due to intensive daily support needed by the individual. Neither seemed aware that intensive supports could be provided in the community; any possible benefits of community placement were not discussed. The PSP for Individual #103 stated that "the most important/priority requests is his family and a community referral in the future." His Living Options Discussion section of the PSP noted that his optimal living options vision is "SASSLC with a community placement in the future with a long-term goal." There was no further discussion of barriers to community living other than to note that "his behaviors are the major issue." The plan did not state what supports could be made available in the community to overcome this barrier or what criteria would need to be met to make community living an option. The PSP noted that community work was in place, but there was no discussion in the PSP related to supported employment. His vocational assessment did not refer to supported employment. The PSP should describe his job duties, schedule, and all supports needed to continue to work successfully in the community. The PSP for Individual #214 stated that both he and his family would like to consider community placement and the team agreed that this was an option, but outcomes were not developed to move him closer to this goal. He did not have any outcomes that were to be implemented in the community. There was generally no consideration of community-based day programs or supported employment by the team. Although trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the sheltered workshop on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. The facility had a vocational program that offered individuals a chance to work on contract work in a segregated setting. The facility did have a small supported employment program and there were some individuals employed in the community. Hopefully, the facility will continue to offer opportunities for individuals to pursue community employment through the expansion of this program.	

#	Provision	Assessment of Status	Compliance
		The facility was rated as being in noncompliance with this provision item.	
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:	This provision will be reviewed in greater detail by the monitoring team following the implementation of newly developed state policies to address PSP development and implementation.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	PSPs included a table with a list of what was most important to the person. This list tended to not be individualized, but rather was a generic list of what most people would say is important in their lives. For example, • Individual #103's list of what was important to him included: family, leisure, money/working, being responsible, living independently, and health. • The list for Individual #146 only stated personal health and family. The PSPs that were reviewed typically had an outcome to participate in some community activity, but plans did not state functional learning that would take place while the individual was in the community. The focus appeared to be on community participation in specific events rather than integration into the community by building relationships and establishing memberships. Some examples of this included: • Individual #103's PSP stated that his long-term vision was to reside in the community. He only had one outcome implemented in the community. It stated that he "will be offered at least one off-campus activity per week." There were no strategies included that would ensure this outcome would be meaningful and move him closer to his vision. • Individual #209, Individual #219, and Individual #47 had the same outcome to "attend an on/off campus activity per month." There was no criterion given to ensure that even some of these activities would be in the community. The implementation plan did not include preferences or any barriers that may need to be addressed for participation in the activity chosen. • Individual #146 did not have any outcomes that were to be implemented in the community. His plan did not address barriers to community participation. Teams should use "what's most important to the person?" section of the PSP to list	Noncompliance

#	Provision	Assessment of Status	Compliance
		specific things that are important for the individual and then develop outcomes and include supports that the person needs to maintain or increase the occurrence of those things in his or her life and address any barriers to occurrence. The facility was rated as being in noncompliance with this provision item.	
	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;	As discussed in the summary above, outcomes were not always related to the individual's preferences and vision. Most outcomes did not contain enough information to be observable and measurable, and plans were not consistent in addressing supports needed to achieve outcomes. For example, • The PSP for Individual #219, had the action step "Will have the opportunity to attend on or off campus community activities..." There was no indication as to what type of activities this would include or what supports would be needed for him to participate. He had multiple recommendations for communication and mobility supports, but none were included in strategies to participate in the community. • The PSP for Individual #199 had several action steps that were not clear in stating what level of participation was needed by the individual to complete the outcome and what supports would be needed for successful completion. The following action steps were included in his PSP: o "Will have the opportunity to attend on or off campus community activities..." There was no indication as to what type of activities this would include or what supports would be needed for him to participate. o "Will have the opportunity to send correspondence to his brother…." The plan did not indicate what level of participation was needed to successfully complete this outcome. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. Treatment plans and clinical care plans were often stand alone documents that were not integrated into an overall plan. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and	Noncompliance

#	Provision	Assessment of Status	Compliance
		incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. The facility was rated as being in noncompliance with this provision item.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes as discussed in F2a2 above. Although target dates for completing objectives were included in most cases, target dates for completion of outcomes were generally one year from the implementation date rather than being based the individual's rate of learning. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As noted in previous sections, a majority of outcomes in the PSPs reviewed did not adequately address supports needed by the individual to achieve outcomes and did not consider what the individual would need to learn to become more independent in the community.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	In the PSPs reviewed, Written Training Program/Data Collection sheets identified data to be collected, frequency of data collection, person responsible for implementation, and named the person responsible for monitoring the plan. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two	The monitoring team found a lack of coordinated supports and services throughout the facility. Although team members from various disciplines met together to develop the PSP, it was not evident that supports were integrated into one plan. The facility did not	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for individuals.	
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 review of home records indicated that current PSPs were not always accessible to staff designated to implement the plan. See examples in F1a.	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.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. For example, Individual #159's PST met following determination by the Health Status Team that he was at high risk due to polypharmacy. The team met and discussed medication reduction strategies. A PST meeting was called for Individual #276 following an increase in behavioral incidents. Individual #103's PST met to discuss injuries resulting from behavioral incidents. It was not evident, however, that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed. None of the PSPs reviewed had been modified outside of the annual PSP meeting, though data collection indicated that individuals had completed outcomes or had made no progress at all on outcomes during the year. QMRPs should monitor plan implementation for progress and convene the team to address barriers when progress is not being made. The facility was rated as being in noncompliance with this provision item.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated or modified. During interviews, direct care professionals indicated that they were often pulled to work in different homes. Staff reported that they received an overview of support needs for each person in the home, but were able to	Noncompliance

#	Provision	Assessment of Status	Compliance
	complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	work with individuals without having competency based training on the needs of individuals in that home. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals. The facility was rated as being in noncompliance with this provision item.	
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 sample of new admissions was not reviewed during this monitoring visit. All PSPs in the sample reviewed had been developed within the past 365 days. As noted in F2a, plans were not revised when objectives were met or no progress was being made. There was evidence that PSTs met when significant events occurred throughout the year. As noted above, numerous PSP in homes were out-of-date or missing, so staff were unable to implement current plans.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E of this report). As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan	Noncompliance

Recommendations:

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

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

3. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation.

4. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step.

5. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal.

6. Ensure that all staff responsible for implementing PSPs have access to a current PSP.

7. Ensure that outcomes are consistently implemented and progress is documented.

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

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

10. Integrate psychiatry into the treatment planning process

11. Include information regarding the individual's psychotropic medication regimen in the PSP. This information should be documented in collaboration between psychology and psychiatry to ensure the accuracy of information.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o SASSLC policy and procedure manual description/table of contents, 200-600 levels o Organizational chart, dated January 2010 o Printout of slides from opening meeting presentation by facility department heads regarding the facility's progress o SASSLC POI, 7/28/10 o SASSLC POI Supplement, 7/28/10 o SASSLC Section G and H Settlement Agreement Presentation Book o List of individuals receiving one to one level of supervision, 8/20/10 o Staffing vacancies as of 5/31/10 for MRA levels I, II, III, IV, and V o Graphic presentation of turnover rate, vacancy rate, and amount of overtime through June 2010 o List of meetings scheduled for the week of 7/19/10 o PIC meeting notes and agendas, eight meetings, January 2010 through July 2010 o SASSLC executive committee meeting notes, nine meetings, January 2010 through July 2010 o Documents related to DNR orders, dated 3/27/03 and 1/12/00 Interviews and Meetings Held: o Ralph Henry, Facility Director o Dr. Carmen Mascarenhas, M.D., medical director o Director of Psychology o Facility psychiatrists o Residential Unit Directors: Greg Vela, David Ptomey, Juan Villalobos o Pat Combs, director of competency training and development o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour. Observations Conducted: o Presentation made to monitoring team by senior staff at SASSLC at opening meeting of onsite monitoring tour o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o PIC Meeting, 8/19/10 o Psychiatry clinics
	Facility Self-Assessment: Please see the Executive Summary section of this report.

	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, however, little activity had occurred regarding this provision item. Clinicians across the facility were not familiar with this provision. Moreover, examples of efforts to create and ensure the integration of clinical services were not evident at SASSLC and this provision was found to be in noncompliance. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item, policies and procedures did not exist, and the absence of integrated services was evident. Consequently, this provision item is rated as being in noncompliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. A number of discussions with the facility director, medical director, chief nurse executive, lead psychologist, unit directors, admissions and placement coordinator, and quality enhancement director, as well as with staff at various levels of management, within clinical services, and at the direct care level indicated that meaningful integration of clinical services was not evident throughout the facility. Surprisingly, clinical staff at SASSLC were not aware of the components of this provision of the Settlement Agreement and although the medical director had been assigned lead responsibility for this provision, little actions had occurred towards addressing this provision. Presentation books for this provision item were absent of any meaningful information. It appeared that the facility was awaiting direction from the state office regarding this provision. Even so, there was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. Under the leadership of the facility director, SASSLC should address the need for integration of clinical services.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Modifications to the executive committee meeting and the PIC meeting can contribute to setting the occasion for this integration to occur. Some examples of the absence of collaborative integrated clinical work are below. • There was little integration between psychiatry and psychology. The facility psychology staff were not producing useful data for the psychiatrists to base decisions regarding medication adjustments. In one clinic encounter observed during the tour, the psychiatrist changed medication based on a verbal report, with no data to validate the accuracy of the statement. Also see sections J10 and K4 of this report. • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting communication and language programming. • There was a lack of desensitization plans written with input from the psychology department. See section S1 of this report. • There was poor monitoring of PBSPs and SPOs that were implemented by DCPs (see sections K and S of this report). • Current nursing assessment, diagnosis and health management planning were not complete and comprehensive (see M1, M2, and M3). A nurse participating in the NMT meeting should be able to immediately access individuals' health data from the most recent quarter, including number of emesis episodes, frequency of PRN oxygen administration, and seizure frequency and type. • Many clinical staff were not familiar with the details of the Settlement Agreement. Even though work will be needed, SASSLC was not without collaborative work. A number of examples are presented below and the monitoring team acknowledges that this list is longer than the list presented immediately above. Note, however, that many of these examples describe activities initiated very recently, or activities that were in the planning stages. • The need for integration and examples of it were discussed at the PIC meeting observed by the monitoring team • Psychology department staff were planning to assist the speech and language pathologists in the development of skill training programs in language and communication. • The facility's new full-time psychiatrist and the director of psychology were starting to work together and had created regular opportunities for communication. • A daily meeting of clinical and medical staff was recently established. This occurred every day at 9 a.m. and included all medical staff, the pharmacist, and the on-call psychologist. They met every morning to review any important	

#	Provision	Assessment of Status	Compliance
		events that had occurred since their previous meeting. • A weekly meeting called the Consumers Services meeting was also initiated very recently. It met Monday morning and consisted of all of the heads of departments supervised by the assistant director of programs. Often, QE staff attended, too. • Smaller groups were to be created in psychiatry clinic to allow for more detailed and individualized discussion and review. • The PMM had begun to attend QMRP meetings with the primary intention to be working on the living options discussion of the PSP meeting. • The Health Status Team (HST) met regularly. The HST was comprised of physicians, nurses, therapists, dieticians, psychologists, and other clinical professionals who were responsible for the regular review and assessment of individuals' level of risk across areas of need. (Note, however, that elsewhere in this report, the HST and the facility's approach to assessing and managing risk are noted to be fraught with problems. • There were initial efforts to conduct a joint neurology-psychiatry clinic. Also, many direct support staff appeared committed to the individuals. For example, the monitoring team sat between two direct care professionals during a PSP meeting. Both participated in the meeting. After the meeting, during a discussion with the monitoring team, one of the MRAs said that she had come in on her off-duty time to attend this meeting. She said that staff were encouraged to do so. It was voluntary and they were paid for their time if they did attend. This type of participation should continue to be encouraged and celebrated. In addition, the staffing vacancies at SASSLC were low, according to the data submitted to the monitoring team. In fact, there were no vacancies at the direct support professional level (called MRA I by the facility). Turnover, however, was indicated to be at an annualized rate of 60 percent, indicating that the facility was having little difficulty recruiting staff, but a lot of difficulty keeping them. This presented an important need that should be addressed by the facility, perhaps via a performance improvement team (see section E of this report).	
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	A plan was not in place to address this item, however, the medical department reported that non-facility clinician recommendations were considered and reviewed. The monitoring team will need to see documentation of its occurrence in order for this provision item to be considered to be in substantial compliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
	whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The monitoring team will review documentation at the next onsite visit to establish whether there is adequate documentation regarding disposition of the recommendations of non-facility clinician	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

3. Adopt a health risk screening tool and assessment process that includes the review and analysis of specific, objective, measurable data to codify/measure health risk.

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 Organizational chart, dated January 2010 o Printout of slides from opening meeting presentation by facility department heads regarding the facility's progress o SASSLC POI, 7/28/10 o SASSLC POI Supplement, 7/28/10 o SASSLC Section G and H Settlement Agreement Presentation Book o List of individuals receiving one to one level of supervision, 8/20/10 o SASSLC executive committee meeting notes, nine meetings, January 2010 through July 2010 o Documents related to DNR orders, dated 3/27/03 and 1/12/00 o Review of records of 18 individuals prescribed psychotropic medication, listed in section J Interviews and Meetings Held: o Ralph Henry, Facility Director o Dr. Carmen Mascarenhas, M.D., medical director o Residential Unit Directors: Greg Vela, David Ptomey, Juan Villalobos o Pat Combs, director of competency training and development o Discussions with medical, pharmacy, nursing, and dental staff o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour Observations Conducted: o Presentation made to monitoring team by senior staff at SASSLC at opening meeting of onsite monitoring tour o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o PIC Meeting, 8/19/10
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement and as a result activities were not occurring at SASSLC to meet this provision of

	the Settlement Agreement. This was further supported by the facility's own POI. It indicated that all aspects of this provision were in noncompliance. Therefore, this provision is rated as being in noncompliance. Similar to section G described above, medical and clinical staff were not aware of the details or contents of this provision and little had been done to address the items in this provision. The presentation book did not have any meaningful information in it. Nevertheless, across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. The facility, however, lacked direction in how to obtain this outcome. This was due in part to (a) the recency of attention to this provision, (b) great confusion as to who was responsible for each component and the monitoring of each component of this provision, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

#	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.	A plan was not in place to address this provision item and the facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status. This was also acknowledged in the facility's POI. The medical staff performed evaluations on sick call based on acute medical problems and the need for follow-up. Follow-up of acute medical problems and post-hospitalization evaluations were inconsistent and at times inadequate. Quarterly assessments were completed, but these assessments were not standardized and were often cursory in nature (see section L of this report). For all 23 individuals reviewed by the monitoring team listed in section M of this report, annual and quarterly nursing assessments were filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner, however, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Further, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Nursing assessments failed to provide a complete, comprehensive review of each individual's past and present health status and needs. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individual's clinical problems, needs, and actual and potential health risks.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As discussed in the psychiatry section of this report, the facility has been completing annual psychiatric evaluations, however, these were inadequate and did not meet generally accepted standards. Facility psychiatric staff have begun scheduling individuals for the completion of the comprehensive psychiatric assessment per Attachment B. While there was some evidence that individuals were scheduled for psychiatry clinic as needed, the facility psychiatric staff were actively discussing the need for increased frequency of the individual's presentation at clinic. For example, the psychiatrists were discussing the need to have individuals return to clinic within one month following a medication change (i.e., addition or discontinuation of a medication, or dosage change). Also, as noted in section K6, psychological assessments were incomplete.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	There was no policy in place to require or guide the activities required to meet this provision item. Further, as per a review of psychiatric evaluations, monthly medication reviews, and quarterly medication reviews, there were no diagnostic formulations outlining the specific symptoms that individuals were experiencing such that met the criteria for a specific diagnosis. For additional information regarding this issue, please refer to the discussion of provision J8. (There was, however, one notable exception of an individual record where the comprehensive psychiatric assessment had been completed.)	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	SASSLC did not have a plan procedure in place to ensure that treatments and interventions were implemented timely and were clinically appropriate. Examples are described in this report, including regarding changes in psychiatry treatment (Section J), updates and modifications to PBSPs based upon the functional assessment and/or a lack of progress (Section K), and changes in risk status based upon occurrences of medical-related events (Sections I, M, and O). The medical staff conducted sick call daily to address new issues, acute medical issues and follow-up, however, as noted above, follow-up of acute medical problems and post-hospitalization evaluations were inconsistent and at times inadequate. Health management plans did not consistently address all of the health care needs of the individuals and ACPs did not address all of their emergent health care problems and risks. The interventions in the HMPs were the same across all of the individuals even	Noncompliance

#	Provision	Assessment of Status	Compliance
		though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised. The objectives and expected outcomes referenced in the HMPs and ACPs were not consistently individualized, and they did not reflect the individuals' participation in their development or their desired health outcomes. (see M2 and M3). In psychiatry, in the same way it was difficult to determine the accuracy of diagnoses, it was also difficult to determine the appropriateness of medication. A review of the records revealed medications prescribed for indications that were not described as specific target symptoms, that were not being monitored by psychology as data points, and that were not in concert with the proposed diagnosis. For additional information, please see the discussion regarding sections J13 and J9.	
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.	Neither a plan nor activities were in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. Consequently, this provision item was rated as being in noncompliance. There were, generally, no measurable goals established for interventions provided. Documentation was more anecdotal in nature, making it difficult to track progress and compare data to determine progress over time. The facility and state should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and had numerous problems as indicated in other sections of this report.	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	Neither a plan nor activities were in place to address this item and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in response to clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
	clinical indicators.		
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. Facility management also acknowledged that this provision item was not yet being addressed.	Noncompliance

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Consider an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.

4. Ensure that there is adequate medical staffing to allow for the provision of quality services.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006: At Risk Individuals o DADS Risk Assessment Tools, dated 8/31/09 o List of individuals requiring sutures/dermabond 1/1/10-6/30/10 o Individual Aggression Log 1/1/0-6/30/10 o PST Interim Meeting Notes for Individual #304 regarding choking incident o List of Risk Level for all individuals at the facility o List of individuals hospitalized 1/1/10-6/30/10 o List of individuals seen in the ER 1/1/10-6/1/10 o SASSLC List of Individuals with Dysphagia as of 6/30/10 o List of individuals with medical diagnosis of pica o List of individuals that required mealtime assistance o List of ER visits since 1/10 o List of hospitalizations since 1/10 o List of 10 individuals with the most injuries 1/1/10 – 6/30/10 o List of 10 individuals causing the most injuries to peers 1/1/10 – 6/30/10 o List of falls 7/1/09-6/30/10 o List of top ten highest injuries 1/1/10-6/30/10 o List of top ten individuals causing peer injuries 1/1/10-6/30/10 o Skin Integrity Committee meeting minutes 8/19/09-7/28/10 o PSPs for the following individuals • Individual #201 dated 2/16/10 • Individual #209 dated 4/22/10 • Individual #146 dated 9/22/09 • Individual #257 dated 12/3/09 • Individual #167 dated 2/11/10 • Individual #47 dated 5/3/10 • Individual #11 dated 4/3/10 • Individual #62 dated 7/28/09 • Individual #199 dated 4/12/10 • Individual #159 dated 6/8/10 • Individual #174 dated 9/15/09 • Individual #103 dated 7/20/10 • Individual #214 dated 5/25/10 • Individual #225 dated 6/17/10 • Individual #219 dated 4/8/10 • Individual #36 dated 3/26/10

	o PSP, Nursing Assessments and Health Risk Assessments for: • Individual #213, Individual #336, Individual #274, Individual #34, Individual #146, Individual #343, Individual #308, Individual #215, Individual #8, Individual #254, Individual #227, Individual #288, Individual #49, Individual #92, Individual #19, Individual #54, Individual #200, Individual #62, Individual #197, Individual #185, Individual #306, Individual #234, Individual #247 o Health Risk Assessments for: • Individual #145, Individual #37, Individual #152 o Individual records identified in section J below. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs; o Three Direct Support Professionals o Ralph Henry, Director o Daisy Ellison, Psychological Services Director o Jane Dahlke, QMRP Coordinator o Leticia Jaloma, Abuse and Neglect Coordinator o Informal meeting of Nutritional Management Team (NMT) and the monitoring team <u>Observations Conducted</u>: o Observations at all residences o Observations at the onsite workshop, prevocational program, and Forever Young program o PSPA Meeting for Individual #276 o PSP Meeting for Individual #212 o Self Advocacy Meeting 8/16/10 o Unit #1 Morning Meeting 8/18/10 o Unit #3 Morning Meeting 8/17/10 o Incident Management Meetings on 8.17.10 and 8/18/10
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern to the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other overwhelming concern of the monitoring team

	regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk even with a plan in place. Note that, for the most part, the population served at SASSLC were admitted due to their high risk for health and/or behavioral issues. Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that considered and analyzed influencing factors contributing to each risk area needed to be completed. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose and process of the identification of at-risk individuals. SASSLC's Health Status Team (HST) Coordinator was scheduling and conducting meetings according to the policy. An HST meeting was not held during the monitoring team's onsite review. The HST was reported and documented to be an interdisciplinary review of risk factors. Risk levels were also assigned by the Nutritional Management Team (NMT) and there were future plans by DADS for another team that would be involved in targeting and managing certain areas of risk. There was a need for integration and the identification and analysis of overlapping team functions.

#	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.	Per state policy a risk review at least every six months for each individual was conducted by the SASSLC Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. The implementation and ongoing revisions to the process were facilitated by the Health Status Team Coordinator. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. Initial change in that process toward more adequate management of individuals' health risks was occurring (e.g., Individual #54 who was changed to a high level of risk related to seizures when a seizure occurred after he was seizure-free for years, Individual #152's assignment of a high risk given a persistent tunneling wound requiring wound vac negative pressure therapy, and Individual #197 whose risk related to aspiration and respiratory problems was finally raised to high after four respiratory and/or aspiration pneumonia related hospitalizations from January 2010 through June 2010). Additionally, the health status data summaries and clinical indicators recorded on the assessment tool often were not objective or not included. For example, pica behavior could be checked off as occurring, but there was no objective data summary, such as "26	Noncompliance

#	Provision	Assessment of Status	Compliance
		pica episodes in last six months, only four occurring in the last quarter." In 17 of the 18 records chosen for review for section J below, a health risk assessment-rating tool was located. A review of these documents revealed that while individuals had an assigned risk rating for polypharmacy, it was unclear how this risk level (low, medium, or high) was assigned. It was also unclear how the facility utilized the information gleaned as a result of a review of the individual's health risk status in this area. As the facility did not currently have a functioning PST team that included psychiatry, it would be not be possible for them to discuss specific risks associated with the administration of psychotropic medications. This was an area that will have to be addressed once psychiatry becomes a bona fide participant in the PST process. Identification of risk and adherence with preventive care guidelines are fundamental to the provision of adequate medical care. Individuals were infrequently appropriately assessed for medical risk factors. This resulted in missed opportunities to assess for mitigation of risk factors and implement plans of care to adequately address the risks. This deficiency was clearly demonstrated in the areas of bowel management and osteoporosis, both of which are significant concerns for individuals with developmental disabilities. The risk systems used within the HST and the NMT committee were not integrated. This was further complicated by the introduction of new draft state policies regarding a Physical and Nutritional Management Team (PNMT). The draft policy was discussed in a meeting of the monitoring team with the NMT regarding the need to also consider integration of this new team's functions. For example, as described in more detail below in section I2 and in section M1 and M3 of this report, an individual was identified at medium risk for urinary tract infections with a recommendation to her PST by the NMT for follow-up, yet she was listed as being at low risk by the HST. There were a number of examples of inconsistencies between these two groups. There was a prevailing philosophy to reduce the risk level if there was an intervention in place.	
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	The policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high-risk condition was identified, the PST would meet within five working days to formulate a plan. The plan had to be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	stabilized and the risk level was reduced. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels be assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • Individual #197 had a risk level of 2 indicating medium risk for aspiration and respiratory, though hospital logs indicated that she had been hospitalized on 1/17/10 for pneumonia, 3/12/10 for acute respiratory distress, 5/25/10 for aspiration pneumonia, and again on 6/3/10 for aspiration pneumonia. This would indicate that she was at high risk for respiratory distress and aspiration and needed to be monitored carefully. • Individual #21 was listed as low risk for respiratory, but was released from the hospital on 3/18/10 and again on 4/26/10 with a diagnosis of acute respiratory distress. Again, this individual should be considered high risk for respiratory. • Individual #225 was rated at low risk for weight and respiratory, though her PSP indicated that she was on a 1000-calorie diet for weight loss and had a diagnosis of Prader-Willi Syndrome. She also was diagnosed with asthma and sleep apnea and used albuterol daily and a CPAP machine at night. • According to the PSP for Individual #175, she was diagnosed with GERD and osteopenia. Her risk levels were rated as low in both of these categories by the HST. Her PSP did not indicate a risk level for either diagnosis. • According to the PSP for Individual #174, she had GERD, constipation, osteopenia, and needed hands on assistance while walking if not using her walker. The HST has rated her at low risk for constipation, GI concerns, osteoporosis, and injury. • According to the PSP for Individual #62, she was at risk for constipation, falls, fractures, and skin integrity, and had been diagnosed with dysphagia, GERD, and osteoporosis. The HST rated her low risk for aspiration, constipation, and osteoporosis.	

#	Provision	Assessment of Status	Compliance
		• Individual #343: Despite identified recurrent episodes of hypothermia and urinary tract infections (UTIs) by history and in the previous 12 months, Individual #343's risk ratings related to UTIs and hypothermia remained low. • Individual #62: Health risk ratings assigned to aspiration, UTIs, and GI concerns remained low despite hospitalizations 2/12/10 for lower respiratory infection, 4/9/10 for UTI, and 5/18/10 for respiratory failure. The NMT assigned a medium level of risk. The NMT noted emeses occurring before the 4/10 hospitalization may have contributed to aspiration. • Individual #213: There were no changes to her low risk ratings for injury or skin integrity after a fracture 6/3/10, which limited her mobility and increased her risk for impaired skin integrity. • Individual #37: She was hospitalized for urosepsis three times in less than six months and insertion of a nephrostomy during one of the hospitalizations and reinsertion of the nephrostomy tube during the most recent hospitalization 5/16/10-5/20/10. Her assigned risk level for UTIs remained medium. • Individual #34 received 14 injuries in the last six months. She was one of the individuals on SASSLC's "Top 10 Highest Injuries " list. Her injury risk level remained medium.	
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 PST. A majority of the PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Some identified risks had no individualized plans developed to address them. Rarely were all the relevant clinical indicators to be monitored and the monitoring frequency clearly specified in individuals' PSPs or Health Management Plans (HMPs). See sections M1 and M3 for examples. Direct care professionals reported that they were notified of changes in plans by therapist or their supervisor and implementation of changes began immediately. Throughout the onsite monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were generally able to accurately identify primary risks or identify primary supports needed to monitor those risks. Each home had huddle meetings at shift change to share information regarding any changes in health or behavioral status for the individuals in the home. This appeared to be a productive way to ensure that all staff were aware of any changes in status. Information from the huddle meetings was presented at Unit meetings, and then at the morning Incident Management meeting. This practice ensured that staff at all levels were aware of changes in status and created the opportunity for various staff to identify possible risk factors and make recommendations for changes in the level of support for the individual.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. For example, Individual #197's positioning to the right had been restricted due to a pressure ulcer on her right ankle post hospitalization. Her Physical and Nutritional management Plan (PNMP), revised 7/1/10, directed staff to follow her formal repositioning plan that was very limiting and, in one case, scheduled her to be positioned in her wheelchair for 2½ hours. An optimal stomach emptying position identified for her was inclined right sidelying, which was restricted. Lack of positioning equipment/therapeutic positioning programs, and her significant physical challenges were noted by the monitoring team to be further limiting factors. A right ankle pressure ulcer, Stage 2, approximately quarter-size was identified, treated, and resolved 7/4/10 through 7/13/10. On 8/16/10 the monitoring team observed a Stage 2 pressure ulcer (i.e., a non-blanchable erythema and superficial partial skin thickness loss) approximately nickel size on the outer aspect of her right ankle that had not been recognized or assessed.	

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. All staff should receive individual specific training on each safety and health care risk identified for the individuals they are assigned to support and implementation of plans should be routinely monitored.

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o An alphabetical list of all individuals served, including name of residence and day/vocational program. o A list of all individuals served by residence/home, including for each home an alphabetized list of individuals served, their age (or date of birth), date of admission, and legal status. o A list of individuals admitted within the last six months.. o A list of daily, weekly, monthly, quarterly meetings that typically occurred at the facility. o A schedule of such meetings scheduled to occur during the week of the visit, including a key to any acronyms used on the schedule. o A table of contents of an individual record. o Any policies, procedures and/or other documents addressing the use of pre-treatment sedation medication. o For the past six months, a list of individuals who have received pre-treatment sedation medication for medical or dental procedures that includes: date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication. o Any auditing monitoring data and/or reports addressing the use of pre-treatment sedation medication. 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 prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. o Facility-wide data regarding polypharmacy was provided for one physician's caseload, including intra-class polypharmacy. o A list of individuals being monitored for tardive dyskinesia. o A list of individuals with tardive dyskinesia. o List of new admissions since 1/1/10, and whether a Reiss scale was used. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects: AIMS, MOSES, DISCUS. o CVs of all psychiatrists, including any special training such as forensics, disabilities, etc. o Overview of psychiatrists' weekly schedule. o Since 1/1/10, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s).

	o Names of every individual who has had a psychiatric assessment per Appendix B with date of assessment and name of M.D. o Randomly chosen desensitization plans (medical/dental) o Last five nursing post sedation monitoring checklists o Caseload list for each psychiatrist o Psychology department caseloads o Clinic schedule for psychiatry for last three months (with names of individuals seen) o Medication list by individual o Pharmacy audit tools o Reiss Screen scoring for 10 individuals o Minutes from the polypharmacy committee for last three months o Lab Matrix regarding psychotropic medication o Dr. Ming's documentation from clinics dated 8/17/10 and 8/18/10 o Dr. Vale's documentation from clinic dated 8/17/10 o These documents: • Demographic data • Human Rights Committee including Health Risk Status review for 2010 • Consents section • Most recent Personal Support Plan and addendums • Most recent Behavioral Support Plan and Human Rights Committee review • Restraint checklist for 2010 • Most recent medical summary • Labs for 2010 • Most recent EKG • Psychiatry documentation for 2010 • MOSES/DISCUS for 2010 • Pharmacy quarterly drug reviews for 2010 • Physicians Orders for 2010 • Integrated Progress notes for 2010 • Most recent Nursing Assessment • Dental documentation for 2010 o For the following individuals: • Individual #276, Individual #250, Individual #133, Individual #277, Individual #214, Individual #264, Individual #272, Individual #150, Individual #347, Individual #113, Individual #141, Individual #191, Individual #223, Individual #218, Individual #1, Individual #323, Individual #211 o These documents for Individual #246: • Demographic data • Consent section • Most recent medical summary • Psychiatric documentation for 2010

	• Physician Orders for 2010 • Integrated Progress notes for 2010 • Most recent nursing assessment <u>Individual Interviews and Meetings Held</u>: o Betty Mitchell, M.D., facility psychiatrist o Thomas Mings, M.D., facility psychiatrist o Sandra Vale, M.D., facility psychiatrist o Daisy Ellison, M.A., Director of Psychology o Carmen Mascarenhas, M.D., Medical Director o Janet Adams, R.N., Director of Nursing o Sharon Tramonte, Pharm.D., Clinical Pharmacologist <u>Observations Conducted</u>: o Observation of neurology clinic for the following individuals: • Individual #347, Individual #133, Individual #223, and Individual #141. o Observation of PSP meeting for Individual #276 o Observation of psychiatric clinic for the following individuals: • Individual #169, Individual #132, Individual #299, Individual #128, Individual #214 o Observation of psychiatric clinic for the following individuals: • Individual #142, Individual #303, Individual #2, Individual #85, Individual #319, Individual #50, Individual #318 o Observation of morning clinical services meeting on four consecutive days o Observation of psychiatric clinic for the following individuals: • Individual #245, Individual #159, Individual #88, Individual #156, Individual #158, Individual #127, Individual #108, Individual #41, Individual #43, Individual #250, Individual #330, o Observation of psychiatric polypharmacy committee meeting
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, SASSLC was found to be in noncompliance with all of the items in this section of the Settlement Agreement. The psychiatry department at the SASSLC was in need of a strong leader. The facility has managed to recruit a quality full time psychiatrist, however, this physician was young and did not have experience in the field of developmental disabilities, and although bright, energetic, and ambitious, she will need administrative support and mentoring.

	The psychiatric physicians, though recently better integrated with primary care and neurology services, were otherwise not integrated into the overall treatment program at the facility. The psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate data in order for them to make data informed decisions regarding pharmacology in an objective manner, and, per a review of records, frequently made medication additions or adjustments in absence of data regarding specific target symptoms. Additionally, while staff from nursing and psychology attended psychiatry clinic, these clinic encounters were rapid and, per observation during this onsite monitoring tour, were not thorough with respect to a review of available records or interaction with the individual. Interviews with psychiatry staff revealed that, in most cases, they were aware of the challenges and need for increased structure and integration with respect to psychiatry, however, some resistance was verbalized by staff, specifically due to increased documentation requirements, and increased need for clinical contact time (which affects disciplines other than psychiatry). In order for psychiatric services to improve to the level of generally accepted practices, the facility will need to make a cultural shift, which will require leadership and integration among all the necessary disciplines. There were challenges in the document review process, both on and offsite for this monitoring tour. The facility response to the document request for this provision area was incomplete, and in some areas, the document provided as a response was either incomplete, or did not include the information requested. This hampered the monitoring process. It would be beneficial for the facility to review its documentation in order to ensure that the requested items are available. This would allow for the most accurate monitoring report and recommendations.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	SASSLC did not have a lead psychiatrist designated, however, the facility had recently retained a permanent full time psychiatric physician. There were also two part time consulting psychiatrists, who both reported extensive experience in the treatment of individuals with developmental disabilities. All three psychiatrists were board certified by the American Board of Psychiatry and Neurology. One physician was also boarded in child and adolescent psychiatry, and one was board eligible in geriatric psychiatry (board examination scheduled for 2012). With regard to the newly recruited full time psychiatrist, she had recently completed her residency. This particular physician, while not experienced in the field of developmental disabilities, had energy, foresight, and ambition. She will need mentoring, and had already established a relationship with another psychiatrist in the DADS system, which may be of benefit to her. She had excellent ideas to improve the practice of psychiatry at the facility, such that it will be more likely to approach meeting the generally accepted professional standard of care, however, without administrative support from senior	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		management, she may experience challenges from her peers. One concern was that there was no lead psychiatrist identified at SASSLC (however, the newly recruited psychiatrist may fill this role over time). This could pose difficulties, and this was noted during the tour. Although the other two psychiatrists practicing at the facility were board certified, the report that follows will indicate areas of concern with regard to their practice at the facility. While it was recognized that many of the challenges could be due to the lack of consultation time available, the lack of appropriate data the physicians were provided, and the lack of their integration into the overall facility treatment program, it was apparent that there were other difficulties with the physician's practice (e.g., documentation issues) that were directly within physician control. Improvements necessary in the quality of services provided will be reviewed over the course of the monitoring period.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per interviews with the three psychiatrists providing clinical services at the facility, individuals were seen in clinic a minimum of once per quarter for their quarterly medication review. The psychiatrists also performed monthly medication reviews, that, per their report and observed during the monitoring tour, were based on verbal report of staff members present in the psychiatry clinic (e.g., the nurse case manager, psychologist, QMRP, direct care staff), some record review, and little review of data. The psychiatrists admitted that, due to time constraints, they had only recently contemplated scheduling comprehensive psychiatric evaluations. This was due to the recent addition of a full time psychiatrist to the psychiatry clinic. Concerns regarding the adequacy of psychiatric clinical availability remained, even with the recruitment of the new full time physician. For further discussion regarding this, please see section J5 below. A review of 18 records of individuals at SASSLC revealed varying quality of the documentation in the monthly and quarterly medication reviews. There were no diagnostic formulations noted, nor were detailed descriptions of the justification for the use of specific psychopharmacological agents located in any of these records other than one notable exception (a completed comprehensive psychiatric assessment located in the record of Individual #218). Given these deficits, it was difficult to determine the adequacy of the diagnosis and treatment for the individuals and, therefore, this provision item was found to be in noncompliance. It is hoped that increased clinical consultation time will allow for improvements in	Noncompliance

#	Provision	Assessment of Status	Compliance
		overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring and/or the implementation of a peer review process. For further discussion regarding diagnostic practices, see the discussion below in sections J6 and J10.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Per this provision, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). Given the challenges with the document request, (discussed fully with respect to this specific data set in Provision J9), this was difficult to determine. A review of the selected records revealed that of the 18 records reviewed, all had a PBSP in the record with the exception of Individual #246, who was reportedly a recent admission. The quality and utility of the PBSP is the subject of provisions relating to psychological services, discussed in section K of this report. As indicated in section K, overall, the PBSPs were inadequate. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a comprehensive treatment program. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the indications for psychotropic medications prescribed to address the diagnoses. For further discussion regarding this issue, please see the discussion below in sections J8 and J13. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. There were concerns regarding the lack of treatment integration between psychiatry and psychology and the need for improved treatment team functioning. There were no specific behavioral-pharmacological hypotheses regarding the individual's treatment located in the records reviewed. The facility had taken the first step in fulfilling this requirement via the completion of one comprehensive psychiatric evaluation and planned to complete additional comprehensive assessments via a schedule. In completing these assessments, the psychiatry and psychology staff should 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.	Noncompliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include	Per staff interviews and record review, individuals were given pretreatment sedation for dental and medical clinic until two months prior to the onsite monitoring tour. The facility had recruited a new dentist who reportedly suspended all pretreatment sedation for dental clinic. Per staff interviews, the dentist preferred to acquaint himself with the individuals first, and had been visiting the individuals in their homes during oral care times.	Noncompliance

#	Provision	Assessment of Status	Compliance
	treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment 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.	The new dentist was on vacation during the tour and, therefore, was not available for interview by the monitoring team. The monitoring team had a difficult time obtaining information regarding pretreatment sedation as evidenced below. • Staff reported that individuals continued to receive pretreatment sedation for medical clinic on a case-by-case basis. As such, five randomly chosen desensitization plans were requested. The facility's response to this request was that they "currently do not have any plans." • In an effort to determine post sedation monitoring and the effects of sedation for specific individuals, the last five nursing post-sedation monitoring documents were requested. In response to this request, the facility's response was "none available." In review of the integrated progress notes in selected records, however, there was documentation in the record indicating that nursing had monitored the individual after administering pretreatment sedation. During future monitoring tours, the records will be reviewed to determine the presence of additional information and/or more detailed desensitization plans for individual's requiring pretreatment sedation for dental or medical appointments. The newly recruited dentist's efforts were laudable. In addition, strategies should be individualized and offer a stepwise method to acquaint the individuals with the clinic in order to address the individuals challenges pertaining to participation in dental and medical examinations. Documentation of the coordination of the pretreatment sedation process with psychiatry was not located in the records. A review of the psychiatric progress notes for the individual records reviewed did not reveal documentation that the physicians were aware that the individual received additional medication for sedation, or that they were aware of the effects of these medications. This was confirmed via interview of psychiatric staff. This lack of communication was concerning given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. Additionally, medications utilized for pretreatment sedation could result in unwanted challenging behaviors or sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen. Further discussion regarding the potential deleterious effects of this lack of communication is included in the discussion regarding Provision J10.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two	There were two part time psychiatrists providing services at the facility. One of these physicians, a board certified adult/child and adolescent psychiatrist was employed .25 full time equivalent (FTE). This physician was on site four hours two days per week. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	remainder of this physician's clinical responsibility was covered via taking all of the after hours call for psychiatry at the facility. A second physician, a board certified adult psychiatrist, was employed .75 FTE. Together these two physicians equaled one FTE. A third physician, a board certified adult psychiatrist who was also board eligible in geriatric psychiatry (boards scheduled for 2012), joined the facility psychiatry department one month prior to this monitoring tour. This physician was full time, and per interview with the monitoring team, the plan was for her to spend 80% of her time in the provision of clinical services, and 20% of her time in the administration of the psychiatric clinic. Unfortunately, this physician was not given the official title of lead psychiatrist. It was obvious during the tour that the new recruit, while energetic and organized, may have difficulties with the established physicians without administrative authority and support from senior management at the facility. It was noted that the facility medical director was very supportive of the new physician and was invested in seeing her succeed. This facility was in need of a designated lead psychiatrist to spearhead the expansion of psychiatric services, and model the collaborative efforts between psychiatry and psychology with the ultimate goal being the integration of psychiatry into the facility treatment program. It was questionable whether the current allotment of psychiatric clinical services will be sufficient to provide clinical services at the facility. At the time of the tour, there were a total of 80 available clinical hours. Two of these hours were consumed in a trade off for on call availability, another eight were going to be spent in administrative duties. This left 70 hours per week or 294 per month (utilizing 4.2 weeks per month) for clinical services. With a current caseload of 188 individuals, this equated to a total of 188 monthly medication reviews, an average of 15.6 quarterly medication reviews and an average of 15.6 annual comprehensive reviews per month for a total of 219.2 clinical contacts per month. This computed to a total of 45 minutes per clinical contact. This computation assumed that all of the clinical hours would be spent in clinical consultation. It did not include participation in meetings other than psychiatry clinic or consultation outside of clinic. As such, it was apparent that the current level of psychiatric clinical contact time was likely inadequate. Over time, the facility may consider workload indicators to objectively determine the need for additional clinical consultation.	
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	The facility did not have policy and procedure outlining the process for psychiatric clinic. Although DADS had recently created a policy and procedure for psychiatric services, it had not been implemented at the facility level. The facility should implement the new DADS policy and also determine if additional facility-specific policies would be helpful to the psychiatry department's operational procedures.	Noncompliance

#	Provision	Assessment of Status	Compliance
	psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The facility psychiatric staff were in the process of evaluating all individuals treated in psychiatry clinic as per the requirements and outline of Appendix B. At the time of the monitoring tour, however, there was only one completed comprehensive evaluation available for review (Individual #218). A review of the records of 17 individuals who were prescribed psychotropic medication revealed annual psychiatric evaluations utilizing a format that was not consistent with generally accepted professional standard of care. This format was brief, offered no historical data, started with a listing of diagnoses, offered no diagnostic formulation regarding what led to the specific diagnoses, gave a listing of target symptoms being monitored, a list of current medications, and a brief annual summary. The psychiatrists who had been consulting at the facility for some time indicated that, in their opinion, these annual summaries provided sufficient information. These physicians, however, also had the benefit of an extensive self-generated database that they maintained on their personal computers. This information was not accessible by other physicians or by other members of the treatment team. During the tour, the physicians offered to share their historical information with the newly recruited physician via a facility based data sharing program, should the facility make that capability available. Regardless, the ongoing use of personal computer equipment is not recommended. The facility must make arrangements for the physicians to have access to computers during clinic for review of historical data, and for presentation of data by psychology staff. Having a data sharing feature for psychiatry will also allow for collaboration with psychology as each discipline could, in theory, obtain read only access of the other discipline's documentation. As stated above, there was one individual record (for a total of 18 records reviewed) that contained the comprehensive psychiatric assessment following the guidelines put forth in Appendix B. The facility psychiatrists indicated their goal was to perform one comprehensive assessment each per week, with a plan to complete comprehensive assessments on all individuals seen in psychiatric clinic. The physicians were hopeful of their ability to meet this goal because the facility had recently hired a full time psychiatrist bringing the total clinical availability of psychiatric services to two full time equivalents. Given the aforementioned goal of completion of comprehensive assessments, a more robust review of these assessments will be performed during future monitoring visits. There were other issues regarding psychiatric clinic that merited discussion. Three psychiatric clinic encounters were observed by the monitoring team. During all three, members of the individual's treatment team, specifically, the psychiatrist, the nurse case	

#	Provision	Assessment of Status	Compliance
		manager, the psychologist, and the QMRP were in attendance. Per staff interviews, these staff generally attended clinic. Despite their attendance, the interactions between the staff members were brief and cursory. One psychiatrist verbalized concern that in the past, the clinics were scheduled less frequently, with the requirement that more individuals were seen during each clinic period. As this psychiatrist astutely noted, with the increased data review requirements and increased documentation needs in order for the clinic services to reach the generally accepted professional standard of care, there will need to be more frequent clinics with fewer individuals scheduled for each clinic. This change in scheduling was reportedly creating some scheduling difficulties, specifically with other disciplines whose presence at psychiatric clinic was necessary. The need to improve psychiatric services such that these services are consistent with generally accepted professional standards of care will require a cultural change at the facility. In one of the clinic observations, quarterly medication reviews were conducted. During this clinic, data must be reviewed, the individual must be present for clinic, and documentation must be completed. During the one hour and 15 minutes that this quarterly medication review clinic was observed, seven individuals were seen. In all seven cases, the physician relied on verbal reports from nursing and psychology staff. The psychiatrist was not observed to review the individual's medical record, but instead reviewed historical information contained in the self-generated database noted above. Additionally, there were no graphs of behavioral data provided to the physician, instead there was a listing of months with numbers of target behaviors occurring during the 30-day span. There was no indication of previous medication adjustments or other potential antecedents for either clinical decompensation or clinical improvement. This elapsed time and number of individuals seen during this clinic observation equated to an average of 10.7 minutes per individual. This rapidity of clinical review did not allow for a comprehensive review of documents, discussion with the other attendees or for any meaningful interaction with the individual. This represented a serious departure from the generally accepted professional standards of care in psychiatry.	
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,	The Reiss Screen is an instrument that was developed to identify individuals who may need a psychiatric evaluation. Per an interview with the Director of Psychology, the facility had performed seven Reiss Screens since January 2010. The Director was not sure of the utility of the instrument for this facility, as it is currently the facility practice to perform psychiatric evaluations on all new admissions regardless of their psychotropic medication status upon admission. Per a review of the facility roster, there were 295 individuals currently residing on	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	campus. Of these, a total of 188 were currently being seen in psychiatry clinic. As such, there were 107 individuals residing at the facility who were not enrolled in psychiatric clinic and would be appropriate for annual Reiss Screening to determine the need for referral for a psychiatric evaluation. It is possible that the facility may have already started the process of performing a Reiss Screen on other individuals not enrolled in psychiatry clinic. In response to the monitoring team's request for the most recent Reiss screens for all individuals at the SASSLC, the facility only provided a list of the seven individuals admitted since January 2010. During the onsite tour, it appeared that Reiss screens were implemented for other individuals who were not named among those designated as recent admissions. Further monitoring regarding this provision will be needed in future tours to determine the full implementation of the Reiss screen at this facility.	
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.	The facility did not have any policy or procedure to guide the development and implementation of a system to integrate pharmacological treatment with behavioral and other interventions. There was a paucity of integration between psychiatry and psychology and, therefore, this provision item was rated as being in noncompliance. The only examples observed during the monitoring tour are noted below. • Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the amount of collaboration between the disciplines was limited to the psychology staff attending psychiatry clinic and providing the number of target behaviors that occurred in the intervening period to the psychiatrist. • The psychology staff participated in the morning clinical services meeting where pertinent information regarding individuals occurring in the intervening period since the last meeting were presented by the various disciplines. One area of integration that required attention was regarding the use of data. While some of the target data points were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the choice of individual target behaviors. It was also notable that, while there were some graphs of data presented to the physician (during the second psychiatry clinic observed), these were rudimentary and did not include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or	Noncompliance

#	Provision	Assessment of Status	Compliance
		health-related variables (e.g., illnesses, allergies). Medication decisions made during the three clinic observations conducted during this monitoring tour were based on the information provided during the time of the clinic. The medication decisions were not based on a long-range view of the individual's behavior/symptom presentation. Admittedly, there would be challenges to overcome in order to increase the use of, and breadth of, data presented during clinic. For example, computer access was not available in all clinic settings, and two of the facility psychiatrists were utilizing personal computers to review historical data during clinic. A review of the psychological and psychiatric documentation for 17 individual records did not reveal case formulations that tied together the information regarding a particular individual's case. There was one exception (for a total of 18 records reviewed), the record of Individual #218, where a comprehensive psychiatric evaluation had been completed. This document provided a diagnostic formulation reviewing each diagnosis, as well as delineated pharmacological and non-pharmacological interventions. Now that this had been completed, the next step would be to meet with psychology to review the PBSP in order to ensure that appropriate behavioral and symptoms targets were being monitored. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located regarding objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions.	
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	Per interviews of both psychiatrists and psychology staff, the psychiatrists did not attend meetings regarding behavioral support planning, and they were not involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. Psychiatrists verbalized a willingness to become more involved, but indicated that until recently, a lack of clinical contact time had made this impossible. They were concerned that even with the recent addition of a full time psychiatrist, that with the increasing documentation demands, they would continue to have insufficient time available to participate as required by this provision item. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	An attempt was made to compare the list of individuals prescribed psychotropic medication at the facility to the list of individuals at the facility who had a positive behavioral support plan (PBSP). This was challenging because the documentation provided in response to the monitoring team's request for a list of individuals with behavior support plans was a list of individuals and the dates of the PSP (i.e., the wrong information was provided). Information regarding the dates of the BSP was not included. This task was further complicated by the lack of data received regarding the requested list of individuals, their diagnoses of record, and list of their prescribed psychotropic medications. The facility provided a list with this information for 26 individuals, however, a review of the caseloads of the facility psychiatrists as well as a review of the medication information sheets provided for each individual residing at the facility, indicated that there were a total of 188 individuals being treated in psychiatry clinic. Again, these impediments in the record review due to difficulties with the document request receipt were discussed in several areas of this report. The document retrieval process for this monitoring visit was cumbersome, and in many areas, documents provided were not reflective of the documents requested. The positive behavior support plans and psychiatric documentation of 17 individuals prescribed psychotropic medications were reviewed (the record of Individual #246 was reviewed, however, this individual was recently admitted and the record did not contain the PBSP). It was impossible to determine collaboration between the disciplines via a review of the record. In a randomly chosen example from the 17 records reviewed, Individual #150 had a positive behavioral support plan that documented target behaviors, including physical aggression, verbal aggression, unauthorized departures, refusals, psychosis, and work refusals. This individual was also seen for a quarterly medication review during the monitoring tour. The interaction with the physician (including data review, observation of the individual, and documentation) was timed at five minutes. The psychologist in attendance at the clinic reported to the physician increased psychotic symptoms present at the end of the 28-day treatment cycle (this individual was prescribed Haldol in both oral and decanoate forms), however, the psychologist did not present the physician with objective data regarding the reported increase of symptoms. There was also no graph of the data provided to determine when during the reporting period the symptoms were exacerbated. A review of the physician's progress note authored on the date of the clinic observation revealed that the physician documented "doing well…improved on polypharmacy." As such, it was apparent that the physician did not recognize the psychologist's verbal report of increased psychotic symptoms. This case illustrated the need for improved collaboration between psychology and psychiatry as well as improved presentation of data.	

#	Provision	Assessment of Status	Compliance
		Another illustration of the challenges posed by psychiatry not participating in the PST process was noted during the monitoring tour when a PSP addendum meeting was observed by the monitoring team. In this meeting, Individual #276 was in attendance as were the assigned QMRP, psychologist, nurse case manager, and direct care staff. The meeting was precipitated by the individual expressing suicidal ideation the evening prior. Even so, this information was not communicated to the treating psychiatrist. In fact, the morning clinical services meeting was also observed. The purpose of this meeting was to communicate pertinent information regarding individuals experiencing difficulties in the 24 hours prior to the meeting. This information was to be shared between psychology, primary care, psychiatry, pharmacy, and nursing. This individual's increased behavioral challenges and suicidal statements were not reported. Further disconcerting to the monitoring was that during this PSP addendum meeting, the facility staff questioned the individual in an antagonistic manner. Staff appeared angry and the individual eventually shut down (i.e., stopped participating). Instead of focusing on positive behaviors and how to reward the individual for avoiding identified negative behaviors, the staff focused on punitive consequences. The individual was threatened with a loss of outings and privileges. Staff appeared to have difficulty interacting with the individual due to what appeared to be anger and irritation with the individual. Having the treating psychiatrist as part of the PSP process may have allowed for better management of the situation. The above case examples were illustrative of the lack of coordination between the disciplines and how this can have a negative effect on the treatment of the individuals.	
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	A review of the records of 18 individuals at the facility who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. There were comments included in the positive behavioral support plans and in the Human Rights Committee (HRC) review of the positive behavior support plans, however, these did not include input from the psychiatrist or primary care physician. In no case did these documents include the signature of the psychiatrist. The health status team recommendations did include team discussion regarding polypharmacy and the team, including the psychiatrist signed these. Interviews of psychology staff and psychiatric physicians indicated that there was no participation of psychiatry in the HRC or PST process. It was understood that the	Noncompliance

#	Provision	Assessment of Status	Compliance
	potentially more dangerous than the medications.	physician's participation in HRC regarding an individual assigned to his or her personal caseload would be a conflict of interest. The physicians could, however, participate in HRC for individuals assigned to the caseload of another physician. Documentation of risk/benefit analysis of the individual's medication regimen was located in the PSP. These documents did not include the signature of the psychiatrist as noted above. These documents did bear the signatures of psychology staff. The review of the medications included a cursory review of potential side effects, and a brief statement regarding potential benefits. The risk/benefit analysis did not address the specific actions and information that is required by this provision item. Examples are provided below. • In the record of Individual #191, the benefits were noted to be improvements in the medications designated target symptoms, and then an identical statement for each of the five prescribed psychotropic medications regarding other supports provided by the plan. For example, regarding the medication Thorazine, the benefit was stated as "decreased physical aggression, property destruction and unauthorized departure…this plan also supports improved communication which will improve…ability…to meet…needs and desires and participate in and benefit from active treatment and leisure activities." The risks of not providing treatment were equally routine "failure to provide this treatment may result in continued physical aggression, property destruction, unauthorized departure…not only could put…and others in physical danger, but also makes him more difficult for staff to work with, resulting in continued difficulties in benefiting from vocational training and leisure activities." • Another example, located in the record of Individual #218, revealed a cursory review of medication side effects for each of the three prescribed psychotropic medications. The benefits listed were the specific target indications designated for each medication. The risks of not providing the medication were documented in two instances as "greater use of restrictive practices." • Similar examples were located in other records reviewed. The above illustrated the need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective or potentially more dangerous than the medications. The success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to	

#	Provision	Assessment of Status	Compliance
		the physician, that the physician review said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item. The lack of a collaborative thoughtful approach to the prescription of psychotropic medication is discussed in further detail in the discussion regarding Provisions J11 and J13 and was observed during the monitoring tour. • During psychiatry clinic, the psychiatrist noted that Individual #319 was sedated. There were no data regarding sedation presented to the physician. Per the documentation for the clinic encounter, the individual was prescribed the antipsychotic medication Risperidone for target behaviors, including psychosis and aggression, but had a documented Axis I diagnosis of Paraphilia, Compulsive Eating Disorder, and Pervasive Developmental Disorder. The physician documented that the individual "appears sleepy in the meeting, but he goes to work everyday." With no objective data, the physician decreased the medication dosage by a total of one milligram. The physician did not request monitoring of sedation in the intervening period until the next scheduled clinic. Additionally, the physician was asked if he would be aware if the individual was given additional medication for pretreatment sedation, and if this could be a causal factor in the individual's sedation. The physician indicated he would not be aware of this complication. This case illustrated the need for overall improvement in the quality of data provided to the physician, increased input by the physician regarding specific target symptoms that should be monitored, the increased analysis of data by the physician, and the need for improvement in the risk/benefit analysis. The input of the psychiatrist, primary care physician and nurse must be documented in order for the facility to meet the requirements of this provision.	
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	The facility had in place a rudimentary review system for polypharmacy that was centered in the pharmacy department. Per the document request submitted prior to the monitoring tour, the facility was to provide data regarding a list of individuals prescribed intra-class polypharmacy, including the names of the medications prescribed and the medication's start date, as well as facility-wide data regarding polypharmacy including intra-class polypharmacy. The documents provided were reviewed, however, they were incomplete. For example, in response to the latter request, a listing of individuals with the designation of polypharmacy was provided, but this only covered the caseload of one physician (at the time of the monitoring tour, there were three physicians with clinical caseloads). In response to the former request, the facility did not submit any documents and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	documents provided upon further request during the onsite tour included a list of individuals' medications and dosages for prescription of anticholinergic medication. As stated several times in this report, the response to the document request as well as receipt of specific documents during the tour was not acceptable. The disorganization surrounding this provision led to questions as to whether the facility was appropriately noting polypharmacy. Minutes from the polypharmacy committee meeting for the three months prior to the monitoring tour were requested during the tour. Minutes for June 2010 and July 2010 were received and reviewed. Per this review, as of 6/15/10, one physician was noted to have a total of 30 individuals prescribed two or more psychotropic medications in the same class, 33 individuals prescribed three medications, 24 individuals prescribed four medications, six individuals prescribed five medications, and six individuals prescribed six medications. When this information was compared to the polypharmacy data provided for the same physician during June 2010, 31 individuals were noted as being prescribed three medications, 24 individuals were noted as prescribed four medications, seven individuals were documented as prescribed five medications, and five individuals were noted as prescribed six medications. The problem here was that data from the polypharmacy data sheet and the minutes of the polypharmacy committee meeting minutes did not match. The minutes also provided polypharmacy data for a second physician that indicated that nine individuals were prescribed two or more antipsychotics, 16 individuals were prescribed three psychotropic medications, 10 individuals were prescribed four psychotropic medications and two individuals were prescribed five or more psychotropic medications. There was no comparative polypharmacy data sheet for this physician provided for review. Additionally, there were no data from either source provided for the third facility psychiatrist, however, this physician only recently began treating individuals via clinic. Given the above information, it was easy to see that the facility staff needed to focus on the collection, collation, and presentation of polypharmacy data, not only for the purposes of monitoring, but, more importantly, for the purposes of the facility review of data. Interviews with the facility pharmacist and full time facility psychiatrist revealed that the facility was in the process of hiring another pharmacist who would play a bigger role in the psychiatry department. For example, the psychiatrist indicated that the new pharmacist would potentially attend psychiatry clinic and offer consultation to the psychiatrist regarding polypharmacy. Also, the psychiatrist indicated plans to continue	

#	Provision	Assessment of Status	Compliance
		the newly formed polypharmacy committee. One challenge noted during the monitoring tour was the reluctance of some physicians to document the rationale for polypharmacy. In review of the documentation from psychiatry clinic, the form that the physician's utilized to document the monthly and quarterly clinical contacts included a space designated "justification for polypharmacy." In general, documentation in this area read, "Improved on polypharmacy," "doing well on polypharmacy," or "symptomatic despite treatment." These justifications were not individualized and did not offer clues to the physician's thought process. In the record of Individual #191, there was better documentation of the justification for polypharmacy. For example, that record noted on 8/12/10 that the individual "still has periods of aggression…but will start trial of tapering Zyprexa to see if tolerates…less medication." It should be noted that this individual was prescribed three antipsychotic medications, one antiepileptic medication for a target of aggression and one antidepressant medication. In an annual psychiatric summary dated 9/29/09, there was a rudimentary review of the medications prescribed for the individual over the prior year. This review did not address factors other than medication as an etiology for the individual's aggression. It was notable that there was documentation of "multiple medication failures" and that "no treatment approach has led this patient to being in remission for any significant period of time." The physician did not take into account that this individual had alterations to the medication regimen as follows: Valproate, Trazodone, and Haloperidol increased in May 2009; Haldol switched to Chlorpromazine, and Trazodone dosage increased June 2009; Chlorpromazine and Valproate dosages increased August 2009: and Clozaril started September 2009. This case illustrated multiple medication changes made without adequate justification or rationale for specific changes. As stated in the discussion regarding Provision J13, the physicians must outline the rationale for utilization of a particular regimen such that there is a thoughtful planned approach to psychopharmacological interventions. Individual #191's record was even more confusing because he had diagnoses, including Bipolar Mood Disorder, and Attention Deficit Hyperactivity Disorder, Inattentive type. He had been noted as experiencing periods of aggression, and although aggression was being monitored as a target symptom, there was no monitoring of mood or mood instability. Difficulties surrounding cohesion of diagnosis, medication, and target symptom monitoring will be discussed in more detail in Provision J13. A review of the records of 18 individuals prescribed psychotropic medication revealed that in each record, there was a quarterly medication review document authored by the facility pharmacist. These documents were useful because they were comprehensive and	

#	Provision	Assessment of Status	Compliance
		provided a recap of recent laboratory data. As the document did not note specific medication dosages, it was difficult to determine if dosages were modified after review of the document. The treating psychiatrist signed the documents, however, information from this review was not noted in the monthly or quarterly psychiatric progress notes. It was notable that none of the records reviewed revealed a detailed description of the potential interactions or problems inherent in the prescription of multiple psychotropic medications authored by the psychiatrist with the exception of one, Individual #218, where the rationale was included as part of a comprehensive psychiatric evaluation following the format of Appendix B. Polypharmacy was routinely noted in Health Status Team Recommendations. Team members, including the primary care provider and the psychiatrist, signed these documents. These documents included a handwritten discussion of polypharmacy risks. For example, in the record of Individual #214, the heading for psychiatry stated, "symptoms are much improved on Haldol, Zyprexa, Thorazine, Lexapro, and Naltrexone." Documentation of a team discussion (author not designated) stated, "polypharmacy…requires multi-drug therapy to better control his psychiatric symptoms…required high dose of Olanzapine…risk of constipation in light of requiring multi-drug therapy and high risk of anticholinergic activity therapy is required and should continue. Continues to be monitored…in psych clinic, quarterly MOSES/DISCUS exam and spontaneous staff reports of efficacy and adverse effects…Had ileus…that required IV fluids. See Polypharmacy for GI concerns…was taken to group home last two months and this caused increase in behaviors, but symptoms are much improved on current meds now." The psychiatrist noted the potential increase in behaviors related to the group home visit, however, there was no other documentation of behavioral interventions, and no other discussion regarding polypharmacy in the psychiatric progress notes other than brief statements, such as "still symptomatic despite treatment."	
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.	The review of a sample of 18 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) were being performed by the Nurse Case Manager. These rating scales were being signed by the prescribing psychiatrist and, in some cases, there was notation on the scale as to how the information would be utilized. In the case of Individual #211, the physician signed the document and wrote that the dosage of antipsychotic medication would be reduced based on the results. A review of the physician progress notes surrounding the time period when this document was dated, did not note the physician's review of the document or how the results of same were integrated into the decision making process regarding medication dosages.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The record of individual #250 had documentation that the scales were performed, and the prescribing physician signed them. The results of the examination were documented in the annual psychiatric summary 1/20/10. Subsequent scales performed were not noted in the regular progress notes (MOSES and DISCUS performed 6/21/10, physician signed off, but no notation of the review in psychiatric clinic progress notes dated 6/22/10 and 7/20/10). This was similar in other records chosen for review. Individual #347 had documentation of the scales in the record. The treating psychiatrist signed them. The information was not noted in the subsequent psychiatric progress notes documenting the individual's treatment. A review of the record for 16 individual's prescribed antipsychotic medication as part of their pharmacological treatment regimen revealed that, generally, the MOSES and DISCUS scales were performed quarterly and reviewed by the physician, however, documentation of the use of this information in making clinical decisions was lacking. The one example of the use of this information in regard to clinical decision-making was located in the record of Individual #218. As noted above, this individual also had the benefit of having had a comprehensive psychiatric evaluation performed utilizing Appendix B as a guideline. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility.	
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	At the time of the onsite monitoring tour, the facility psychiatrists were not participating in the PSP process. Their contact with the PST members occurred during psychiatric clinic. As stated above, this contact was brief and, per observation of three clinic dates, unsatisfactory. Moreover, there was not a separate treatment-planning document regarding psychotropic medications. This was done somewhat via the monthly and quarterly medication reviews, according to staff interviews. There were references to psychotropic medications in some of the PSP documents reviewed. Even so, this was in sufficient to meet the requirements of this provision item. In review of the psychiatric documentation from the records of 18 individuals, it was difficult to determine the validity of the psychiatric diagnoses. A list of the names of every individual who had a completed psychiatric assessment per Appendix B was requested. This documentation was not provided, and as such, did not allow for a secondary request for copies of specific individual evaluations. There was one	Noncompliance

#	Provision	Assessment of Status	Compliance
	monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	comprehensive psychiatric evaluation regarding Individual #218 that had been completed and transcribed and was provided for review. This document contained a detailed bio-psycho-social case/diagnostic formulation and treatment recommendations encompassing both pharmacological and non-pharmacological interventions. The other annual psychiatric evaluations reviewed were lacking in diagnostic detail. Examples are presented below. • The annual psychiatric summary regarding Individual #133 was reviewed and documented a diagnosis of Intermittent Explosive Disorder. The document did not review the presence or absence of specific criteria required for this specific diagnosis as per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or per the Diagnostic Manual-Intellectual Disability (DM-ID). The psychiatric target symptoms were documented and were consistent with the diagnosis (i.e., aggression, self injurious behavior, property destruction, and stealing). There was, however, no notation of how these target symptoms were defined, what the result of the data collection was, or how the data had been affected by any specific intervention. The annual psychiatric summary did note that the individual "has had a difficult year…a long history of chronic aggression...not…stabilized despite being on multiple medications…" The summary noted multiple medication adjustments that were made, but made no note of any potential antecedents for the individual's challenging behavior, nor were any behavioral interventions noted. • A second example, chosen at random from among the medical records available for off site review, revealed similar issues with diagnostic formulation and inclusion of behavioral data. The annual psychiatric summary regarding Individual #113 revealed the following diagnoses: Intermittent Explosive Disorder; Bipolar Disorder, mixed type; Attention Deficit Hyperactivity Disorder, combined type; and Autism spectrum symptoms. The annual evaluation did not include a review of the presence or absence of specific criteria required for this specific diagnosis per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or per the Diagnostic Manual-Intellectual Disability (DM-ID). The psychiatric target symptoms were documented and were attributable to the diagnosis, however, there were notable exceptions to the target symptom data collection. For example, there were medications prescribed for indications, including mood stabilization, however, there was no documentation of target symptom monitoring of mood symptoms. • Other records revealed additional deficits. For example, in the record of Individual #272, diagnoses were not justified via a discussion of criteria. Nor was a detailed psychopharmacological/behavioral plan located in the psychiatric	

#	Provision	Assessment of Status	Compliance
		documentation. This individual, however, was being prescribed two antipsychotic medications for indications documented as aggression and psychosis. There was no monitoring of psychotic symptoms documented. There was documentation that prior attempts to "reduce or change…current regimen resulted in deterioration of behaviors." The psychiatric documentation made no note of the additional medication the individual was prescribed, specifically Ritalin, a stimulant medication that has a side effect of increasing psychotic symptoms. While treatment with these medications concurrently is acceptable, there must be some documentation of the rationale for this regimen and recognition that the regimen itself could be part and parcel of the individual's increased challenges. In the above noted examples, there was no documentation of a detailed rationale for the individual's specific medication regimen. This was typical for the 18 records reviewed. Further review of the psychiatric documentation revealed that in approximately 70% of the 18 cases reviewed, there was some connection between the behavioral target symptoms being monitored, the medication prescribed, and the diagnosis, however, there were notable exceptions. • Individual #272 was prescribed antipsychotic medication for an indication of psychosis, with no diagnosis of a psychotic disorder, and no monitoring of psychotic symptoms per the listing of target symptoms being monitored. • Individual #133 had a mood disorder diagnosis with medications targeting mood and mood stabilization, however, target symptoms did not include mood. Individual #211 had documented increased symptoms early in 2010. Antipsychotic medication was prescribed, with a documented indication of psychosis, albeit the individual did not have a thought disorder diagnosis and there was no noted monitoring of psychosis as a target symptom. While there was notation that the individual was experiencing increasing behavioral challenges (that may have been attributed to the discontinuation of one anti epileptic medication and the start of another anti epileptic medication), the psychiatrist opted to add another medication, Lithium and concurrently prescribed an intramuscular injection of benzodiazepine. Then in two subsequent meetings, the dosage of Lithium was increased as a result of the individual experiencing ongoing agitation and aggression. The above examples illustrated the need for medication treatment plans that outlined a thoughtful planned approach to psychopharmacological interventions. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the physician can	

#	Provision	Assessment of Status	Compliance
		determine the benefit, or lack thereof, of a medication adjustment.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	In response to the monitoring team's document request regarding a listing of all facility-wide policy and procedure, the facility produced a listing of policies including one entitled "Consent" with an effective date of 2/4/10. The facility indicated it had submitted a copy of the policy, however, this was not located in the documents submitted. Additionally, another item in the document request, specifically for all policies pertaining to the provision of psychiatric treatment, was also not provided. As stated above, the receipt of documents during the facility tour was challenging and, for some provision items, consumed more time than necessary and inhibited the extensiveness of review. Per interviews with facility staff, including the Director of Nursing, the facility pharmacist, the Director of Psychology, and the facility psychiatrists, as well as review of facility medical records, there was a parallel process occurring with regard to informed consent. There were consent forms located in the records that reviewed the medications prescribed to the individual, but delineated that the consent form "includes only medication that is not proposed for the purpose of behavior management. Consent for all drugs for behavior management, if any, will be obtained using another form that is maintained by the [SASSLC] Psychology Department." Nursing staff completed this document. Even though the document clearly stated it was not to be utilized for psychotropic medication consent, the forms still contained a list of the specific psychotropic medications prescribed to the individual. At the time of the facility tour, the responsibility for informed consent for psychotropic medication was delegated to psychology staff. Evidence of this process was located in five of the individual records reviewed and confirmed via staff interview. In an effort to obtain assistance in completing this task, it was reported that psychologists were approaching the facility pharmacist to obtain information sheets that were then shared with the individual or their legally authorized representative. A review of the documentation of this process revealed that the consent forms were not in keeping with generally accepted professional standards. They had a signature of only the individual or his or her legally authorized representative. The signature of the staff participating in the process was not included. Also, the list of side effects included for each identified medication was incomplete. For example, in one document, side effects listed for the antipsychotic medication Haldol stated "fast, slow, or irregular heartbeat, tremors, drowsiness, depression or headache." There was no mention of other deleterious side effects of this medication, which would include Tardive Dyskinesia and Neuroleptic Malignant Syndrome, among others. Side effects documented for the medication Lithobid stated, "change in how often or how much you urinate. Cold feeling	Noncompliance

#	Provision	Assessment of Status	Compliance
		or paleness in hands or feet. Extreme thirst. Headache. Trouble seeing. Irregular heartbeat." This list makes no mention of the need for regular monitoring of the Lithium level, the potential for Lithium toxicity, kidney effects, and the need for yearly 24-hour urine creatinine clearance, and possible thyroid abnormalities, to name a few. The informed consent process at the facility was not consistent with generally accepted professional standards that require that the prescribing practitioner disclose to the individual 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 individual's record. To delegate this responsibility to psychology staff, who do not have prescriptive authority and would not be able to respond to specific questions an individual or legally authorized representative may have regarding the specific medication was inappropriate. In an effort to address the deficit in these informed consent practices, it was recommended that the facility consult with the state office who, in turn, may want to consider a state wide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice. In a separate but related issue, review of the medical records revealed information regarding the individual and his or her guardianship status, however, this information was not included in the psychiatric annual evaluations or progress notes. Easy identification of an individual's guardianship status for the purposes of consent is necessary. Inclusion of this information in the demographic data located in the beginning of the psychiatric evaluations/progress notes may assist in this regard.	
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.	Per interviews with the three facility psychiatric physicians as well as the facility medical director, attempts to coordinate treatment efforts between primary care, neurology, and psychiatry were beginning. The facility recently increased neurology consultation hours to two half-day clinics per month, for a total of six hours. Per an observation during the tour, facility staff (psychiatric physicians, primary care physicians, facility medical director, and pharmacist) were in attendance for neurology clinic. The primary care physician was responsible for presenting the individual's case to the consulting neurologist, who then reviewed the pertinent clinical data, interviewed the individual, performed a brief/focused neurological examination, and then dictated a progress note with recommendations. The physicians were able to confer with the neurologist and discuss specific treatment recommendations.	Noncompliance

#	Provision	Assessment of Status	Compliance
		While this clinical communication was laudable, there were challenges. For example, there were a high percentage of individuals living at this facility with concomitant mental health diagnoses and seizure disorder: out of a total of 281 individuals prescribed medication, 127 had indications designated as "seizure" or "epilepsy." As such, it would be challenging for the neurologist to follow these individuals with the limited amount of clinical consultation time available, much less participate in regular coordination of treatment with other professionals. It would be beneficial to determine the amount of clinical neurology time needed via an examination of the number of individuals in need of neurology consultation and the recommended follow up frequency. It was apparent that the current assigned hours were inadequate, as during record reviews, no current neurological progress notes were located. Those that were located were one to two years old. The facility may want to consider options for increasing of neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers current contracted in other DADS facilities. This method of meeting en banc to ensure the availability of communication was not the best use of time. During the three-hour clinic, all three psychiatrists were in the room and in attendance for every individual's consultation. Given the increased requirements for the psychiatrists (e.g., integration into the treatment process, more extensive documentation) this was likely not the best use of their clinical time. It may be prudent to schedule psychiatrists to attend neurology clinic when individuals assigned to their caseload are scheduled (i.e., each psychiatrist would attend clinic every third time). This would also allow for more in depth collaboration with a particular psychiatrist. Unfortunately, even with the beginning attempts at coordination noted above, the psychiatrists and other facility physicians were not integrated into the PST or PSP process. While previously, this lack of integration was attributed to lack of psychiatry clinical consult time, the facility had recently retained a new full time psychiatrist, giving a total of two full time equivalents. This increase should allow for an increased psychiatric presence and integration, however, with the increase in overall requirements per the Settlement Agreement, the time may quickly become scheduled, requiring either increased hours or streamlining of responsibilities (as noted earlier in this provision discussion).	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in decisions to utilize emergency psychotropic medications and, more importantly, in discussions regarding treatment planning and behavioral support planning.

2. Individualize the desensitization plans for dental and medical clinic. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes.

3. Consider the designation of a lead facility psychiatrist.

4. Monitor psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines.

5. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate.

6. Consider the utilization of scales and screeners normed for this population in an effort to obtain objective data regarding symptoms as well as to monitor symptom response to targeted interventions.

7. Draft and implement policy and procedure governing psychiatric clinic at the facility.

8. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B.

9. Examine the scheduling process of psychiatric clinic at the facility. Clinic will need to be more comprehensive and detailed. This should include access to computer programs containing historical patient data as well as data graphs regarding individual target symptoms. Some physicians have created a reportedly extensive historical database. This information needs to be imported onto facility servers for security and then shared with all psychiatrists. Improved computer access for psychiatrists allowing read only access to psychology data may also allow for increased collaboration and integration.

10. Implement the Reiss screen for new admissions as well as those individuals who do not have a current psychiatric evaluation.

11. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. This data must be presented in a manner that is useful to the physician (i.e., in graph form, with medication adjustments, identified antecedents, and specific stressors identified).

12. Formalization of the PSP process to review risk/benefit ratios for the prescription of psychotropic medications.

13. Continue and expand the utility of meetings of the polypharmacy review committee.

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

15. Increase the frequency of the pharmacy quarterly drug regimen reviews to monthly in order to meet the requirements of the settlement agreement.

16. Improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

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

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

19. Review the target behavioral data for each individual to determine if appropriate data points are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start dates of medication, stop dates of medication, and dosage adjustments) included.

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

21. Make the identification of the individual's legal status and the identify/contact information of their legally authorized representative (if any) part of the regular demographic information included in the psychiatric assessment and progress notes. This will make the informed consent process and the regular contact of families/legal representatives during treatment a simpler process.

22. Individualize the process for Informed Consent.

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

24. Integrate psychiatry into the PSP process.

25. Streamline the psychiatrists attendance at neurology clinic such that they are available for consultation when individuals assigned to their caseload attend clinic, and have availability to confer with the neurologist, yet on other days are available to engage in other activities (i.e., participation in PST or PSP planning).

26. Explore options to increase the availability of neurology consultation.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #191, Individual #73, Individual #177, Individual #104, Individual #107, Individual #79, Individual #90, Individual #85, Individual #149, Individual #255, Individual #268, Individual #216, Individual #304, Individual #219, Individual #327, Individual #279, Individual #166, Individual #41, Individual #61, Individual #337, Individual #294, Individual #130, Individual #65, Individual #137, Individual #1 o Positive Behavior Support Plans (PBSPs) for: • Individual #79, Individual #149, Individual #166, Individual #268, Individual #41, Individual #177, Individual #327, Individual #279, Individual #191, Individual #73, Individual #90, Individual #255, Individual #219, Individual #61, Individual #337, Individual #294, Individual #107, Individual #130, Individual #137, Individual #104, Individual #65, Individual #85, Individual #1, Individual #276, Individual #304, Individual #323, Individual #103, Individual #216 o PBSP progress notes for: • Individual #219, Individual #85, Individual #304 o Psychological Assessments for: • Individual #177, Individual #325, Individual #263, Individual #167, Individual #81, Individual #152, Individual #168, Individual #73, Individual #191, Individual #315, Individual #105, Individual #255, Individual #298, Individual #132 o List of Psychological Evaluations (undated) o Spreadsheet of BCBA coursework completed for each psychologist, dated 5/14/10 o List of People Attending Circles, and Progress Notes and Data Sheets for: • Individual #209, Individual #101 o Behavior Therapy/Peer Review Committee minutes for 6/1/10, 6/7/10, 6/28/10, 7/5/10, 7/12/10, 7/19/10 o List of Psychological Services Referral Form o Psychology Department Caseload List, dated July 2010 o Director of Psychology CV o PBSP Assessment-Guided Staff Training Form, dated 6/16/10 <u>Interviews and Meetings Held</u>: o Daisy Ellison, Director of Psychology o Charlotte Fisher, Associate Psychologist V o Steven Boncek, Associate Psychologist III o Laura Lewis, Associate Psychologist, III

	Observations Conducted: o Behavior Therapy/Peer Review Committee meeting: • Staff present: o Estelita Lajzerowicz, RN; Daisy Ellison, Director of Psychology; Barbara Smith, Behavior Technician; Kim Earnhartt, Psychology Adm. Asst.; Laura Lewis, Associate Psychologist; Allison Block Trammell, Speech-Language Pathologist; Melissa Steerman, Associate Psychologist; Charlotte Fisher, Associate Psychologist; Gary Sarli, Associate Psychologist; Alan Almogela, Associate Psychologist; Steven Boncek, Associate Psychologist; Miguel Phillips, Associate Psychologist; Mark Boozer, Associate Psychologist; Charles Obi, Associate Psychologist; Tiffany Nash, Psychological Assistant • Individuals presented: o Individual #164, Individual #306, Individual #87, Individual #39, Individual #115, Individual #103 o Psychiatry Clinic: • Staff present: o Dr. Vale, Psychiatrist; Charles Obi, Associate Psychologist; Cynthia McLoflin, residential supervisor, Eric Saenz, QMRP, Maria Alzardo, DCP, Carlos Rodriques, Psychiatry Assistant, Steve Trevino, RN • Individuals Presented: o Individual #169, Individual #132, Individual #299, Individual #128, Individual #214 o Morning Unit meeting for units 670, 665, 766 o Observations occurred in every day program and residence at SASSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: None of the items in this provision were found to be in substantial compliance with the Settlement Agreement. There was, however, measurable progress in some items. There were also areas that the monitoring team believes require immediate attention.

	Those needs and progress are discussed in detail below. Finally, SASSLC's Plan of Improvement (POI) established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will take some time for SASSLC to make these changes, it may be useful for the facility to also establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because the psychologists were not yet demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification and the quality of the PBSPs at the facility (see K9). SASSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. While these efforts had not resulted in an increase in staff trained or certified in ABA, there was a noticeable increase in staff interest in pursuing board certification in this area since the baseline monitoring visit. At the time of the onsite tour, two of the facility's nine psychologists had begun course work toward becoming board certified behavior analysts (BCBA). Four additional psychologists, and the director of psychology, were scheduled to begin BCBA class work in the fall of 2010. It is recommended that the facility develop a plan to ensure that the remaining three psychologists attain BCBA certification. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials. Additionally, the facility had arranged to have a credentialed psychologist to provide BCBA supervision. It was clear that the facility was working to develop Positive Behavior Support Plans (PBSPs) that promoted growth, development, and independence while ensuring the safety, security and freedom from undue restraints of the individuals they served. Nevertheless, because effective PBSPs are the result of compliance with many of the items in this provision, the PBSPs were not as effective as necessary to adequately address the behavioral needs of many of the individuals residing at SASSLC (see K9 below for a more detailed review of PBSPs).	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a	This provision item was rated as being in noncompliance because the director of psychology was not a board certified behavior analyst or a licensed psychologist. The director of psychology possessed an advanced degree (Masters Degree) and over 20	Noncompliance

#	Provision	Assessment of Status	Compliance
	qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	years experience working with individuals with intellectual or developmental disabilities. She did not, however, possess a BCBA. Psychology staff reported positive interactions and professional support from the Director of Psychology. Additionally, the director had implemented several new procedures to improve clinical outcomes and achieve compliance with this provision. These include increasing the number of psychologists received training in ABA (see K1), the establishment of internal peer review meetings (see K3), the use of a new methodology for assessing integrity of PBSP implementation (see K11), and improved tracking of direct care professionals (DCPs) training in the implementation of PBSPs (see K 12).	
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.	This item was rated as being in noncompliance because the internal peer review consisted of only annual reviews of PBSPs, and because there was no external peer review. The facility had made substantial progress on this provision item of the Settlement Agreement by recently adding internal peer review to the Behavior Therapy Committee meeting. Review of available minutes and observation of a Behavior Therapy/Peer Review Committee meeting demonstrated active participation among the psychologists. During the meeting observed by the monitoring team, there were several examples of staff sharing strategies and suggestions to improve both data systems and PBSPs. Missing from the peer review meeting, however, was the opportunity to present cases that were not progressing as expected, or PBSPs for individuals new to the facility. It is recommended that peer review meetings be extended, from just annual reviews, to include any case that a psychologist (or his or her supervisor) believes would benefit from the input of other psychologists. Additionally, at the time of the onsite review, there was no evidence that the facility was conducting external peer review. The monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS BCBAs and supervisors (perhaps by teleconference). Operating procedures for both internal and external peer review committees will need to be established.	Noncompliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures	The data collection methodology used at SASSLC did not conform to ABA generally accepted professional standards and, therefore, this provision item has been rated as being in noncompliance. Since the baseline review, the facility had improved its data collection by introducing individual data books (that included each individual's PBSP and data sheets) that followed each individual throughout the day. This change will likely	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	improve the reliability of data collection by allowing direct care professionals (DCPs) to record data immediately after it occurs, rather than waiting to return to the location of the data sheets before recording individual data. The monitoring team, however, found that in many of the homes, the data books were in locked rooms, requiring DCPs to wait until the end of their shift to record data. It is recommended that the data books be readily available to DCPs, and data be recorded as soon after it occurs as is possible. At the time of the onsite tour, data on target and replacement behaviors were collected. The data system consisted of recording target behaviors, antecedents to target behaviors, and consequences following the behaviors. As discussed in the baseline report, Antecedent-Behavior-Consequences (ABC) data systems are typically used for limited periods during assessment, but not routinely during treatment monitoring. The reason for this is that they require DCPs to record considerable amounts of data for each instance of a target behavior. Therefore, the routine use of structured ABC data systems can lead to unreliable data. The often unavailable data sheets (noted above), complex data system, and the large number of target behaviors tracked (see K9), likely contributed to several of the psychologists indicating that they did not believe that data collected from the DCPs were reliable. It is recommended that SASSLC simplify its routine data system and reserve the use of structured ABC data for when a direct assessment of the variables affecting a behavior is needed (e.g., during a functional assessment; see K5). This simpler data system also needs to be more sensitive to each individual's needs. That is, in addition to being simpler for DCPs to collect, the data system needs to be able to accurately assess both behaviors that occur at low rates, as well as behaviors that occur at very high rates (e.g., stereotypies, undesirable verbal behavior). Depending on the target behavior and its frequency, the facility should use a range of measures such as frequency, time sampling, and duration measures. It is recommended that the facility expand its data collection system to allow it to accurately assess the occurrence of all target and replacement behaviors. Direct Care Professionals interviewed all indicated that they did have input in the establishment of data collection systems. No one, however, could show the monitoring team documentation of DCP involvement in the data system. It is recommended that DCP input in data system development be documented by DCP presence at meetings, or summarized in psychologists' training notes (see K11). At the time of the onsite tour of SASSLC, data reliability (i.e., interobserver agreement, IOA) was not collected. The most direct method for assessing and improving the integrity with which data are collected is to regularly measure IOA. It is recommended that the facility begin the collection of IOA for all target and replacement behaviors in	

#	Provision	Assessment of Status	Compliance
		each residential and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained, or data systems modified, if scores fall below those targets. Target behaviors were analyzed individually. Replacement behaviors were not graphed. At the time of the onsite tour, target behaviors were beginning to be graphed. They were graphed monthly, that is, each datum point represented one month of data. Some behaviors, however, need to be graphed more frequently to ensure that sufficient data-based decision making can occur. Monthly data points, for example, would not allow one to identify the effects of a new medication or change in the PBSP for several months. A more sensitive data system (i.e., each datum point representing weekly data or even daily data) that identifies behavioral trends quickly could assist the psychiatrist or psychologist in the most effective use of a medication or treatment intervention. It is recommended that SASSLC graph target and replacement behaviors at a frequency sufficient to make data-based treatment decisions. Monthly data documenting the progress of target and replacement behaviors were completed for all 28 PBSPs reviewed. Four individuals reviewed demonstrated improvements in physical aggression and self-injurious behavior (SIB). For example, Individual #137's physical aggression went from an average of four instances a month from August 2009 to December 2009, to zero for the last six months prior to the onsite tour. The monitoring team was encouraged to see that the PBSPs had been revised for six individuals (i.e., Individual #65, Individual #85, Individual #103, Individual #216, Individual #211, and Individual #323) because of lack of progress or an increase in targeted behaviors. Nevertheless, the majority of PBSPs reviewed demonstrated no change in target behaviors, and the PBSP data from four other individuals (i.e., Individual #104, Individual #61, Individual #41, and Individual #149) demonstrated an increase in SIB or aggression without evidence of PBSP modifications, retraining of staff, change in an antecedent procedure, and/or additional data collection. It is important, when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes made to the PBSP, attempts be made to collect additional information (i.e., modification to the functional assessment), retraining of staff, and so forth occur immediately and are documented in the progress notes. Finally, the PBSPs stated that plans will be modified if the individual's behavior indicated that there was no progress. It is recommended that this criterion for modification be individualized and more specifically stated (e.g., if aggression is not decreased to X per week for two weeks by X date).	

#	Provision	Assessment of Status	Compliance
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of psychological assessments for the majority of individuals at SASSLC, and due to the need for the content of both psychological and functional assessments to be more comprehensive and complete. <u>Psychological Assessments</u> Only fifteen of the 283 individuals at SASSLC had a psychological assessment. Those psychological assessments had annual psychological updates, which contained a review of the individual's intellectual ability, an assessment of adaptive ability, and a review of personal history. There was no screening for psychopathology or assessment or review of biological, physical, and medical status. Each individual's record should contain a psychological assessment that consists of an assessment of intellectual ability, adaptive ability, and biological (or physical) status. Additionally, the assessment should include a personal history as well as a screening for psychopathology and behavioral issues. <u>Functional Assessments</u> All individuals whose records indicated a behavioral disturbance had a functional assessment of the variable or variables affecting the individual's target behaviors. It is recommended that all functional assessments use a format that includes the following components. Since the functional assessments and the PBSPs were generally presented together, these components could be included in either the functional assessment or PBSP: • Direct and indirect measures of targeted behaviors reflecting a process or instrument widely accepted by the field of applied behavior analysis • Differentiation between learned and biologically based behaviors • Identification of setting events and motivating operations relevant to the undesired behavior • Identification of antecedents relevant to the undesired behavior • Identification of consequences relevant to the undesired behavior • Identification of functions relevant to the undesired behavior • Identification of functionally equivalent replacement behaviors relevant to the undesired behavior • Summary statements identifying the variable or variables maintaining the target behavior • Identification of functionally equivalent replacement behaviors • Identification of preference and reinforcers The 25 functional assessments reviewed utilized two functional assessment formats.	Noncompliance

#	Provision	Assessment of Status	Compliance
		One format utilized for Individual #191, Individual #73, and Individual #177 did not include direct measures of the functional assessment, or include a summary statement identifying the variable or variables maintaining the target behavior. The remaining 22 functional assessments did include direct measures. Fifteen functional assessments reviewed used ABC data for the direct assessment. As discussed above in item K4, ABC data systems are ideally suited for short-term assessment data collection. Many of the ABC direct measurements, however, did not sample examples of the target behaviors. Therefore, they were not particularly useful assessment tools. The facility should conduct ABC assessments until the target behavior occurs so that it can be useful in identifying the variable or variables controlling the target behavior. Other direct measures did not include ABC data but were very complete and descriptive, for example: • Individual #104's direct assessment results stated, "….based on my observations there is an increase in his targeted behaviors when he is working with new and unfamiliar staff…. He also displays aggression when he is too close to others….he appears to need consistency and routine…" Some direct measures that did not include ABC data, however, did not appear to be very helpful in understanding the target behavior, for example: • Individual #79's direct assessment results stated, "Individual #79 was observed at various times throughout the year. Most of the time, she appeared calm. She would often chew on one key for several minutes, and then switch to another key." All of the functional assessments reviewed identified antecedents and consequences hypothesized to be relevant to the undesired behavior. Many of the functional assessments attempted to differentiate between learned and biologically based behaviors (e.g., Individual #149). All of the functional assessments reviewed identified potential reinforcers. All of the functional assessments identified hypothesized functions of undesired behavior (although, as discussed below, the method for identifying this function was not always clear). All 25 of the functional assessments reviewed attempted to identify setting and motivating events. Some of the functional assessments, however, appeared to confuse the use of setting events and antecedents (e.g., Individual #85). All of the functional assessments used included indirect measures. Although the majority of functional assessments reviewed included most of the necessary assessment tools and components of a functional assessment, the conclusions of the assessment, and therefore the purpose of the functional assessment, were not consistently useful. For example, many functional assessments reviewed either had no summary statements, summary statements that were not based on operational behaviors identifying the variable or variables maintaining the target behavior, or the summary statement did not appear to be consistent with reported results. For example:	

#	Provision	Assessment of Status	Compliance
		• Individual #191's functional assessment indicated that the variables maintaining his physical aggression and work refusal included his desire to harm others, and a means to express frustration and anger. Indicating that an individual engaged in a target behavior because he or she wanted to hurts others, or to express frustration and anger are not useful in understanding the variables maintaining a behavior. It would be more helpful to know why he wanted to hurt others (e.g., to get them to stop doing something, as a means to get a response or attention). Similarly it would more useful for developing an effective PBSP to better understand what made him frustrated or angry. • Results from Individual #85's interviews of DCPs indicated that his target behaviors were maintained by attention and by escape from unpleasant activities. The behavior rating scales indicated they were related to positive attention, and one of the direct observation measures indicated that his target behaviors might have been maintained by negative reinforcement. The summary statement concluded that Individual #85's target behaviors were maintained by attention or access to preferred items. There was no mention of negative reinforcement playing a role in his target behaviors despite the fact that it appeared to be a variable in both the direct and indirect assessments conducted. Clearly when comprehensive functional assessments (as was done for Individual #85) are conducted there are going to be some variables identified or suggested that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Although many of the functional assessments reviewed were comprehensive, typically they did not attempt to integrate the information into a summary statement identifying the variables (both antecedent and consequent) that were hypothesized to affect the behavior. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors. The functional assessments reviewed did not contain replacement behaviors, however, replacement behaviors were included in 27 of the 28 PBSPs reviewed (Individual #90's PBSP did not contain replacement behaviors). Replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior. For example Individual #149's targeted behaviors were hypothesized to be maintained by positive attention and escape of non-preferred activities. Her replacement behaviors included teaching her to use signs to obtain staff attention and express her desire not to do specific activities. This was a good example of	

#	Provision	Assessment of Status	Compliance
		a functionally equivalent replacement behavior because it provided the same reinforcer (i.e., attention from staff and a way to escape non-preferred activities) as hypothesized to be maintaining the target behavior. Many of the replacement behaviors reviewed, however, did not appear to be related to the function of the target behavior. For example: • Individual #107's replacement behaviors consisted of learning improved problem solving skills and anger management, and meeting with her psychologist at least four times per month. These may be important skills and activities for Individual #107, however, they are not functionally equivalent to the purposed function of her target behaviors; staff attention. • Replacement behaviors for Individual #103 were problem solving, relaxation techniques, and anger management. His target behaviors, however, were hypothesized to be maintained by attention and task avoidance. Many of the PBSPs included replacement behaviors that were operationally defined. The PBSPs included a section called "Replacement Behavior Training." For example Individual #268's replacement behavior included a training objective, training schedule, and specific teaching instructions. It is recommended that all replacement behaviors include specific skill acquisition plans for developing replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility, that is, they should not be treated any differently because they are part of a PBSP. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 of this report). There was some evidence that functional assessments at SASSLC were reviewed and modified when an individual did not meet treatment expectations. The documentation of these modifications occurred as PBSP revisions (see K4). Some of these modifications, however, did come about as a function of a better understanding of the variables affecting an individual's behavior (e.g., Individual #85 and Individual #65). Therefore, it is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment. Additionally, functional assessments should be reviewed at least annually to ensure accuracy. These examples of modifications in the functional assessment and PBSP in response to the absence of progress or an increase in target behaviors represented an important step toward the functional use of behavioral assessment and treatment. Although there was no documentation indicating that this practice occurred for all PBSPs, or even for most individual's PBSPs where behavioral progress was absent (see review of progress notes	

#	Provision	Assessment of Status	Compliance
		in K4), it was encouraging that the process of modifying the functional assessment (i.e., attempting to understand the behavior) and modifying the PBSP based on the results of that assessment, were beginning to occur at SASSLC. In future onsite reviews, the monitoring team will be looking for documentation that functional assessment and subsequent PBSP modifications are routinely conducted when individuals' behavior does not meet treatment expectations.	
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 psychological assessments were not based on current, accurate, and complete clinical and behavioral data (see K5 and K7) and, therefore, this provision item was rated as being in noncompliance. At the time of the onsite tour, SASSLC did not conduct intellectual/cognitive assessments. Annual adaptive assessments were completed for some, but not all, individuals (see K5). The assessments reported a combination of historical data (e.g., intellectual assessments) and some new assessment data (e.g., review of behavioral, medical status, and adaptive status).	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.	As indicated in K5, psychological assessments were not completed for every individual at SASSLC and, therefore, this provision item was rated as being in noncompliance. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. A recent admission, Individual #255 had a psychological assessment completed on 7/30/10, within the 30 day requirement for newly admitted individuals specified in this provision. Although a cognitive assessment from May 2010, a review of behavioral issues, and a personal history were included, there was no adaptive assessment or assessment or review of medical status (see K5).	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than	Psychological services, other than PBSPs were provided at SASSLC, however, more work is needed to be done before this provision item can be considered to be in substantial compliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Psychological assessments reviewed did not document the need for psychological services other than PBSPs. It is recommended that needed services be documented in the psychological assessments. At the time of the onsite review, 16 individuals participated in "Circles." Each of the classes had specific measurable objectives and treatment expectations. They also included documentation and review of progress reflecting evidence-based practices. The service appeared to be provided by a qualified staff (i.e., a psychologist with a degree in counseling). The need for these services, however, should be documented in the individual's psychological assessment and implemented within six weeks of the assessment. Additionally, the service plan should also include a plan of service, a "fail criteria" that will trigger a review, a revision of interventions to ensure that services do not continue if objectives are not achieved, and a process to generalize skills learned to living, work, leisure, and other settings. Discussions with the director of psychology revealed that the facility planned to expand psychological services offered to social skills classes, relaxation classes, and communication groups. It is recommended that the facility continue to develop needed psychological 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 item was rated as being in noncompliance because the PBSPs reviewed did not contain all of the components necessary for an effective plan, and the quality of the content of some of the components included did not meet the generally accepted professional standard of care. All of the PBSPs reviewed had the necessary consents and approvals. There are several important components that should be included in every PBSP. The PBSPs and functional assessments were generally presented together and, therefore, the monitoring team looked at both of these documents to determine if the following components were present. All of PBSPs and/or functional assessments reviewed included: • Rationale for selection of the proposed intervention. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. Although present in all PBSPs/functional assessments reviewed, the quality of some of the above components appeared insufficient for the plans to be as effective as they could be. The following examples were typical: • Although Individual #103's PBSP contained definitions of target behaviors, some were not clear or operational. For example suicidal threats/attempts were defined as "Any verbal threat/act of killing self or hurting self." This definition did not, however, appear to be clearly differentiated from the definition of self-injurious behavior (SIB) that was defined as "Cutting himself with sharp objects…." Both targets involved Individual #103 hurting himself. Similarly, Individual #276's PBSP targeted delusional thinking. It is, however, impossible to operationally define a mental state. One could operationally define specific overt behaviors, such as talking to individuals not present, but observers cannot infer a mental state. Additionally, several PBSPs contained so many target behaviors (e.g., eight target behaviors for Individual #41, 13 for Individual #216) that it was impractical and unlikely that DCPs could accurately record the target behaviors (see K4 and K11). • The description of the potential functions of Individual #191's property destruction included a way for him to express frustration. Saying a behavior is the result of frustration does not, however, help us to better understand the behavior. In order to eliminate property destruction, we need to understand why Individual #191 becomes frustrated and destroys property. That is, it is important to identify the variable or variables that frustrate Individual #191 and result in property destruction. Concluding that a behavior is maintained by frustration is not a useful description of the function of the behavior. Similarly one of the listed functions for Individual #211's physical aggression was to harm others. The more important question is why does he want to harm others (see K5)? • The problems associated with the operational definitions and teaching strategies of replacement behaviors were discussed in detail in K5. • Although all PBSPs reviewed strategies for weakening undesired behaviors, many were inconsistent with the reported functions of the behavior, and appeared contraindicated. For example, Individual #130's PBSP indicated that her undesirable behavior was maintained by avoiding undesirable activities. The intervention following undesired behavior, however, directed staff to ask her to go to her room, stay and talk to her, ask her to explain why she was mad,	

#	Provision	Assessment of Status	Compliance
		and ask her to apologize to the person she hit. If the function of the behavior was in fact negative reinforcement (i.e., escaping/avoiding unpleasant activities), then this intervention would likely increase physical aggression because it allowed Individual #130 to escape activities by engaging in aggression. An intervention based on the results of the functional assessment would, for example, include having her return to the previous activity, and allow her to get breaks from, or avoid, certain activities by indicating (in a more socially acceptable manner than aggression) that she did not want to engage in the activity. • Other PBSPs strategies to weaken undesirable behaviors appeared general and imprecise. For example, Individual #85's PBSP indicated that the function of physical aggression was negative reinforcement. The intervention for this behavior involved 10 steps that appeared very generic and unrelated to the function of the behavior. These steps generally consisted of attempting to find out why he was upset, keeping others safe, and reminding him that he will lose his reinforcer. It is recommended that the plan also include interventions related to the results of the functional assessment. • In another example, during the PSP for Individual #205, the psychologist labeled a procedure to be environmental time out. He said it was meant to reduce behavior and involved taking the individual outside, such as to sit on the porch, or to any other quiet spot. This was described as being implemented to help her calm when her environment became chaotic and noisy. Environmental time out usually refers to removal of the individual from a reinforcing situation to a less reinforcing situation. Correct use of behavior analytic terminology is recommended to ensure consistency of practice. The following items were not consistently found in the functional assessments or PBSPs reviewed: • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric, and healthcare issues. • Treatment expectations and timeframes written in objective, observable, and measureable terms. • Clear, simple, precise interventions for responding to the behavior when it occurs (see above comments describing the quality of some components of the PBSP). • Plan, or considerations, to reduce intensity of intervention, if applicable. All of the components discussed in this provision should be included in every individual's functional assessment and/or PBSP.	

#	Provision	Assessment of Status	Compliance
		As discussed above many PBSPs reviewed did not appear to be based on functional assessment results, and many were not modified based on ongoing individual behavior (see K4).	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite tour (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for meeting the requirement of this provision item. PBSP data were consistently graphed monthly at SASSLC. As discussed in K4, however, these data should be graphed and presented in increments that would be sensitive to individual needs and situations. Looking at a datum point that represents one month of data is typically not sufficient to understand why an individual's behavior is trending in an undesirable direction. For example, graphing Individual #149's target behavior daily (rather than monthly) may show a variable pattern of behavior that, when compared with corresponding environmental or medical events, may aid in a better understanding of the increase in her dangerous behaviors and, therefore, a more effective treatment. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. They did not contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	This provision item was rated as being in noncompliance because SASSLC's newly developed treatment integrity system did not, at the time of the onsite tour, track treatment integrity data, and many of the plans were lengthy, with multiple target behaviors and interventions. All staff interviewed indicated that they understood each individual's PBSP. Additionally, staff were able to explain (in very general terms) how they would implement an individual's PBSP. Observations of DCPs implementing PBSPs also appeared to be consistent with written plans. The only way to ensure, however, that PBSPs are implemented as written is to implement a system to monitor treatment integrity. SASSLC made progress on this provision item by introducing a system to monitor and ensure treatment integrity. The integrity system had recently been introduced, and the tracking of integrity data for each DCP implementing PBSPs had not begun at the time of the onsite review. The integrity measure was reportedly administered 15 times each week (across different staff). The tool involved asking staff specific questions about the PBSP, such as regarding antecedent behaviors and replacement behaviors. The integrity system also included direct observations of staff implementing PBSPs. The monitoring team will look more closely at this new behavioral system during subsequent onsite	Noncompliance

#	Provision	Assessment of Status	Compliance
		visits. In order to ensure that all staff have been trained, integrity trends have been identified, and all staff are implementing PBSPs with integrity, it is recommended that integrity data be tracked and maintained centrally, the data reviewed regularly, and minimal acceptable integrity measures established. The monitoring team did not have the opportunity to observe the integrity system, and will be looking more closely at it in future visits. As discussed in K9 and in the baseline review, many PBSPs were very long and complicated, with eight or more target behaviors and accompanying interventions. These PBSPs and accompanying data systems (see comments concerning the complicated data systems) likely contributed to poor treatment integrity. It is recommended that SASSLC begin a process of reviewing each PBSP and attempt to eliminate unnecessary target behaviors, and simplify the interventions.	
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.	The psychology department maintained logs documenting each staff member that been trained on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. The trainings did not, however, include a competency-based component. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally, there was no systematic way to identify all of the staff who required remedial training. In order to meet the requirements of this provision item, it is recommended that the staff training procedures include a competency-based component, and the development of a coordinated system to ensure that all staff are trained in the implementation of each individual's PBSP.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite tour, SASSLC had a census of 283individuals and employed nine psychologists and five psychology assistants. None of the psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have 10 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Continue with training and supervision of psychology staff towards obtaining the BCBA certification.

2. Develop a plan to ensure that the remaining three psychologists attain BCBA certification.

3. Peer review meetings should be extended to include any case that a psychologist (or his or her supervisor) believes would benefit from others input.

4. Include external peer review meetings consisting of, at minimum, other Texas DADS BCBAs and supervisors (perhaps by teleconference).

5. Each individual's notebook (that contains daily data sheets) should be readily available to DCPs, and data should be recorded as soon after it occurs as is possible.

6. Simplify the routine data system and reserve the use of structured ABC data collection for when a direct assessment of the variables affecting a behavior is needed.

7. Expand the data collection system to allow it to accurately assess the occurrence of all target and replacement behaviors.

8. DCP input in data system development should be documented by DCP presence at meetings, or summarized in psychologists' training notes.

9. Collect IOA for all target and replacement behaviors in each residential and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained, or data systems modified, if scores fall below those goals.

10. Target and replacement behaviors should be graphed at a frequency sufficient to make data-based treatment decisions.

11. PBSPs modifications should be data-based.

12. The criterion for modification of PBSPs should be more specifically stated (e.g., if aggression is not decreased to X per week for two weeks by X date).

13. Each individual's record should contain a psychological assessment that is current, accurate, and complete. Psychological assessments should consist of an assessment of intellectual ability, adaptive ability, and biological (or physical) status. Additionally the assessment should include a personal history as well as a screening for psychopathology and behavioral issues.

14. A single format for functional assessments should be used and they, or PBSPs, should include the following components:
    - Direct and indirect measures of targeted behaviors reflecting a process or instrument widely accepted by the field of applied behavior analysis
    - Differentiation between learned and biologically based behaviors
    - Identification of setting events and motivating operations relevant to the undesired behavior
    - Identification of antecedents relevant to the undesired behavior
    - Identification of consequences relevant to the undesired behavior

- Identification of functions relevant to the undesired behavior
- Identification of functionally equivalent replacement behaviors relevant to the undesired behavior
- Summary statements identifying the variable or variables maintaining the target behavior
- Identification of functionally equivalent replacement behaviors
- Identification of preference and reinforcers

15. Conduct ABC assessments until the target behavior occurs so that it can be useful in identifying the variable or variables controlling the target behavior

16. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors

17. Ensure that replacement behaviors are functional

18. All replacement behaviors should include specific skill acquisition training plans. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility

19. Functional assessments should be reviewed when the individual does not meet treatment expectations and should be revised as needed with a maximum of one year between reviews

20. Conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility

21. Each individual at the facility should receive an annual psychological assessment update.

22. The need for services (other than PBSPs) should be documented in the psychological assessments.

23. The service plan for psychological services other than PBSPs should include the following additional components:
    a. a "fail criteria" that will trigger a review and revision of interventions to ensure that services do not continue if objectives are not achieved
    b. and a process to generalize skills learned to living, work, leisure, and other settings

24. The facility should continue to develop needed psychological services.

25. All of the components discussed in provision item K9 should be included in every individual's functional assessment and/or PBSP.

26. All PBSPs should be based on functional assessment results.

27. Integrity data should be tracked and maintained centrally, the data reviewed regularly, and minimal acceptable integrity measures established.

28. Simplify PBSPs by eliminating unnecessary target behaviors, and ensuring that interventions are as uncomplicated as possible.

29. Staff training procedures should include a competency-based component, and the development of a coordinated system to ensure that all staff

are trained in the implementation of each individual's PBSP.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC Standard Operating Procedure 200-5: Medical/Dental Services, dated 7/1/10 o DADS Policy#006: At Risk Individuals, dated 10/5/09 o SASSLC Nursing Manual: Seizure Protocol and Seizure Record o Bowel Management Mentoring Instructions o DADS Policy #09-001 Clinical Death Review, dated 3/09 o DADS Policy #09-002 Administrative Death Review, dated 3/09 o Clinical and Administrative Death Reviews of the following individuals: • Individual #29, Individual #26, Individual #66, Individual #182, Individual #175, Individual #231, Individual #27 (clinical review only) o Records of the following 22 individuals: • Individual #21, Individual #35, Individual #71, Individual #75, Individual #99, Individual #122, Individual #124, Individual #135, Individual #174, Individual #190, Individual #192, Individual #199, Individual #209, Individual #213, Individual #218, Individual #223, Individual #245, Individual #264, Individual #300, Individual #310, Individual #317, Individual #336 o Neurology Clinic notes, dated 2/23/10, /3/30/10, 4/13/10, 4/27/10, 6/29/10 Interviews and Meetings Held: o Carmen Mascarenhas, M.D., Medical Director o David Hazlett, M.D., Primary Care Physician o Albert Thomason, M.D., Primary Care Physician o Janet Adams, R.N., Chief Nursing Executive Observations Conducted: o SASSLC neurology clinic o SASSLC orthopedic clinic o Clinical review morning meetings o Cottage and dorms o Day services areas
	Facility Self-Assessment: Please see the Executive Summary section of this report.

	Summary of Monitor's Assessment: The facility was in the early stages of implementing the requirements of the Settlement Agreement. Although some progress was made, the facility was awaiting guidance from the state office on many provisions contained within the Settlement Agreement. Medical care was provided by a staff that included a full time medical director and two primary care physicians. All of these physicians were long term employees of the facility. Psychiatric services were provided onsite as well as several subspecialty clinics. Acute care was provided by several local hospitals. There was no formal medical quality program in place. The medical director had started some quality initiatives. The mortality review process was in place. Clinical death reviews were completed for all deaths reviewed, but this process appeared inadequate as it resulted in zero recommendations. Overall, individuals received a wide variety of healthcare services. Policies and procedures were needed to guide the medical staff in the delivery of those services. SASSLC was found to be in noncompliance with this provision of the Settlement Agreement because a number of areas of weakness existed in the medical services practice at the facility as indicated below in this section of the report.

#	Provision	Assessment of Status	Compliance
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 state policy for this provision was not in place at SASSLC at the time of the onsite review. Comments in this section are based on current generally accepted professional standards of care as proposed in the Healthcare Guidelines, 2009. The PCPs and psychiatrists were all aware of the standards set forth in the Health Care Guidelines. Overall, a variety of appropriate medical services were provided to the individuals at SASSLC. There were areas of progress as noted below. The significant deficiencies in medical services, however, resulted in a rating of noncompliance. **General Medical Care and Documentation** Medical care was provided by a staff that included a full time medical director and two primary care physicians (PCP). One PCP worked 30 hours per week. The medical director functioned as a PCP and carried a full caseload of slightly more than 100 individuals. Two psychiatrists provided services for a total of 1.0 FTE. An additional psychiatrist was recently hired to bring the total FTEs in psychiatry to 2.0. The facility also utilized several local physicians for onsite specialty clinics. A local pulmonary group admitted individuals to Methodist Hospital. This informal agreement had been in place for 18 years and provided continuity of care.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Medical care was provided in the sick call format. Each PCP visited his or her assigned homes on a daily basis and each saw approximately six to eight individuals per day. Nurses maintained logs of the individuals requiring attention. The PCPs reported that this structure allowed surveillance in the homes and early identification of problems. The focus of documentation was on acute illness rather than identification of medical risks and preventive care. Labs were drawn and processed at the facility and sent to Austin State Hospital. Stat labs were done at the Texas Center for Infectious Diseases (TCID) within three hours. X-rays were done at the TCID and preliminary reports received by 4 pm the same day. The daily clinical services review, initiated in August 2010, was a significant step towards integration of services. This was a morning review and was attended by the medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, and the psychologist on call (or designee). The meeting allowed the participants to discuss relevant events that occurred over the past 24 hours. The PCPs reported this meeting was helpful in transferring information among PCPs and between PCPs and the other disciplines. Multiple observations of this meeting by the monitoring team confirmed its utility in sharing information important in therapeutic decision-making. <u>Annual Assessments</u> The annual assessments were completed within the designated timeframes. The assessments were comprised of three separate documents: 1. Annual medical summary 2. Clinical evaluation (physical exam) 3. Annual medical evaluation The annual medical summaries included a brief background as well as summaries of each medical problem of the individual. The clinical evaluation reported the findings of the physical exam in a handwritten document. The annual medical evaluation contained the past medical history, family/social history, diagnostic studies, therapeutic procedures, medication history, current medication therapy, significant illnesses, and diagnoses. The medical summaries and medical evaluations were not standardized. Style and format varied among the three physicians. The annual medical evaluation was particularly difficult to read due to all of the text being underlined and single spaced. The most notable deficiency was the lack of a summary of an individual's active problems and a corresponding plan of care. <u>Active Problem List</u> Problem lists were present in all of the records reviewed. The lists were not	

#	Provision	Assessment of Status	Compliance
		continuously updated in accordance with the health care guidelines. There were several instances in which the lists did not contain active diagnoses found in other documents, such as the annual medical summary or did not contain a diagnosis for which the individual received medication. <u>Integrated Progress Notes</u> Progress notes were dated, timed, and signed. Notes were not consistently completed in SOAP format and the legibility of notes varied among physicians. Quarterly (90 day review) notes of various formats were found in most records. In many cases, the note was a two to three line summary. Documentation of abnormal labs and findings was very inconsistent in the records. <u>Physician Orders</u> Physician orders were written in accordance with the pharmacy and therapeutics guidelines of the Health Care Guidelines. Orders were routinely dated, timed, and signed. Most orders included a diagnosis or indication for the medication. Monitoring parameters were not seen in the records reviewed. The physician order sheets in the records reviewed did not include a header with the full official name of the facility or the name of the PCP. The header included the name and date of birth of the individual. <u>Consultations</u> Individuals were frequently referred to providers for consultation and diagnostic testing. The physicians included in the consults, the reason the request was being made as well pertinent information, such as lab values and drug levels. The date of the request was included in the majority of the consults. There were several examples in which the actual date of the consult was missing. **Routine and Preventive Care** <u>Screenings</u> A preventive care flow sheet was noted in all of the records in the sample. The flow sheets indicated when certain studies were to be completed. The flow sheet was not linked to any operational procedure that provided guidance or the source of the recommendations that were to be followed. Generally, there was evidence that preventive care was, and was not, provided as noted below: • Audiology evaluations and vision assessments were consistently documented in the records reviewed.	

#	Provision	Assessment of Status	Compliance
		• Mammography was completed for many of the women whose records were reviewed. • Pelvic exams and pap smears were not documented for many of the women included in the record reviews. This may have been appropriate in some situations but documentation for the decision and discussion of a risk benefit analysis related to this preventive care requirement was lacking. • Colonoscopies were done relatively infrequently on individuals in the sample. Fecal occult blood testing was usually documented on the preventative care flow sheets. Further discussion on this item is provided below in this provision item. • PSAs were frequently documented. • Osteoporosis screening was included in the preventive care flow sheet but DEXA scans were lacking on several individuals who appeared to be at risk for osteoporosis. In the case of the guidelines for pap smears, the medical director acknowledged that the guideline needed revision. The recommendation was listed: "Women age 21 & older. If one pap smear is normal and no risk for HPV, may be performed at the physician's discretion." The colorectal cancer screening guidelines on the flow sheet prompted clinicians to "Initiate screening at age 50 for men/women. Fecal occult blood testing annually or colonoscopy every 10 years." While recommendations for this screening varied, the U.S. Preventive Services Task Force (USPSTF) required that annual testing be high sensitivity fecal occult blood testing. This was not specified in the flow sheet. Screening and follow-up for osteoporosis was not consistent. The following represent several examples of individuals with clear indications for measurement of bone mineral density who did not have a screening study: • Individual #264 received long-term carbamazepine therapy, but had not been screened. • Individual #99 had a history of osteopenia on left ankle x-ray in 2002, but had not been screened. • Individual #317 received long-term carbamazepine therapy, but was not screened. <u>Immunizations</u> All of the records reviewed contained documentation of administration of appropriate immunizations, however: • Documentation in the immunization records was difficult to follow and read. • The annual assessment documents rarely provided any information on	

#	Provision	Assessment of Status	Compliance
		immunization status. Risk identification The annual assessments did not address medical risk factors other than osteoporosis. The approach to the risk assessment for osteoporosis varied among practitioners. Several individuals had risk factors for osteoporosis that were not addressed. In those instances, the decision not to screen for osteoporosis was not discussed. Disease Management --Diabetes o Two individuals with a diagnosis of diabetes mellitus were reviewed. • Individual #35 was appropriately monitored, but most outcomes did not meet targets set by the American Diabetes Association (ADA). This individual had numerous medical problems complicating the management of diabetes. • Individual #218 was appropriately monitored and clinical outcomes met targets established by the ADA. --Hepatitis C o Two individuals in the records reviewed had a diagnosis of Hepatitis C. • Individual #264 did not have documentation of recent surveillance for hepatocellular carcinoma. • Individual #317 had documented Hepatitis C, but no documentation of screening for hepatocellular carcinoma. The diagnosis of Hepatitis C was embedded within the medical evaluation and was not noted in any other medical or nursing documents. --Osteoporosis o Most individuals treated for osteoporosis were treated with alendronate. There were instances in which individuals had significant disease that would potentially benefit from treatment, but the individual had a relative contraindication to treatment with alendronate, such as active GERD or esophagitis. The drugs were discontinued or not used at all, and no consideration was given to alternative therapies for these individuals. • Individual #245 was diagnosed in 2002 with osteoporosis by DEXA, and started on alendronate. There was no repeat DEXA documented and alendronate was discontinued in 8/09 due to esophagitis. There was no documentation of discussion of alternative therapies in the annual medical summary completed 12/09. The individual received calcium and vitamin D supplementation. • Individual #300 had a diagnosis of severe osteoporosis by DEXA. The active problem list stated that GERD precluded the use of alendronate therapy. The individual did not receive calcium or vitamin D	

#	Provision	Assessment of Status	Compliance
		supplementation. • Individual #317 was treated with carbamazepine for seizure disorder. An x-ray in 1991 demonstrated osteoporosis. The individual had an osteoporosis prevention program implemented. Calcium and vitamin D levels were normal in 2004, so no supplementation was provided. The annual medical summary stated that fundoplication and PEG precluded the use of alendronate. No DEXA was done and no consideration was given to alternative therapies. <u>Bowel Management</u> The facility did not have bowel management protocols. Several individuals were noted to receive multiple interventions for constipation and impaction. In all of the records reviewed, the PCP assessments and plans of care focused on treatment with stimulating agents. Attention to fluid administration, and other non-pharmacologic and dietary interventions were not present in the records reviewed. A diagnostic approach to management of constipation was not seen in any of the records of the individuals with incapacitating and intractable constipation. The physician annual summaries and problem lists, in some cases, did not contain the diagnosis of constipation although drugs for the treatment of constipation were included in the drug regimen reviews. None of the individuals with incapacitating and intractable constipation were referred for colonic transit studies. Several individuals were admitted to local hospitals with bowel obstructions and required surgical intervention. Requests for further documentation on these individuals were not met. Although further details on the specific individuals were lacking, the fact that several individuals required surgical interventions warrants further exploration and questioning of current practices. Examples related to bowel management are provided below: • Individual #317 was treated with polyethylene glycol (PEG) for high fecal impactions. The problem list did not mention fecal impaction or GERD, and there was little discussion on management of this problem. The diagnoses of fecal impaction and constipation were not listed in the annual medical summary, dated 6/1/10, or in the problem list. Three stool specimens were positive for occult blood in June 2009. There was no documentation of a colonoscopy. The individual required multiple interventions in July 2010 and August 2010. A stat GI consultation was requested in August 2010 for evaluation of constipation. • Individual #35 had a history of constipation and fecal impactions requiring frequent interventions.	

#	Provision	Assessment of Status	Compliance
		• Individual #21 had a history of Ogilvie's Syndrome. Records documented multiple interventions in July 2009 due to the presence of a hard abdomen. In numerous instances, enemas and suppositories were used, followed by placement of a rectal tube. In 3/10, the individual developed a bowel obstruction, toxic megacolon, and acute respiratory failure. A sub-total colectomy with ileostomy was required. • Individual #127 had a history of chronic constipation treated with polyethylene glycol. On 1/13/10 he was given a suppository and fleets for abdominal distention. On 1/14/10 the individual was transferred to the ER for fecal impaction. On 1/18/10 the individual returned from the hospital for a fecal impaction. On 1/21/10 he returned to the hospital where he underwent a sigmoid resection and left sided colostomy. **Medical Management** There was ample evidence that the physicians responded to the needs of the individuals. When notified by nursing staff or direct care professionals of problems, physicians responded by conducting assessments, giving orders for care, and scheduling diagnostics or appointments. There were several examples of care that indicated, to some degree, a lack of clinical follow-up. The medical staff did not have guidance from policy or procedure related to the requirements for follow-up of acute problems or individuals returning from hospitalization. <u>Management of acute problems</u> • Individual #20: Individual was hospitalized 4/21/10 – 4/27/10 with pneumonia. The individual was seen by the PCP on 4/28/10 and, at that time, was in stable condition. The next PCP note was dated 5/4/10 for evaluation of neck redness. On 5/8/10, the individual was noted to be in respiratory distress at which time the PCP requested transfer to local hospital. The individual returned on 5/14/10 and was seen by the PCP for follow-up of pneumonia. There was no further physician documentation until 5/30/10. • Individual #213: This individual was reported to slip and fall on 5/29/10. The nursing assessment was normal and the PCP was not notified. The next nursing assessment was on 6/3/10 when the individual was noted to be unable to bear weight. An x-ray was ordered following PCP assessment. The x-ray revealed a distal fibula fracture and the individual was transferred to the emergency department for evaluation. The individual was evaluated again on 6/4/10 and 6/7/10 by the PCP. • Individual #245: This individual was prescribed clozaril with monthly	

#	Provision	Assessment of Status	Compliance
		monitoring of CBCs. Nursing documentation on 2/19/10 stated, "Stat CBC for reduction in WBCs. Lab to call Dr. Mings' cell with results." There was no physician documentation in the progress notes and no results available in the records provided. • Individual #317: On 11/17/09, a PCP order was written to clean right axilla abscess with peroxide and dry and apply bacitracin BID for 10 days, to notify the MD if cellulitis or infection developed, and for the PCP to follow-up on 11/28/09. On 11/22/09 at 2:00 pm a verbal order was given to start Bactrim DS for 10 days and have the attending physician see the individual the following day. At 8pm, nursing documentation stated that there was no drainage from abscess. At 9:30 pm, nursing documented that an abscess to right side of neck was getting bigger and protruding, and that the individual had a temperature of 101.4. The PCP ordered transfer to the local hospital. • Individual #317 was also diagnosed with Hepatitis C in 2008. Abnormal liver enzymes /Hepatitis C was listed in the medical evaluation, but this was very difficult to read. Viral loads and genotyping were completed at that time. While the individual had monitoring of liver enzymes, there was no documentation of surveillance for hepatocellular carcinoma. The diagnosis of Hepatitis C was not mentioned in the annual medical summary or active problem list. Nursing assessments did not note this diagnosis. • Individual #174 was seen by the PCP on 2/27/10 for an early abdominal abscess. Local treatment and bacitracin ointment were prescribed. The PCP was to follow-up on 3/2/10. Bactrim DS was started on 3/2/10. On 3/12/10, there was a PCP evaluation for pubic area boils and the individual was started again on Bactrim. On 3/24/10, the individual was again evaluated for right thigh abscess. These infections reoccurred for several months before a culture was obtained. Given the possibility of an MRSA infection, culturing was warranted earlier to help guide the antibiotic therapy. **Seizure Management** The facility utilized the services of a contract epileptologist. The medical director reported that neurology clinic was held twice a month. Participants included the medical director, staff physicians, and the psychiatrists. The neurologist and psychiatrist jointly issued recommendations from the clinic. EEGs were obtained at Santa Rosa Hospital. MRIs were available for those persons not requiring sedation at Southeast Baptist Imaging. The facility also conducted a VNS clinic. There were several issues related to seizure management noted in record documentation	

#	Provision	Assessment of Status	Compliance
		and observed during the neurology clinic. These are listed below. • The requirements for follow-up as outlined in the Health Care Guidelines were not adhered to. • The clinic notes lacked key information including: o Documentation of a review of the complete drug regimen. o Documentation that the seizure rating tools were reviewed and considered in the overall treatment plan. o Attention to quality of life issues, such as the individual's ability for self-care, to communicate, to enjoy leisure activities, and to participate in vocational and skills acquisitions programs. Very few clinic notes mentioned the level of alertness and interaction of the individual in clinic. o Timeframes for follow-up visits were not present even when medications were adjusted or additional work-up was recommended. o Clinic notes in the records reviewed were almost always signed by the medical director or PCP for the neurologist. o A rationale for maintaining individual on AED therapy was not always clear. • Protocols for laboratory and diagnostic monitoring for side effects of the medications did not appear to be used consistently. For example, the 180 day medical review did not include monitoring of BMDs for individuals receiving carbamazepine and mysoline. There also was no routine monitoring for complications of metabolic acidosis such as nephrolithiasis for those individuals receiving topiramate. The following are examples of how the concerns listed above affected specific individuals at SASSLC: • Individual #99: This individual was on dilantin for a history of seizure disorder. Seizures recurred each time the medication was discontinued. The last attempt to wean off AEDs was in 10/94. The last neurology clinic appointment was in 2005. • Individual #245: This individual was evaluated in neurology clinic on 6/30/09. The individual had been seizure free since 8/03 and possibly had a seizure in 2007. Keppra was decreased due to behavior changes. A dementia work-up was recommended. No return clinic date was specified. The annual medical summary dated 12/09 did not discuss the dementia work-up in the neurology section. The medical evaluation documented, "Advised basic dementia workup which was negative." There has been no further neurology follow-up. • Individual #331: This individual was evaluated in neurology clinic on 3/30/10. The individual was on trileptal and there was concern about electrolyte values.	

#	Provision	Assessment of Status	Compliance
		The clinic note repeatedly referred to hypernatremia. This likely represented a documentation error that went uncorrected due to the neurologist not reviewing the notes. Trileptal is associated with hyponatremia. • Individual #37: This individual was evaluated in clinic on 4/27/10. The individual was treated with Topamax. The note documented that "the patient is having serious problems with kidney stones." It was unclear if the kidney stones were newly diagnosed or if appropriate monitoring was in place. Monitoring should be done for potential complications of chronic acidosis, such as kidney stones. • Individual #143: This individual was evaluated in clinic on 4/27/10. The individual was seizure free since 11/01 and treated with phenobarbital. The recommendation was "continue with the same medication schedule and I will see her again on a prn basis." There was no explanation provided in the consult for the decision, and no timeframe was set for follow-up. • Individual #294: This individual was evaluated in neurology clinic on 4/27/10. The individual had a low sodium level and was referred to clinic for assessment of the need to change her medications. The recommendation was to start a trial of fluid restriction to see if the levels increased. No parameters were given, such as an acceptable level, and no follow-up timeframe was specified. <u>Training and Data Collection</u> Seizure training was provided in orientation to all new staff. Annual training was not required. The medical director had recently done some in servicing with the nursing staff on seizure management. A new seizure form was issued in July 2010 from the state DADS office. The PCPs were taught by the epileptologist to adjust the vagal nerve stimulators (VNS). Direct care professionals were taught how to use the VNS magnets. The facility did not have processes in place to track data to determine the overall quality and effectiveness of the seizure management program. There was no process in place to track key seizure data, such as: • the number of individuals prescribed two, three, or four drugs, • the number of individuals on monotherapy, • the number of individuals with a history of status, • the number of individuals with refractory seizure disorder, • the number of persons with refractory disorder who had been evaluated for alternative treatments such an VNS, and • the number of persons who have been seizure free for five years.	

#	Provision	Assessment of Status	Compliance
		The facility responded to a request from the monitoring team for a list of individuals with a history of status and intractable seizures by stating that this list was not available.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	The facility had not established a medical review system and, therefore, this provision item was found to be in noncompliance. The facility had a process in place for completing mortality reviews. The system involved three action steps per policy: 1. Within five working days of notification of death, the physician completes a death summary for the record. 2. Within 14 working days of notification of death (45 with autopsy), the clinical death review committee meets. 3. Within 21 calendar days of completion of review by the clinical death committee (52 with autopsy), the clinical death review committee will forward a report to the administrative death review committee. This goal of the mortality review was to provide a comprehensive review of clinical care and operational procedures that may have affected the overall care of the individual. Recommendations for correction actions were to be made when appropriate. Each review committee required the participation of an external representative. • Individual o Date of death: 7/9/09 o Clinical death review: 7/21/09 o Administrative death review: 7/29/09 o The Clinical Death Review Committee made no recommendations. The Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 8/28/09 o Clinical death review: 9/24/09 o Administrative death review: 10/2/09 o The Clinical Death Review Committee made no recommendations. The Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 9/19/09 o Clinical death review: 10/6/09 o Administrative death review: 10/14/09 o The Clinical Death Review Committee made no recommendations. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 10/20/09 o Clinical death review: 11/30/09 o Administrative death review: not provided o The Clinical Death Review Committee made no recommendations. • Individual o Date of death: 12/6/09 o Clinical death review: 12/21/09 o Administrative death review: 1/11/10 o The Clinical Death Review Committee made no recommendations. The Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 2/25/10 o Clinical death review: 3/22/10 o Administrative death review: 4/5/10 o The Clinical Death Review Committee made no recommendations. The Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 7/1/10 o Clinical death review: 7/15/10 o Administrative death review: 7/20/10 o The Clinical Death Review Committee made no recommendations. The Administrative Death Review Committee concurred with recommendations presented. • Individual o Date of death: 8/9/10 o Clinical death review: 8/31/10 (pending) o Administrative death review: pending The clinical and administrative death reviews were completed per state policy. The documentation reviewed indicated that all of the required participants were present. There were seven deaths from July 2009 to July 2010 representing a mortality rate of roughly 2.5%. It should be noted that following the evaluation of the quality of medical and nursing care given prior to death, no recommendations were produced from the seven clinical death	

#	Provision	Assessment of Status	Compliance
		reviews conducted by the facility.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a formal medical quality improvement process in place at the time of this review, resulting in a rating of non-compliance. There was evidence that some quality initiatives had begun. The medical director expressed concern about lacking specific training with regards to the area of quality improvement. Two initiatives were presented by the medical director: • Infection control – medical staff, in conjunction with the infection control coordinator, instituted quality efforts related to aspiration pneumonia, pneumonia, methicillin resistant staph aurues (MRSA), and urinary tract infections (UTI). • Diabetes mellitus – the medical director collected data on the management of diabetes mellitus at the facility. The metrics were those recommended by the American Diabetes Association. Compliance with process measures was 100%. Outcomes and clinical monitoring measures provided opportunity for improvement. Blood pressure targets were met in 93% of individuals. Eye exams were completed for 93% of individuals. Comprehensive foot exams were completed on none of the individuals. Interventions and corrective actions were implemented based on the data analysis. One corrective action involved implementing the use of silver tipped foley catheters to decrease the UTI rate. Another corrective action was to provide PCPs with equipment to complete sensory testing as part of the comprehensive foot exams in diabetic individuals. The medical director reported that quarterly in-house reviews for medical and psychiatric services were scheduled to start September 2010. The reviews will measure performance based on the Health Care Guidelines.	Noncompliance
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	This provision item referred to the Health Care Guidelines that provided the framework for the standards of medical care to be provided by the facility. Medical policies based on these guidelines were in development by the state. This provision is rated as being in noncompliance. The medical department recently revised the core policy Medical/Dental Services. This policy outlined duties and responsibilities for medical practitioners. The policy did not specify other requirements included in the Health Care Guidelines, such as documentation, the specific requirements for attending an individual's annual meeting,	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.	or requirements for post-hospital assessments.	

Recommendations:

1. The facility must maintain adequate medical staffing. Caseloads of each PCP, under normal circumstances, should not exceed 100 individuals. A fulltime medical director is needed in order to implement and monitor the systems that must be put in place to meet the provisions of the Settlement Agreement. If the medical director maintains a caseload, it should be limited.

2. Policies and procedures must be developed to guide the provision of medical care.

3. The annual assessments should be revised to align with the requirements of the annual plan of care specified in the health care guidelines. Problem lists should be updated with changes as specified in the health care guidelines.

4. Quarterly summaries of each individual's status should be done. These summaries should be standardized and provide a concise summary of the events. This can be accomplished without additional documents by generating a health profile that contains a problem list and additional information, such as current medications and diagnostic studies. This document is updated with changes as they occur and is reproduced quarterly.

5. A bowel management program is needed. This should focus on important aspects of bowel management, including fluid administration and positioning. Individuals with bowel management problems should undergo appropriate diagnostic testing when necessary.

6. Preventive care flow sheets should be revised to be consistent with the Health Care Guidelines.

7. Disease management flow sheets should be implemented and available in the records. The focus should be on common conditions as well as conditions commonly seen in persons with developmental disabilities, such as diabetes mellitus, osteoporosis, and hepatitis. These flow sheets must be linked to procedural guidelines on management of these conditions.

8. Guidelines need to be implemented and enforced on the follow-up of persons with acute medical problems and those returning from the hospital. Individuals with acute medical problems, or those returning from the hospital, should receive daily medical evaluation until stable or until the problem is resolved.

9. A comprehensive seizure management policy should be developed. This policy should include the requirements for medical management, documentation in the clinic notes, training, and response to seizures and status epilepticus. Consideration should be given to the development

of drug protocols that specify the labs and other diagnostics that must be monitored as well as the frequency of the monitoring. The facility should track essential data related to seizure management, such as polypharmacy and individuals with intractable seizures. These data should be included as part of the medical quality review system, as well as the facility's quality program.

10. Develop, improve, and address absence of recommendations in clinical death review process.

11. A medical quality improvement program is needed. Measures of medical quality must be determined and should include process and outcome measures that are appropriate for the individuals being supported. Once determined, data should be collected and analyzed, and corrective actions taken when necessary. This process should integrate into the facility's quality improvement program.

12. The hepatitis status of Individual #317 should be verified since this diagnosis appeared in only one document. If the diagnosis is incorrect, the medical evaluation should be updated.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SASSLC Organizational Chart o Map of SASSLC o DADS State Supported Living Center Policy: Nursing Services (1/31/10) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o DADS State Supported Living Center Policy: Nursing Competency-based Training Curriculum (August 2009) and accompanying competency checklists o DADS State Supported Living Center Policy: Care Plan Development (July 2010) o DADS State Supported Living Center Policy: At Risk Individuals including exhibits A through H o DADS State Supported Living Center Policy: Record Keeping Practices and Record Order Guidelines and Modifications o DADS State Supported Living Center Policy: Incident Management o DADS State Supported Living Center Policy: Use of Restraint, Restraint Checklist, and Restraint Documentation Guidelines o DADS State Supported Living Center Policy: Emergency Equipment Competency Checklist (June 2010) o Seizure Management form, new 8/1/10 o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o Alphabetical list of individuals by residence including date of birth, date of admission, and legal status o List of Emergency Room Visits 1/1/10 – 6/30/10 o List of Fractures/Injuries Requiring Sutures/Dermabond 1/1/10 – 6/30/10 o List of Hospitalizations 1/1/10 – 6/30/10 o List of expired individuals since 1/1/10 o List of Skin Information from January 2010– June 2010 o List of Pneumonia Diagnoses 7/1/09 – 6/30/10 o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals with unplanned weight loss at six months of $\geq$ 10% o List of one choking incident in last 12 months including Summary of PST Interim Meeting and follow-up recommendations on the choking incident for Individual #304 o Nursing 24 hour staffing reports for January 2010 and February 2010 o The last six months, minutes from the following meetings: Infection Control, Department of Nursing, Pharmacy and Therapeutics, Medication Error, Skin Integrity Committee o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS

	o Infection control monitoring tools o Infection Control Committee Meeting minutes 1/20/10 through 6/23/10 o Infection incidence list o SASSLC Pandemic Respiratory Infectious Disease Readiness Plan o SASSLC Standard Precautions Principles o SASSLC Standard Precautions-Hand Hygiene o SASSLC Standard Precautions-Personal Protective Equipment o SASSLC Standard Precautions-Management of Infectious (Medical) Waste o SASSLC Standard Precautions-Respiratory Hygiene/Cough Etiquette o SASSLC Standard Precautions-Contact Precautions o SASSLC Standard Precautions-Droplet Precautions o SASSLC Standard Precautions-Airborne Precautions o SASSLC Standard Precautions-Transmission-based Precautions Recommendations o Medication Administration Competency Checklist form and completed checklists 1/1/10 to date o Medication Errors FY 2010 Rolling Trends and the Medication Error Synopses through June 2010 o Emergency competency check list o Mock Medical Emergency Drill checklists completed January 2010 through June 2010 o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o Current Medication Administration and Treatment Records for 23 of 39 individuals residing on home 670 o Roster of Emergency Equipment Competency Checklist updated July 30, 2010 o Daily oxygen and emergency equipment inspection reports completed January-June 2010 o SASSLC Self Assessment and POIs August 2010 o SASSLC Nursing Department Self-Assessment July 2010 o SASSLC Meeting Schedule for August 2010, updated o Records of: • Individual #213, Individual #336, Individual #274, Individual #34, Individual #146, Individual #343, Individual #308, Individual #215, Individual #8, Individual #254, Individual #227, Individual #288, Individual #49, Individual #92, Individual #19, Individual #54, Individual #200, Individual #62, Individual #197, Individual #185, Individual #306, Individual #234, Individual #247 <u>Interviews and Meetings Held</u>: o Opening meeting and power point presentation on SASSLC progress held 8/16/10 o Staff nurses (LVNs and RNs on 673, 674, 665, , 670 and 770) o Chief Nurse Executive, Janet Adams, and Nursing Operations Officer, Shirley Fennell o Hospital Liaison Nurse , Gayindria Collier o Nurse Manager 673 and 674, Lola Faulkner o Nurse Manager 668, 670 and 671, Ida Perez o QMRP 673, Kelsey Hanson

	o Case Manager 665, Idalia o Case Manager 672, Christine Mukama o Case Managers 673, Velma Flores and Isabell Jemenez o Case Managers 674, Gabby Szettella and Josie Villarreal o Home 674, Carmita Young, LVN o Floor Supervisor 665, Mary Zapata, MRA2 o Home 665, Laura Esparza, MRA2 o Home Supervisor 673, Pat Jones o Home 672W, Alex Brooks, MRA1 o Home 672, Melany Thomas, MRA1 o Home 673, Michelle Tovar, MRA o Director of Pharmacy Services, Sharon Tramonte, Ph.D. o Informal group meeting with available nursing management staff to discuss progress and priorities; meeting participants were Chief Nurse Executive, Janet Adams, Nursing Operations Officer, Shirley Fennell, Clara Wallace, Nurse Educator, Gayindria Collier, Hospital Liaison Nurse, Ida Perez, Nurse Manager, Lola Faulkner, Nurse Manager, and Mandy Pena, Quality Assurance Nurse o NMT including Medical Director met with monitoring team members to discuss DADS draft policies and procedures for PNMT and discuss overlapping roles of HST, PNMT, and NMT <u>Observations Conducted</u>: o Medication pass on Thursday, 8/19/10 @ 7:30 am in Bldg 670 o Nebulizing treatments (670 and 673) o Enteral nutrition (673 and 674) o Suctioning (673) o Glucometer blood glucose checks (670 and 673)
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Although SASSLC had been undergoing significant change and faced almost daily challenges in communicating and enforcing expectations for performance improvement, as noted in the baseline monitoring review, the nursing staff members were dedicated to providing quality care and individualized supports and services. During the conduct of this review, 23 individuals were visited, and their records were reviewed. In general, recordkeeping practices were improved from the baseline monitoring review. There was ample evidence across the 23 individuals reviewed that the individuals' physician was generally notified of significant changes in their health status and needs, and/or when they needed to be seen, usually within less than 24 hours, by their physician or nurse practitioner.

	Observations of medication administration were conducted on 670E and 670W and for medications administered via the enteral route on 673 and 674. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals; they identified the individuals receiving medications; presented the medication in the proper form such as crushed mixed with applesauce; and, they did not initial medications on the MAR prior to the individuals' receipt of the medications. Omissions (i.e., holes or blanks) on the MARs were greatly reduced from baseline, however, there were several areas of medication administration practice that did not meet acceptable professional standards, such as timely administration and appropriate follow-up for response to treatment with PRN medications. All 23 individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner. Notwithstanding these positive findings, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. All 23 individuals reviewed had some of their health needs and risks referenced by Health Management Plans (HMP) and Acute Health Care Plans (ACP). These plans were established by their RN case manager in response to identified health needs, risks, and/or significant changes in health status. The plans were generally generic and more appropriate for acute episodes than for individualized long term management of a health risk or problem. The forms, processes, and plans in place at the time of the review, however, had problems, and they were in dire need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. It was clear that a large part of the problems noted in the HMPs and ACPs were associated with the inadequate and incomplete nursing assessments and nurses' identification and follow-up to significant changes in individuals' health status and needs. At SASSLC, there were a number of monitoring and training efforts underway within the Nursing Department and across the facility. These included committees to address monitoring and follow-up for each of the areas addressed in the Texas Health Monitoring Tools that were related to nursing services.

#	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,	With the initial implementation of many new systems and procedures, SASSLC was making some progress towards meeting this provision, but consistent and functional implementation was not yet occurring. There continued to be a pattern of frequent and regular absence of consistent identification of health care problems, implementation of appropriate and individualized interventions, and appropriate follow-up to resolution by the nursing department.	Noncompliance

#	Provision	Assessment of Status	Compliance
	monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	During the onsite monitoring review, 23 individuals were visited, and their records were reviewed. Records were organized, and nurses' notes were usually in the DAP (Data, Analysis, Plan) format. It was a rare occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late entry, when needed. The time notes were written was not consistently present in the records reviewed and is discussed in section V of this report. There was ample evidence across the 23 individuals' reviewed that their physician was generally notified of significant changes in their health status and needs and/or when the individuals needed to be seen, usually within less than 24 hours, by their physician or nurse practitioner. The individuals' physician and/or nurse practitioner were usually notified of individuals with changes in seizure activity, mental status, behavior, injuries, and illnesses (e.g., vomiting, diarrhea, elevated temperature). Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Across all 23 individuals reviewed, Integrated Progress Notes (IPNs) and other health status tracking systems failed to document nurses were consistently assessing health care problems and changes in health status, adequately intervening, and appropriately providing follow up to problems once identified, as required by this provision item. Numerous examples from this sample indicated the seriousness of this problem at SASSLC and extend to all phases of the nursing process from assessment to evaluation of plan effectiveness. Many examples are presented below. Examples below involve both problems that emerged primarily over the last quarter and existing problems that were reassessed and tracked using the new procedures during the last quarter. • Individual #213 was receiving orthopedic follow along after a spiral fracture of her right ankle extending through the distal fibula that was initially noted 6/3/10. The 6/3/10 IPN documenting the nurse's assessment specified vital signs, no weight bearing by the individual, swelling and bruising. Other components of an appropriate assessment were not included, such as the amount and location of swelling and the location, size, and color of the bruise. On a 6/15/10 follow up visit, the orthopedist recommended consideration of 325 mg ASA daily as prophylaxis against development of DVT (deep vein thrombosis). There was no documentation the recommendation was considered by the primary care physician and the rationale for not following the recommendation was not written in the record. The orthopedist also recommended frequent checks of her skin for pressure ulcerations under the CAM Walker/Fracture Boot and removal of the boot for bathing. Frequent skin checks were not consistently recorded and condition of the ankle upon removal	

#	Provision	Assessment of Status	Compliance
		of the CAM boot at bathing times were not recorded daily. Check of the leg boot twice a week (Wed 6 am-2 pm shift and Sat 2 pm-10 pm shift) was implemented by nursing staff and completed 6/16/10-Wed, 6/20/10-Sun, 6/24/10-Thurs, and 6/26/10-Sat. The shift when the check took place, and not the actual time of the skin check, was recorded. Skin checks were not implemented as ordered. In July 2010, she had a hip skin break that was followed by nursing on a flow sheet with the initial entry of "I" (Improving) on 7/27/10, but there was no documentation or indication of the initial assessment for comparison. The flow sheet, following her continued use of the CAM boot post right ankle fracture on 6/3/10, was initiated 7/27/10 with the initial entry of "S" (same), but there was no documentation or indication of the initial assessment for comparison. Individual #213 also had an eight pound weight gain from 103 pounds on 5/5/10 to 111 pounds 6/1/10. At the time of the onsite review, her recorded weights were 113 pounds for July 2010, increasing to 126 pounds for August 2010, an 11% gain in one month. There was no indication the nurse recording the weights had recognized or acted on the changes in weight, including confirming the weight change and considering influencing factors such as possible weight measuring method changes due to changes in mobility, or assuring the weight of the boot was subtracted from the weight. An overall weight gain of 23 pounds or 22% in body weight, since the limitations placed on her mobility post fracture, had been documented. Her HST recommendations and signature sheet dated 4/22/10 stated her calorie intake had been increased due to weight loss. The monthly weight record received for review had the 126 pound weight from 8/5/10 with an additional "reweighted 115 lb" written in under the 126 pound entry. • Individual #336: Trazadone prescribed for insomnia was discontinued 8/24/10, but a flow sheet tracking assessment and monitoring of his response was not completed. • Individual #343: On 6/2/10 at 6:00 am, an integrated progress note (IPN) from nursing reported Individual #343 had not voided overnight. Follow up was not timely with the next IPN written 15 hours later at 9 pm stating, "staff reported heavy diaper." • Individual #308: A 7/12/10 7:10 pm IPN noted a nursing evaluation of Individual #308after a choking episode was reported. Appropriate evaluation and vital signs, including breath sounds, were recorded and he was noted to have been given a PRN Albuterol nebulizing treatment. The administration of Albuterol was not recorded on his MAR. There was no documentation of assessment results indicating the need for treatment. Follow up assessment including vital signs was noted at 9:55 pm. • Individual #215's flow sheet was implemented in July 2010 to track a buttocks rash, bilateral lower extremity edema, and a scalp lesion. Initiation of this	

#	Provision	Assessment of Status	Compliance
		tracking form did not include the initial assessment or reassessment results, therefore, nurses' notations of "same" or "improving were meaningless. • Individual #254's MAR documented receipt of a tetanus/diphtheria vaccine 0.5ml left deltoid 7/10/10. There was no IPN or follow-up note to evaluate the site or take his vital signs. An IPN on 6/28/10 indicated a nursing assessment was performed after he fell on his back to the floor from a standing position at his walker. He was then walked back to his room before an assessment of his range of motion. A 8/17/10- 3:15 am IPN by nursing stated Individual #254 had complained to staff of his stomach hurting. Follow-up assessment by the RN was refused. The note stated he was "in bed asleep" at the time. The plan was to continue care follow up PRN. IPNs were out of chronological order at this point, with another 8/17/10 IPN on a page as a single entry with "11" for the time written as a follow up note to the stomach complaint. There was also an IPN dated 8/18/10 that was on a page as a single entry. The next note was 8/20/10. Additionally, on 4/28/10 he had a physician's order to "place patient on high risk for head injury." No change was made to his risk profile or health risk assessment. There was no documentation of review or follow-up on the order. • Individual #227was sent to the ER on 6/25/10 and received a diagnosis of dehydration and IV fluid treatment. He also had severe difficulty swallowing food, fluids, and medications. There were no new individualized orders or plans to address the dehydration. His 6/25/10 ER evaluation and diagnosis of dehydration was noted in his quarterly nursing assessment summary as one of several diagnoses/health risks requiring an HMP. They included weight $\leq$ 20 BMI, dehydration, impaired skin integrity, constipation, oral hygiene, fractures, anemia, and falls. All but dehydration had an HMP. Each HMP was a generic protocol that did not specify who, when, and/or how often interventions were to be implemented. There were no individualized strategies to improve, for example, his oral hygiene with the primary intervention specified in the plan of "assuring good oral hygiene." The HMP for his underweight status did not include his current individualized specific diet and caloric intake plan: double portions EXCEPT FOR MEAT AND MILK; ensure pudding with all meals; one Benecalorie supplement with meals; and give additional Ensure Plus or Boost Plus if eats 50% or less; and supplemental snacks three times daily. Instead, the plan was generic, including interventions such as "provide double portions and monitor response" and "offer/assure substitutes for uneaten food." The monitoring team noted sacral area (6/10/10) and left buttocks (6/17/10) pressure areas of concern preceded his dehydration diagnosis and treatment. Daily weights ordered for 7/14/10-8/25/10 were not completed after 8/1/10. He was noted to have experienced a gradual and steady downward weight loss trend from August 2009 at 108 pounds to July 2010 at 93.5 pounds. • Individual #288 had an HMP for risk of constipation, risk for infection, risk for	

#	Provision	Assessment of Status	Compliance
		injury, and impaired dentition. Her HMP was not updated to incorporate other health risks, such as GERD, that were identified in her nursing assessment summary 6/14/10. She had experienced repeated gastrointestinal problems including a bowel obstruction 9/16/08, 3/19/09, and again 4/27/10; an acute abdominal distention exploratory laparotomy with colon resection and segmental resection mesenteric abscess 3/10/09-4/10/09; and exploratory laparotomy with colon resection 4/16/09-4/21/09 with fluid in right lower quadrant of abdomen aspirated and drained. Her health risk rating related to gastrointestinal concerns was "medium" on 2/16/10 with no changes to date. After her hospitalization for obstipation/bowel obstruction 4/27/10, she had orders for PRN Bisacodyl suppository after no bowel movement in 24 hours. She had an episode of no bowel movement for 24 hours on 5/25/10. There was a nurses' note that she was positive for impaction. There was no documented administration of the PRN Bisacodyl suppository or follow-up. The next Integrated Progress Note (IPN) from nursing was on 5/28/10 and indicated again that she had not had a bowel movement in 24 hours. A Bisacodyl suppository was administered but there was no documented follow-up assessment for effectiveness. Charting of gastric residual began consistently in May 2010. Changes in the amount of residual had been noted as a sign of possible constipation/obstruction. The FLACC form used to chart the treatment and monitoring of pain for individuals was not implemented for Individual #288 after treatment for pain with acetaminophen on 5/2/10, the day after returning from the hospital on 5/1/10. The type of pain was not identified. A review of the appropriate body system (noting the hospital discharge the day before with discharge diagnoses of obstipation/bowel obstruction), behavioral observations and changes, and vital signs were not recorded. • Individual #49 had end stage renal disease (ESRD) and hypertension, among other medical diagnoses. He received dialysis three times weekly. He received lisinopril, metoprolol, minoxidil, and nifedipine for hypertension. His blood pressure was to be monitored before administering blood pressure medications at 800 and 2000 hours. Blood pressure measures were not noted on his MAR and vital sign records from 6/24/10 through 7/30/10 were incomplete, with many days where only one blood pressure was recorded (e.g., 6/25/10, 6/26/10, 6/27/10, 6/29/10, 7/7/10, 7/12/10, and 7/20/10. Many entries did not specify the time using 24 hour clock or labeling with am or pm. Due to his ESRD he had 1500 ml fluid restrictions, but without a complete fluid intake record with 24 hours totals. There was no initiation of the skin tracking (PUSH) form for monitoring and treatment tracking of his sacral area-open lesion identified in IPN 8/15/10 8:00 pm as an "open lesion to mid sacral area of left buttocks noted redness 0 drainage noted applied Curosol gel per orders." Skin tracking on flow sheets had not been initiated on Individual #49's recurrent,	

#	Provision	Assessment of Status	Compliance
		scrotal skin tears including a scrotal ulcer documented 6/25/10 with prescribed treatment to "clean left scrotal ulcers with peroxide, dry and apply triple AB bid and PRN x 10 d or healed" and 7/23/10 "L scrotum x3 open lesions with redness." Individual #49 also had PRN medication orders for Clonidine 0.1 mg oral every four hours PRN for blood pressure over 170/70. He had eight episodes of blood pressure over 170/70 in July 2010 without intervention. Further description is provided in section M6 related to PRN medication administration. • Individual #92 had orders to check gastric residual via his gastrostomy tube before each medication administration that were not documented for June or July 2010, providing no data for assessment and/or trend analysis. There was inconsistent implementation of his PNMP that addressed a number of his health risks including aspiration, constipation, and impaired skin integrity. Individual #92 was observed to sit with his head and trunk curved to the left. He had no trunk support and the seat depth on his chair did not allow for an upright and aligned position on a good base of support. This was one factor contributing to his discomfort and pain. He was treated with Ibuprofen every six hours daily for back/ leg pain. As reported in section M6 below, these orders were changed to PRN, but were not implemented. He continued to receive every six hour Ibuprofen. He also had orders for a Lidoderm 5% patch every 12 hours PRN for pain that had not been implemented. It was reported that Individual #92 experienced periodic, but chronic pain. The FLACC form used to track the treatment and monitoring of pain for individuals was not implemented for Individual #92. Elastic hose for edema were prescribed 6/26/10. He had multiple refusals documented without nursing intervention including individual education. In addition, there were multiple days without documentation of elastic hose use. • Individual #54 had continued, steady weight gain without appropriate or timely intervention. His 8/4/09 annual nursing assessment indicated he was at 157 pounds, 16 pounds above his 113-141 IBWR. His diet was 1800 calorie low cholesterol with a nutritional supplement, Ensure offered if he ate <50%. Nursing recommended a consult with the dietician, but this led to no change. His 11/16/09 quarterly assessment noted he was at 161 pounds and continued to receive three times a day snacks and to be offered Ensure Plus if he consumed <50% of a meal. Consultation with the dietician again recommended checking on "further decreases in calories," but calories had yet to be decreased. There were no changes to his HMP. His 2/19/10 quarterly assessment noted his weight at 167 pounds, 26 pounds above his IBWR. There had been a calorie reduction to 1500 calories and he continued to receive three times a day snacks and to be offered Ensure Plus if he consumed <50% of a meal. There continued to be no changes in his HMP related to his unplanned weight gain/overweight	

#	Provision	Assessment of Status	Compliance
		status, such as increasing the frequency of weight monitoring or collection and analysis of relevant data such as intake patterns and frequency of supplement administration. His 5/20/10 quarterly nursing assessment noted continued weight gain to 170 pounds at 20.56%>IBWR (9.7% gain in last 180 days), a 17.2% weight gain in the last 12 months. There were no changes to his HMP. • Individual #197 had five hospitalizations since January 2010 related to significant respiratory problems including aspiration (1/17/10-2/5/10 pneumonia , 3/10/10-3/30/10 acute respiratory distress, 5/25/10-6/1/10 aspiration pneumonia, 6/3/10-6/9/10 aspiration pneumonia, and 7/31/10-8/4/10 pneumonia). Her health risk ratings for respiratory and aspiration remained "medium" until 6/10/10 when it was increased to "high." There continued to be no changes to her HMPs. Augmentin, an antibiotic, was prescribed for seven days after her 6/1/10 hospitalization for aspiration pneumonia without three days of evaluation of treatment for efficacy and/or side effects. Individual #197 was re-hospitalized on 6/3/10. It was also noted that given her respiratory risks, her 7/31/10 nursing assessment did not include an evaluation of breath sounds. Her positioning to the right had been restricted due to a pressure ulcer on her ankle post hospitalization. Her PNMP revised 7/1/10 directed staff to follow her formal repositioning plan that included keeping her in her wheelchair for 2 ½ hours (8:30-11:00 am), not the recommended "no position for longer than 2 hours." Her only positions were inclined supine, sitting in her wheelchair, and left sidelying in poor alignment with optimal stomach emptying identified to be in inclined right sidelying which was restricted due to a pressure ulcer on her ankle. Lack of therapeutic positioning programs and her significant physical challenges were noted by the monitoring team. A right ankle pressure ulcer, Stage 2, approximately quarter-size was identified, treated and resolved 7/4/10 through 7/13/10 as documented on a skin tracking form (i.e., "PUSH" form). On 8/16/10, the monitoring team observed a Stage 2 pressure ulcer (i.e., a non-blanchable erythema and superficial partial skin thickness loss) approximately nickel size on the outer aspect of her right ankle. Use of padded booties and initiation of the facility's skin tracking procedure were observed to be immediately implemented.	
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	A revised nursing assessment form and state policy and procedure on nursing assessment was initiated at SASSLC in June 2010. Timely nursing assessments were present in each individual's record, however, most of the nursing assessments were not complete, updated, or comprehensive. The first step of the nursing process that one would expect to find in a facility such as SASSLC is the nursing assessment. The nursing assessment is an ongoing and continuous	Noncompliance

#	Provision	Assessment of Status	Compliance
	indicated by the individual's health status.	process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, regardless of the reason for the nursing encounter. Generally accepted professional standards of care indicate that nursing assessments must be complete, accurate, documented, and accessible to all members of the healthcare team. It is from the nurses' assessment that actual problems, high-risk potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. Moreover, the assessment records and summarizes pertinent health data against which change can be measured and goal achievement determined. Twenty-three individuals reviewed had annual and quarterly nursing assessments completed and filed in their records. All 23 had completed Braden Scales to rate skin integrity risk. The assessments were conducted by RN case managers. Documentation was such that it was difficult to determine when the assessment was completed due to the lack of dates accompanying nurses' signatures. Recent assessments that were completed during June 2010 and July 2010 included the actual date of the annual or quarterly assessment and the date the nurse signed the assessment. The use of a new comprehensive nursing assessment format had been initiated within the last quarter. It included items to gather more detailed health status data and facilitate analysis leading to more complete and appropriate diagnoses, but unfortunately this was not evident in the sample reviewed. Inclusion of medical diagnoses and current medication and treatment orders were items now included in the most recent version of the nursing assessment. Notwithstanding the positive findings, performance of nursing assessments failed to provide a complete and accurate review of individuals' health status. Annual and quarterly nursing assessments completed in June 2010 and July 2010 with the new format continued to be incomplete. They lacked the comprehensive health care data needed for analysis to identify changes, patterns and/or trends and provide a foundation for appropriate diagnosis and planning. Examples indicating this are presented below. • Individual #213's most recent quarterly nursing assessment completed 6/1/10 contained a number of omissions and inconsistencies. The summary of PRN medications administered included a listing of medications given after the date of the quarterly assessment (i.e., given on 6/04/10, 6/07/10 and 6/21/10). The reason for the administrations of her PRN medications was not specified and the physician's order changed to "acetaminophen/hydrocodone 500/5 every 6 hours pain x 4 days" without an assessment specifying the type and location of the pain being treated. The nutritional management section indicated she received regular consistency fluids when nectar consistency was prescribed. Her appetite or usual amount eaten and average daily fluid intake were not included. The weight management section recorded a weight of 103 pounds for	

#	Provision	Assessment of Status	Compliance
		5/5/10 and a current (6/1/10) weight of 111.04 pounds, an increase of eight pounds (7%) in one month. Her weight range was 89-111. The weight change was not noted, and the nursing summary or nursing recommendations were not included in the weight assessment item for weight change. The health history section did not indicate her history of constipation or GERD, both currently treated with medications. Assessment data related to her bowel elimination pattern did not identify changes in status from previous assessments, such as a change in medication treatment from lactulose on 5/6/10 to the current treatment for constipation, Golytely solution, 200 ml, twice daily. Items were left blank, such as the number of Fleets/Suppositories given per quarter. Entries of "0/zero" episodes or N/A (non-applicable) were not used. Her nursing assessments indicated that she wore a helmet for protection, but did not specify the type of helmet, identify protection from what, or explain why protection was necessary. Her 6/1/10 quarterly nursing assessment did not include her oral hygiene rating per the dentist, but the nursing physical assessment documented her current oral hygiene as poor. • Individual #336's quarterly nursing assessment was dated 7/9/10. The nursing summary stated he had required "Ativan (lorazepam) for 2 seizures in 24 hours on many occasions during the past quarter," but the number and monthly distribution of the frequency of use of PRN lorazepam for seizures or other PRN medications were not included in the quarterly assessment (e.g., the number for each month and total for the quarter). The monitoring team noted that his MAR documented that he had lorazepam given 14 times in July 2010 including 13 buccal administrations and one intramuscular administration. • Individual #343's assessment had repeatedly noted amenorrhea (no menses). She was 58 years of age and there was no mention of menopause, post menopause, or the need for evaluation for possible Hormone Replacement Therapy (HRT). Individual #343 was noted to have health risks associated with low body weight (≤20 BMI), aspiration, and respiratory infections, but her assessment 6/30/10 did not record her SPO2 (pulse oximetry) or height. • Individual #227's nursing assessments since 9/22/09 indicated no immunizations for Hepatitis B or Varicella and referred to the comments section that contained no further information. Quarterly assessments through 7/15/10 did not address his need for these immunizations. A nursing assessment was not provided during or after two weeks of treatment with Baclofen 10 mg, three times daily, for increased tone caused by pain post surgical repair of a fracture 5/27/10. • Individual #288 had a history of abdominal distention associated with bowel obstruction, but her assessments had no baseline abdominal girth. No measure was taken upon her return from a four day hospitalization on 5/1/10 with a discharge diagnosis of bowel obstruction. The PO2Sat (pulse oximetry) item	

#	Provision	Assessment of Status	Compliance
		was also blank. These items were not completed for successive quarterly nursing assessments through 6/14/10, with the exception of O2Sats for the 6/14/10 quarterly assessment. The 6/14/10 quarterly assessment listed changes in PRN medications to address constipation, but had not identified the actual frequency of use. She had identified chronic constipation, but no specified bowel management plan. She had recurrent vomiting and ileus since 1996, but the number and rate of vomiting episodes was not noted. • Individual #49's quarterly nursing assessment of 6/1/10 stated his health had remained stable, although he had been hospitalized for a planned bladder flush secondary to a bladder infection and remained hospitalized for seven days (5/3/10 – 5/10/10) with a discharge diagnosis of pyelocystitis. During this same quarter, he was also evaluated at the ER for elevated blood pressure with a discharge diagnosis of a bladder infection on 5/30/10. Although he was within his acceptable body weight range (95-115), he had lost 7.8 pounds since January 2010, from 120 to 112.2 pounds with a downward trend that was not identified. • Individual #168, an adolescent recently admitted to SASSLC received clonidine and lisinopril for hypertension and also received lamicatal, divalroex sodium, quietapine, and chlorpromazine for mood stabilization. Nursing identified health risks were skin integrity/enuresis, decreased cardiac output/hypertension, and constipation treated with Docusate calcium 240 mg daily. He was overweight with a loss of two pounds since admission. He had no HMP to address the effects of polypharmacy or his overweight status.. • Individual #200's 6/8/10 assessment reported that he was spoon fed honey consistency fluids. His orders and plan were to offer regular fluids and if he refused, to change his fluids to honey consistency. • Individual #62's 7/1/10 annual assessment was blank for labs, consults, and receipt of tertiary care despite two hospitalizations. One hospitalization, on 4/9/10-4/13/10, was for "emesis x4 large amounts" with a discharge diagnosis of a urinary tract infection and possible aspiration pneumonia. The second was on 5/18/10-5/25/10 with a discharge diagnosis of respiratory failure. She was sent to the ER for tachycardia, increased respirations, and PO2Sats 88-90. No weight, height (segmental height), or vital signs were recorded on the assessment. Continuous oxygen use was noted and included in the nursing summary, "not been able to be weaned off this year," but the assessment did not include the rate or method of administration or an objective summary of weaning attempts. • Individual #306's 7/12/10 quarterly nursing assessment provided no gastrostomy tube data including size, location, or the date it was last changed. Use of continuous oxygen was noted, but not the rate or administration apparatus used (i.e., nasal cannula). She was noted to have difficulty sleeping, (i.e., sleeping only two to three hours per night), but there was no problem	

#	Provision	Assessment of Status	Compliance
		identification or associated diagnosis. For numerous assessments: ▪ Oral hygiene ratings from the dentist and current oral hygiene status items assessed by the nurse were blank. ▪ Baselines established regarding individuals' bowel elimination most often did not include prescribed routine laxatives necessary to maintain an adequate elimination pattern and eliminate or reduce acute constipation episodes, as well as specific numbers of suppositories and/or enemas administered each month. ▪ Although all 23 assessments included completed Braden Scales with total scores, the ratings based on the scores were not provided (i.e., the score key: 12 or less high risk, 13-15 moderate risk, ≥ 16 minimum risk).	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Health management plans and acute care plans existed at SASSLC. Nursing staff at SASSLC had initiated the new (July 2010) state policy on care plan development. The plans continued to need a great deal of improvement as detailed below in order to meet the requirements of this provision item. In a facility such as SASSLC, the health management plan and acute care plan are designed to promote health and/or prevent, reduce, or resolve the problems and risks that are identified via the nurses' assessment and nursing and medical diagnoses. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals and outcomes. The individuals' status, and the effectiveness of the plans, must be consistently implemented and continuously evaluated and modified as needed. All 23 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Acute Health Care Plans (ACP). These plans were developed by their RN case managers in response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review had many problems and were in need of complete review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. Part of the problems noted in the HMPs and ACPs were due to the inadequate and incomplete assessments noted in sections M1 and M2. Other parts were due to the application of generic/standard plans or protocols to health problems that instead required individualized approaches and interventions. Some general comments are presented below. ▪ Across all individuals reviewed, HMPs and ACPs were in various forms, formats, and states of completion.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Across all individuals reviewed, HMPs did not consistently address all of the health care needs of the individuals; and ACPs did not address all of their emergent health care problems and risks. ▪ The interventions in the HMPs were the same across all of the individuals even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. The newer HMPs were standard health care protocols generally more suitable for use in an acute care situation such as management of a prolonged seizure or healing fracture. The protocols provided the nurse guidance in applying the nursing process to the presenting health problem or risk, making decisions regarding reporting and consultation with other health care professionals, and specifying follow-up plan criteria. With the addition of the individual's baseline data and a goal, each plan was essentially a generic health care protocol that did not provide specific person-centered interventions as a foundation for positive outcomes. Some of the HMPs had not clearly identified nursing interventions from interventions to be taken by direct support staff. The frequency of monitoring and assessment as well as the frequency of other interventions were generally not specified. ▪ Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised. ▪ There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and ACPs to ensure that the plans were implemented as planned and continued to be appropriate and relevant to the individuals' health status based on a review and analysis of comprehensive health status data. ▪ The objectives and expected outcomes referenced in the HMPs and ACPs were not consistently individualized, and they did not reflect the individuals' participation in their development or their desired health outcomes. Examples of HMPs and ACPs of specific individuals from the last quarter are presented below: • Individual #274's annual nursing assessment of 6/18/10 reported specific data on vomiting occurring once per quarter, but no signs or symptoms of GERD were reported. She received famotidine (Pepcid) for GERD. She was diagnosed with gastroenteritis and anemia 11/13/09. GERD was not addressed in her HMP. • Individual #34: Seizures and polypharmacy were identified as high health risks for Individual #34. She had 32 seizures over the last quarter, 85 over the past year with continued treatment with four antiepileptic medications including phenytoin, phenobarbital, rufinamide, and clonazepam. She was evaluated and treated at the ER for extended or prolonged seizures on 5/15/10 and 6/30/10. She also received clonazepam for anxiety and two additional psychotropic	

#	Provision	Assessment of Status	Compliance
		medications, quetiapine and mirtazapine. The HMP for reduction of her seizures was merely a reiteration of the seizure first aid procedure and directed the nurse to administer medications as ordered. She also had skin integrity problems secondary to behavior, but following her PBSP was not an HMP intervention. • Individual #343: Despite identified recurrent episodes of hypothermia and urinary tract infections (UTIs) by history and in the previous 12 months, Individual #343's HMPs were not revised to address monitoring and prevention for either. She had continued at risk for both conditions. To address the need for additional fluids identified 6/4/10, the intervention she received was "additional fluids through g-tube flushes." ACPs were implemented following UTIs and intake and output catheterization for urinary retention PRN was implemented. Although nurses noted the frequency of straight catheterizations for urinary retention were increasing, the number per quarter were not tracked and included in baseline data. She had a BMI $\leq$20, a positive behavior support plan (PBSP) to address hand mouthing, and diagnoses of GERD and hiatal hernia. She received nutrition both orally and via gastrostomy (i.e., antireflux high calorie double portions, pureed and, if eats 50% or less, administer one can of Jevity @300cc/hour via g-tube via pump). There was no consideration of the possibility that the hand mouthing behavior may be associated with the GERD or eating double portions. There was no health data summary included in the nursing assessment, such as the number of times per month she eats <50%, at which meals, and so forth. Vital signs were ordered every shift. Blood pressure and pulse measures not found in Individual #343's record were found on the Nurses Log form, but this form did not become part of her individual record. • Individual #254's 6/4/10 quarterly assessment noted his 4/23/10 ER evaluation with a discharge diagnosis of staph sepsis thought to be associated with dehydration. Cogentin was subsequently decreased from 5 mg to 4 mg daily. Dry chapped lips and dry skin were recurrent. Dehydration risk was identified in his assessment, but no changes were made to his existing HMPs, and HMPs to address and prevent dehydration and possibly future sepsis episodes were not developed. • Individual #19's HMP to address hypothermia was not only generic, but emphasized treatment once an episode occurred, not the prevention of episodes. Other interventions were general such as "identify factors related to the development of hypothermia and ways to reduce or modify them." • Individual #200 had orders for daily blood pressure measures. He often refused blood pressure monitoring, but there was no program in place to provide opportunities for education and or development of tolerance to the procedure. His HMP related to hypothermia specified monitoring his body temperature every shift. Vital signs were missing periodically, as on 6/4/10 and for several days in a row, such as 7/29/10-8/1/10. His first seizure since 1985 occurred in	

#	Provision	Assessment of Status	Compliance
		6/2/10. There was timely identification as a high risk related to seizures, but without follow-up HMP developmental and implementation. • Individual #62 had not had a seizure since 1990 and received no antiepileptic medication. She had a generic HMP for "Prolonged Seizures." Other HMPs to address appropriately identified actual and potential health risks were again generic and did not include the baseline data needed to evaluate change and goals that were unclear, not person-centered, or an intervention (not a goal). The HMP goal "to tolerate feeding and medications without difficulty" had no data to support it, and interventions were a gastrostomy tube protocol. Recurrent pneumonias were identified as a health risk with a HMP goal "to provide Individual #62 with supplemental oxygen and provide scheduled breathing treatments and help prevent exacerbations of infection, prevent possible exacerbation emesis and provide good oral hygiene." Routine data in her record for the last two weeks of July 2010 and first two weeks of August 2010 did not reflect implementation of interventions specified in her HMPs (e.g., PO2sat every shift when below 90%, received breathing treatment, and oxygen would be supplied), but PO2sats were not recorded every shift. The HMP related to oral hygiene deficit included the intervention to brush qid (four times daily), but her teeth were brushed twice daily. There was no record of assessing oral status daily per the HMP. The HMP for vomiting episodes, one with aspiration 4/9/10-4/13/10, did not include instructions for positioning to prevent aspiration, both routinely and during an episode or education of the direct support staff in assisting the individual into a safe position. She was on continuous pulse oximeter, but the resultant measurements were not included in the assessment, such as her usual PO2sat range. She was also identified as high risk for urinary tract infections (UTIs), the only high risk identified in her 3/31/10 HST review, but there was no HMP to address UTI. • Individual #185 had left ventricular hypertrophy with mild congestive heart failure, a pacemaker and several aortic valve replacements. Monitoring of vital signs (blood pressure and pulse) was ordered for twice daily. On 6/30/10, vital signs every four hours while awake were ordered for three days, given cardiac condition, multiple hospitalizations, and emergency room visits over the last two years for chest pain , abdominal pain, or shortness of breath. For multiple days over the last quarter, however, vital signs were documented as taken only once per day, or were not documented at all, including no entries after 5/31/10 until 6/8/10, and none from 6/20/10-6/29/10. The every-four-hour vital signs for three days ordered on 6/30/10 were not documented. Individual #185 also had orders for daily weights. There were no daily weights recorded. Weekly weights were recorded. On 6/23/10, he weighed 140 pounds and, on 6/30/10, his recorded weight was 151 pounds. There was no documented identification of the 11 pound (7%) weight gain or action taken to verify and address the	

#	Provision	Assessment of Status	Compliance
		change. He was hospitalized 7/1/10 through 7/14/10 with weight upon readmission of 130 pounds. Daily weights continued not to be documented. His weight was 115 pounds in August 2010 with the nutritionist starting pudding supplements. Neurological assessments completed 2/8/10 and 6/30/10 did not document the type of episode being monitored that determined the appropriate frequency of assessments he was required to receive. Individual #185 was treated multiple times with PRN acetaminophen for pain. The FLACC form was used to chart the treatment and monitoring of pain after treatment, but the type of pain was not identified. The pain assessment and monitoring did not include a review of the appropriate body system and behavioral observations and changes, but PO2sats and vital signs were recorded. Episodes of edema and edema requiring additional PRN treatment were noted to be "up," but there were no specific data. There was a general HMP that did not include directions to track edema episodes on flow sheets and monitor to resolution. Individual #306 had MMR vaccine ordered 7/28/10 to be followed by three days of monitoring her vital signs. On 8/16/10, the order had yet to be implemented. It was reported the pharmacy had been contacted but this was not reflected in her individual record. A call made to the pharmacy reported the MMR vaccine was available. After discontinuing Trazadone, Ambien for insomnia was ordered and started on 8/11/10. There was no initial nursing assessment or documentation related to assessment for effects or side effects through 8/16/10. <u>Intervention for poor oral hygiene</u>: All but one of the individuals had fair to poor oral hygiene. For most of the individuals in the sample reviewed, their oral hygiene was poor. The one individual with good oral hygiene was edentulous. Examples below are representative of the 22 individuals with oral hygiene issues, many with periodontal disease. • Individual #213 had fair oral hygiene noted by the dentist and recorded in her annual nursing assessment 9/9/09. The section of the nursing assessment "current oral hygiene" was not completed at the time of the physical assessment or at subsequent quarterly assessments on 12/1/09 and 3/3/10. Her 6/1/10 quarterly nursing assessment did not include her oral hygiene rating per the dentist, but the nursing physical assessment documented her current oral hygiene as poor. Following this quarterly review there were no recommendations or changes to her HMP strategies to address her poor oral hygiene and periodontal disease. The routine/generic HMP continued. • Individual #308 had consistently poor oral hygiene. He was independent in performing his own oral hygiene and his direct support staff reported he did not like to be assisted. Poor oral hygiene leading to periodontal disease increased his risk of negative effects on his diabetes and cardiac conditions. His nursing assessment and health management plan generally addressed poor oral hygiene,	

#	Provision	Assessment of Status	Compliance
		including provision of education. His assessments indicated improvement to fair, then a return to poor oral hygiene, but not all dental evaluations rated oral hygiene. His health management plan remained the facility's routine plan. No changes to his plan were made when he continued with poor oral hygiene for six months through his 7/16/10 quarterly assessment. There were no identified changes in educational or alternative equipment strategies, such as additional education from the dental hygienist or use of a rotating electric toothbrush. • Individual #34 had poor oral hygiene with recommendations for effective brushing and a routine care plan without individualized interventions to improve oral hygiene. The recommendation for effective brushing and presence of a routine care plan with non-specific interventions unchanged from quarter to quarter over long periods of time was generally true for 22 of 23 individuals in the sample. <u>Intervention to maintain bowel elimination:</u> Twelve of 23 individuals received Colyte/GoLYTELY/PEG solution (Polyethylene glycol and electrolyte solution) generally prescribed for bowel preparation and GI examination and contraindicated for those with megacolon or gastric retention of GI obstruction. Dosage of the solution for bowel preparation is usually 240 ml every 10 minutes until the individual consumes 4L. The monitoring team had not generally found this approach to bowel management prescribed for individuals with chronic constipation. Two of 23 individuals received Miralax/Polyethylene glycol (PEG) usually prescribed for short term treatment of occasional constipation with the usual dosage at approximately 17g daily in eight ounces of water or juice daily and contraindicated for known or suspected bowel obstruction. Individualized interventions to maintain bowel elimination were not evident. HMPs to address constipation or risk of constipation were the same for individuals receiving daily stool softeners as those receiving more intense interventions. Individuals receiving PEG solution were: • Individual #34: PEG solution 100 ml quid • Individual #213: PEG solution 200 ml bid • Individual #343: PEG solution bid • Individual #215: PEG solution 200 ml each morning • Individual #8: PEG solution 200 ml bid • Individual #288: PEG solution 250 ml bid • Individual #92: PEG solution 100 ml each morning • Individual #200s: PEG solution 100cc twice daily • Individual #62: PEG solution daily and senna daily • Individual #197 : PEG solution 100cc twice daily	

#	Provision	Assessment of Status	Compliance
		• Individual #306: PEG solution 100cc twice daily • Individual #234: PEG solution 200 ml each morning	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	At SASSLC, nursing assessment and reporting protocols were in place, however, the presence of protocols was not sufficient to ensure that the health status of the individuals at SASSLC was consistently addressed. The facility's implementation of its nursing assessment and reporting protocols was in the early stage of implementation. As noted, there were numerous problems, described above in sections M1, M2, and M3. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not yet evident in the records reviewed. At SASSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Quality Assurance Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all had a role and responsibility to ensure the implementation of nursing assessment and reporting to address the health status of the individuals. An informal meeting was held between the monitoring team and nursing management staff to discuss progress and priorities. Meeting participants included the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison Nurse, two Nurse Managers, and the Quality Assurance Nurse. The top priorities for the nursing department were described as first assuring the SASSLC nurses were knowledgeable regarding the Texas Health Monitoring Instrument items and move towards full implementation. They agreed they were in the early stages of implementation. The second was to fully implement new nursing assessment and health care planning policies and procedures and complete assessments in a timely fashion. The broad scope of these priorities and the possible need for focus on a smaller number of areas that would have the greatest impact on quality of care was discussed. Activities related to these priorities included involving the nursing staff in the process. Committees of seven nurses that each included administrative, case manager, and shift nurses were formed and assigned two to three of the monitoring tools on which they received training. They then applied the tools for self-assessment and follow-up action. The monitoring tools were being rotated among committees to assure training was received on all areas of nursing performance related to the provisions of the Settlement Agreement. The self-assessment by the nursing committees was considered and reviewed in preparation for the facility's August 2010 Self Assessment. Follow-up action included implementing a "Nursing Focus Topic of the Week" to be discussed during huddle report. The topic during the week of the onsite monitoring team review was bowel management and included the education of direct support staff.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The SASSLC presentation on progress toward meeting the Settlement Agreement provisions provided to the monitoring team on 8/16/10 included progress in the nursing care provision presented by the Chief Nurse Executive. In addition to initial implementation of the new assessment and care planning procedures and forms, there was also implementation of flow sheets for documenting injuries and/or illnesses to resolution and monitoring medication response, daily auditing of the MARs, and nurses' training on the "Healthcare Guidelines and Seizures" that needed to be repeated to reach all the SASSLC nurses. As was noted in M1, M2, and M3 above, appropriate and consistent implementation of the flow sheets and their functional use to track injuries, illnesses and medication effects were not yet in place. Flow sheets were new at SASSLC and were being used to track a number of health issues (e.g., skin conditions other that decubiti, responses to changes in or discontinuation of medications). The term "flow sheets" is used in this report because that is what the forms were labeled as at SASSLC. Note that the use of flow sheets should not circumvent the Integrated Progress Notes and integration of care goals of SASSLC. For example, the initial assessment of a skin rash would be recorded in the Integrated Progress Notes, followed by initiation of the flow sheet. Usually, flow sheets are utilized to record routine aspects of nursing care and monitoring (e.g., bowel elimination records, intake and output, vital sign records). Tracking forms are generally utilized to organize data related to a specific health problem or issue that is complex and/or recurrent in order to facilitate data analysis (examples are diabetic or decubitus records). Tracking forms generally lend themselves more readily to retrospective analysis and early identification of patterns and trends. Tracking forms provide for easy comparison of baseline assessment data with subsequent assessment findings. Below are additional comments regarding the activities, progress, and status of a number of areas of nursing assessment and reporting practices and protocols. The expectation for adequate numbers of trained, competent, and capable nurses was clearly articulated by the Chief Nurse Executive, the Nursing Operations Officer, and the Nurse Educator. It was noted that future changes in nursing, as well as affiliated departments, needed to be monitored closely for the effects on demands for nursing time so that there is adequate staffing to meet the needs (e.g., one suggestion for future change was increasing the amount of time spent with each individual in the psychiatric clinic which may impact the amount of nursing time needed). Emergency equipment competency training was completed for all the nursing staff with mock CPR drills yet to be completed for 29 nurses. Emergency CPR Drills were documented held for each residence each month. Competency-based training for skills	

#	Provision	Assessment of Status	Compliance
		such as tracheostomy care and straight urinary catheterization were provided and completed in new employee orientation (NEO), but there was no competency-based training for assessment and care planning. The monitoring team did not meet with the Infection Control Nurse during the onsite review, but did review the infection control related documents and interview nursing staff regarding infection control issues and procedures. The Infection Control Nurse was reported to be directly involved in the daily process of nursing assessment and reporting. He attended the DCS shift reports to receive information about any new infections and the status of identified infections and infection control at the facility. The Infection Control Nurse also received information from the facility's Medical Director and Pharmacist related to antibiotic prescriptions and practices across the facility. All of the information related to identification, tracking and trending, and reporting of infections was recorded by the Infection Control Nurse who reported these data to the facility's Infection Control Committee. The Infection Control Nurse provided direct support staff with re-education and training in standard precautions and follow-up on individuals who were diagnosed with infections. The Infection Control Nurse also provided technical assistance to nurses working in the residences who had questions about specific infection control practices and procedures. The Hospital Liaison was directly involved in the daily process of nursing assessment and reports. She assured that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at SASSLC. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via verbal reports at morning (nursing) staff meetings and written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. The Quality Assurance (QA) Nurse was not a member of the Nursing Department but a member of the Quality Enhancement Department and reported to the Director of Quality Enhancement. The QA nurse was involved in all aspects of quality oversight of the delivery of health care services to individuals at SASSLC. Further, she was a member of many of the facility's committees (e.g., Medication Error, Infection Control). A quality improvement approach focused on areas targeted by analyzing data from the revised monitoring system was identified for discussion at the next onsite review. Finally, nursing assessment and reporting protocols and processes at SASSLC would not be complete without the role and responsibilities of the RN Case Managers, Campus Nurse Supervisors, and Nurse Managers. These were the nurses who were responsible for data gathering and direct observations of individuals, documentation, collection, aggregation, and interpretation of these observations/data, and communication of these	

#	Provision	Assessment of Status	Compliance
		observations and data through assessments (verbal and written) to members of the individuals' personal support team (PST). If there were problems at this level of actual nursing assessment and reporting, there were problems at each and every level as were referenced above in sections M1, M2, and M3 of this report. Nursing assessment and reporting protocols sufficient to address the health status of the individuals served relies on organized data conducive to analysis for identification of changes in health status, early identification of emerging health problems, and measures on which to base an evaluation of a plan's effectiveness. In addition to the need for consistent and appropriate implementation of flow sheets described in M1 and M3, there were other tracking systems related to individuals' health status that were not consistently and appropriately implemented. Other tracking instruments, such as the new seizure record form were only recently implemented. Examples of problems identified in assessment and reporting practices are provided below. • Individual #200 had Type I Diabetes with glucometer blood glucose monitoring four times daily (7 am, 12 pm, 5 pm, and 9 pm) and insulin twice daily including sliding scale insulin with multiple changes to the sliding scale in the last six months. Diabetic records were difficult to follow and were spread across several documents including multiple pages of a Diabetic Record and sections of the MAR. Entries on the Diabetic record were frequently out of order, both by the day and the time of day. The information regarding blood glucose levels, sliding scale and other insulin given, and treatment for hypoglycemia was difficult to analyze concurrently as well as retrospectively. Glucometer measures of blood glucose records for June, July, and August to date 2010 were recorded inconsistently. For example, no measures were recorded for 6/7/10 at 7 am and 12 pm, 6/12/10 at 7 am and 12 pm, 6/26/10 at 12 pm, 6/29/10 at 7 am and 12 pm, 6/30/10 at 12 pm, 7/3/10 at 5 pm and 9 pm, 7/7/10 with no time recorded for first 2 of 4 entries, 7/14/10 9 pm, none for 7/15/10, 7/16/10 at 5 pm and 9 pm, none for 7/19/10, 7/20/10 at 5 pm and 9 pm, 7/24/10 at 9 pm , 7/26/10 at 5 pm and 9 pm, 7/28/10 at 12 pm , 7/31/10 at 5 pm and 9 pm, 8/4/10 at 5 pm and 9 pm, 8/8/10 at 12 pm, 5 pm and 9 pm, and 8/13/10 at 5 pm and 9 pm. • Implementation of the new seizure record form (6/10 version) was in place and implemented to record seizures for August 2010. In the case of Individual #336, the new seizure records had not provided more detailed characteristics of his seizure and pre-seizure behaviors/influencing factors, but documentation of nursing and medical follow-up, as well as use of his vagal nerve stimulator (VNS), was improved over documentation on the previous form. Other individuals from the sample had not yet had seizures since 8/1/10. Further evaluation was needed to determine effectiveness in gathering more detailed	

#	Provision	Assessment of Status	Compliance
		objective information related to seizure characteristics. • MOSES administration results were often inconsistent with individuals' reported health status. Several of the examples from the sample include: o Individual #336's MOSES was last completed on 6/25/10 and did not include ratings for a number of symptoms well documented in his record. For example, he was being treated medically for insomnia, nasal congestion and sinusitis, constipation, and dry skin. All were items on the MOSES that were scored "none." o Individual #34 had insomnia noted with three to four hours of sleep per night. Insomnia was not consistently noted on her quarterly MOSES forms . o Individual #254's MOSES, completed quarterly over the last six months, did not consistently record his gait imbalances resulting in falls. o Individual #288's MOSES of 7/10/10 did not include her episode of obstipation/bowel obstruction with hospitalization 4/27/10-5/1/10 and did not identify irregular menses as was otherwise noted in her record. • Bowel elimination data was to be documented daily and monitored by nursing staff daily. Daily monitoring and appropriate follow-up action by nursing was not consistently implemented and bowel elimination records were incomplete for Individual #213, Individual #336, Individual #145, Individual #215, Individual #254, and Individual #227. Bowel and Bladder Record forms used through 8/24/10 did not provide adequate information indicating a daily monitoring by nursing staff including the codes for no action or to see the nursing notes for an explanation of action taken.	
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.	SASSLC had implemented the state approved health risk assessment rating tool and held regular health status team meetings. The Health Risk Assessment Rating Tool was to assess and identify each individual's levels of risk (low, medium, or high) across a number of particular areas: seizures, aspiration, choking, medical, cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, osteoporosis, polypharmacy, respiratory, skin integrity, UTIs, weight, injuries, and their overall risk level. The rating tools were completed in conjunction with members of the individuals' PST. Health Status Team (HST) meetings were held to review and assign health risk ratings. Individuals' PSTs were not identifying and prioritizing health risks as a foundation for appropriate and consistent management. All 23 individuals reviewed had a completed Health Risk Assessment Rating Tool that was timely. Individuals' Health Risk Assessment Rating Tools often provided incomplete or very subjective data and criteria that were not stated in clear, measurable terms. For example, when assessing an individual's constipation risk, low risk was assigned because	Noncompliance

#	Provision	Assessment of Status	Compliance
		he or she took "docusate sodium" and "no need rescue suppositories." When assessing an individual's behavior risk, low risk for challenging behavior was assigned on the basis of their assessment, which was, "Doing well" noted on the tool or checking "yes" to self injurious behavior without further data or comment. This was less evident in the completion of June 2010 Health Risk Assessment Rating Tools reviewed in the sample. All 23 individuals whose records were reviewed were also reviewed by the HST. All of the 23 individuals reviewed had multiple risks related to their health and/or behavior. Health risk ratings as identified in the baseline review were not consistently revised when significant changes in individuals' health status and needs occurred. For example: • Individual #288 had health risks, such as GERD, identified in her nursing assessment summary 6/14/10, but no HMP to address the problem. She had experienced repeated gastrointestinal problems, including a bowel obstruction 9/16/08, 3/19/09, and again on 4/27/10; an acute abdominal distention exploratory laparotomy with colon resection and segmental resection mesenteric abscess 3/10/09-4/10/09; and, an exploratory laparotomy with colon resection 4/16/09-4/21/09 with fluid in right lower quadrant of abdomen aspirated and drained. Her health risk rating related to gastrointestinal concerns was "medium" on 2/16/10 with no changes to date, even after her hospitalization for obstipation/bowel obstruction 4/27/10. • Individual #197 had five hospitalizations since January 2010 related to significant respiratory problems including aspiration: 1/17/10-2/5/10 pneumonia , 3/10/10-3/30/10 acute respiratory distress, 5/25/10-6/1/10 aspiration pneumonia, 6/3/10-6/9/10 aspiration pneumonia, and 7/31/10-8/4/10 pneumonia. Her health risk ratings for respiratory and aspiration remained "medium" until 6/10/10 when it was changed to "high." • Individual #306 had eight hospitalizations in the 12 months preceding her formal health risk assessment rating, but no high risks were assigned. She had been hospitalized 10/26/09 for seizure, hypothermia 1/29/09 and 11/4/09, hypotension 11/13/09- 12/7/09, and tachycardia and tachypnea 12/20/09. During the 11/13/09- 12/7/09 hospitalization, her multiple psychotropic medications were all discontinued and Trazadone was started. Keppra was also started for seizures and then discontinued. Since that time she had been tapered off Trazadone and another psychotropic medication, naltrexone, had been prescribed. Her health risk ratings remained "medium" to "low." Please also see section I of this report.	
M6	Commencing within six months of the Effective Date hereof and with	The administration of medication and the management of the medication administration system at SASSLC had improved in the one area identified in the baseline monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	tour, omissions (i.e., numerous "holes" or "blanks"), on the MARs. As indicated in more detail below, there were additional areas of the medication administration management system found to be inconsistent with generally accepted professional standards of care. These areas will require additional analysis and intervention including proper completion of the MARs, management of the medications (routine and PRN) by the nurses, and in the oversight of medication errors. The nursing department had implemented a system for daily monitoring of the MARs by RNs. A review of 15 individuals' medication administration records (MARs) and treatment administration records for May 2010 through July 2010 identified an improvement over baseline. There was generally appropriate and accurate documentation of administrations as indicated by the nurse's initials in the appropriate space of the MAR (i.e., a reduced number of omission, "holes" or "blanks"). The following omissions, however, were found during this onsite review: • Individual #213: 5/31/10 2000H Aprodine • Individual #274: 8/18/10 all 7:00 am medications including carbamazepine • Individual #200s: 7/21 and 7/22/10 Albuterol • Individual #92: 7/9/10 1200H misoprostol • Individual #197: 5/22/10 Ketoconazole 2% shampoo and 7/11/10 Pulmicort Observations of medication administration were conducted on Homes 670E and 670W and for medications administered via the enteral route on Homes 673 and 674. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals, they identified the individuals receiving medications, presented the medication in the proper form such as crushed mixed with applesauce, and they did not initial medications on the MAR prior to the individuals' receipt of the medications. For the observation on 670, the nurses were in the nurses' station behind a Dutch door with the bottom portion of the door locked and the upper portion open. Nurses presented medications through the opening in the door to individuals who were brought to, or called to, the window by a residential staff person or case manager. The staff person had a list of all individuals scheduled to receive medications and confirmed the identity of the individual with the nurse who called the individual's full name twice. Once the medications were given, the staff person crossed the individual's name off the list. This was presented as the system to prevent the wrong person receiving medications for another. On six occasions during the observation, individuals were able to come to the window, lean over the window and open the locked lower half of the door and on two occasions	

#	Provision	Assessment of Status	Compliance
		enter the room. The staff person, who was monitoring medication administration on the outside of the medication room door and assisting in identifying and keeping only one individual at the door at a time, was not always able to keep her undivided attention on the individual to whom the medications were being administered. This was identified as an opportunity and thus increased risk for an individual to take another individual's medication or other unsafe items from the nurses' station. Medication administration on 670E and 670W was reported by the nurses working in this residence to start at 7:30 am. Four nurses were present including two LVNs to administer the medications, one RN/Campus Nurse, and one RN Nurse administering treatments and assisting the physicians. Medication administration began at 7:35 am for administration of 6:30 am, 7:00 am, and 8:00 am medications, already making the 6:30 am medications administered one hour after the prescribed time. Given the usual start time of 7:30 am reported, it was noted the late administration of 6:30 am medications would routinely be the case. Individuals receiving treatments such as glucometer blood glucose checks or nebulized medications were ensured privacy and dignity in a second room of the nurses' station, but all other individuals stood or sat in their wheelchair at the window in the hallway open to the living room. During the medication pass observed, there was minimal to no interaction with the individuals regarding the medication. Interactions with the individuals were primarily a general direction to "take this" or "finish this" while directing the individual to finish swallowing solid or liquid medications. It was not a person-centered process. The medication pass observed included several areas which were inconsistent with generally accepted professional standards of care as described below: • Medications were not administered in a timely manner the morning of 8/19/10 on residence 670. For the 39 individuals scheduled to receive medications, all of their 6:30 am, 7:00 am, and 8:00 am medications were administered beginning at 7:35 am. 6:30 am medications, such as Individual #149's lansoprozole were administered at 8:30 am or later without notation of late administration in her record. This medication should be administered 30 minutes before eating, but had been administered after breakfast. At 10:05 am, 16 individuals had not yet received their morning medications. When prompted by the monitoring team, the RN contacted the three prescribing physicians and orders were received from each for late administration. Medication administration documentation on the MARs continued to include initials only and did not circle the initials to indicate a notation on the back of the form, in this case for late administration. • Whole tablets and capsules mixed with chewable tablets were presented in one	

#	Provision	Assessment of Status	Compliance
		medicine cup. After the first such administration to Individual #101, she removed the chewable tablets and placed them on the counter of the nursing station door. The counter on the Dutch door had been touched by numerous individuals before her, thereby presenting an infection control issue. After prompting by the monitoring team, other individuals received chewable medications in a separate medicine cup. • Many oral medications (tablets and/or capsules) were presented by the nurse together in a medicine cup and swallowed together in a single mouthful presenting a choking risk to individuals. Eight oral medications were observed presented to Individual #274 and swallowed in a single swallow without intervention or correction by the nurse. • The narcotics record for Individual #241's clonazepam administration was observed charted as given before administration. • Ear drops for Individual #190 were administered while she was standing with her head erect. She was not asked or assisted to sit with support for her head during administration, nor was she asked to position her head to at least 45 degrees for appropriate administration of ear drops. During administration, the end of the dropper touched both of her ears and was returned to the bottle. She was prescribed the drops for fissures and ear tissue overgrowth. After prompting by the monitoring team, new ear drops were ordered to replace the contaminated bottle and directions for use of a disposable syringe were put in place to avoid contamination in the future. • The medication cart in 670 was observed to be dirty throughout. Several hours later it was observed to have been thoroughly cleaned. The facility policy was noted to be to clean the cart before and after each use. During medication administration at one residence (670) the day shift nursing staff were observed using adaptive spoons and mealtime equipment as well as appropriately thickening liquids as specified for individuals with PNMPs. Day shift nursing staff of another residence (668) were observed not to use adaptive equipment, particularly adaptive spoons, during medication administration. Nebulizing treatments (673 and 670) observed and documented included appropriate pre and post treatment assessments including vital signs, breath sounds, and PO2 Sats (oxygen levels). For enteral administration of medications (673 and 674), individuals' nurses checked their stoma sites and abdomens for signs of distension, pain, and skin breakdown, checked the positions of the individuals and their feeding tubes, appropriately flushed and clamped their feeding tubes, and properly administered the individuals' medications in accordance with their physician's orders.	

#	Provision	Assessment of Status	Compliance
		A review of 15 individuals' MARs for May 2010 through July 2010 contained inadequate documentation of PRN/as needed medication administration with potentially negative consequences to the individuals receiving, and in one case not receiving, prescribed PRN treatment. • There were several examples of PRN medications being administered without a clear notation of the individual's complaint or condition that led to administration. Examples of medications given on specific dates without documentation of the reason for administration included: o Individual #145: Acetaminophen 325 mg prescribed for pain or elevated temperature, given 7/29/10 and 7/30/10; Bisacodyl rectal suppositories prescribed for 3rd day without a bowel movement, given 7/13/10 and 7/17/10. o Individual #308: Albuterol prescribed for wheezing, given 7/12/10. o Individual #227: Bisacodyl suppositories prescribed for 3rd day without a bowel movement, given 6/19/10; Acetaminophen prescribed for discomfort/pain, given 6/05, 6/09, 6/17, 6/25 and 6/28/10. o Individual #288: Acetaminophen prescribed for discomfort/pain, given 5/2/10. o Individual #306: PRN administration of Duoderm to her left cheek, given 7/01, 7/05, 7/06, 7/11, 7/20 and 7/25/10 without documentation of assessment of the condition of the site. • Administration of PRN/as needed medications frequently did not provide a clear notation of the individual's response to treatment, including the date and time of follow-up assessment for effectiveness. No response or follow-up assessment for effectiveness was documented for: o Individual #145: Acetaminophen 325 mg prescribed for pain/temp, administered on 7/29/10 and 7/30/10; and Bisacodyl rectal suppositories prescribed for 3rd day without a bowel movement, given 7/13/10 and 7/17/10. o Individual #308: Albuterol prescribed for wheezing, given 7/12/10 o Individual #288: Acetaminophen prescribed for discomfort/pain, given 5/2/10. o Individual #227: Bisacodyl suppositories prescribed for 3rd day without a bowel movement, given 6/16, 6/19 and 6/26/10; Acetaminophen prescribed for discomfort/pain associated post right trans cervical femoral neck fracture with hemiarthroplasty, given 6/05, 6/07, 6/08, 6/09, 6/10, 6/17, 6/25, 6/28 and 6/29/10. o Individual #49: Acetaminophen prescribed for discomfort/pain, given	

#	Provision	Assessment of Status	Compliance
		7/3/10, specifically for headache on 6/27/10 and for ear pain on 7/20 and 7/22/10. o Individual #174: Acetaminophen prescribed for discomfort/pain, given 8/19/10 8:50 am (during 670 medication pass observation). o Individual #200: Albuterol prescribed twice daily and PRN for wheezing was administered three times on 6/16/10 without any documentation of the need for a PRN administration (i.e., for wheezing). o Individual #197: Acetaminophen prescribed for discomfort/pain, given 6/3/10, 6/11/10, 6/29/10 and 7/13/10. o Roosevelt Toney: Acetaminophen prescribed for discomfort/pain, given 5/11, 5/15 and 5/19/10. o Individual #306: Bisacodyl suppository prescribed for no bowel movement in three days, given 6/19/10. • Individual #92 had physician's orders to increase Golytely by 50cc if no bowel movement in three days. He also had orders for a Bisacodyl suppository if no bowel movement in three days. Clarification of the orders or the integration of these medications into a consistently implemented individualized bowel management plan was not evident. • Individual #92 was prescribed ibuprofen every six hours for chronic back/leg pain. On 6/24/10, the physician changed the order to PRN use of Ibuprofen for the back/leg pain. The ibuprofen continued to be given every six hours through 7/9/10. On 7/9/10, the nurse called the prescribing physician to clarify the order and a new order was given to return to routine every six hour administration. • Individual #288: After her hospitalization for obstipation/bowel obstruction from 4/27/10-5/1/10, she had orders for PRN Bisacodyl suppository after no bowel movement in 24 hours. She had an episode of no bowel movement for 24 hours on 5/25/10. There was a nurses' note that she was positive for impaction. There was no documented administration of the Bisacodyl or follow-up. The next nurses' note was on 5/28/10 and indicated again she had not had a bowel movement in 24 hours. Bisacodyl suppository was administered, but there was no documented follow-up assessment for effectiveness. • Individual #49 with diagnoses of hypertension and end stage renal disease among others had PRN medication orders for Clonidine 0.1 mg oral every four hours PRN for blood pressure over 170/70. His vital sign records documented eight episodes of blood pressures over 170/70 in July 2010 without implementation of the physician's order for Clonidine or reporting these abnormal measures. Episodes in July 2010 included 7/03-8:00 am 176/95, 7/10-7:00 am 184/96, 7/19- 7:00 am 187/92, 7/21- 8:00 am 178/93, 7/23-	

#	Provision	Assessment of Status	Compliance
		7:00 pm 190/92, 7/24-8:00 am 190/90, 7/27-8:00 am 185/96, and 7/29-7:00 pm 188/81. Medication administration monitoring and observation by the nursing department included implementation of the Medication Administration Competency Checklist. RNs periodically directly monitored medication administration. Checklists from January 2010 through July 2010 were presented for review. There was no summary or analysis of the data with documented follow-up as indicated. The forms did not consistently indicate if the nurse was tenured or a new hire per the form. There was no notation of the residence where the observation took place, although the schedule of medication observations included a list of the nurses' names and "home." No monitoring checklist that was completed included the observation of an entire medication pass. Usually two to four individuals were observed, but there were some that included observations of from five to 11 individuals. Although the checklist included an item for "medication room is clean," it did not include an item for the cleanliness of the medication cart. There were very few items checked as unmet. For example, of the 30 checklists completed in January 2010, two nurses had unmet items. They were related to not reading the label again before returning to the box, for "nurse identifies med up to point of administration, gives indication/side effects of medication" (unspecified which or both were unmet), no picture of the individual was available, and for out of date items in the medication room. Of the 30 checklists completed in July 2010, five nurses had unmet items, two related to lack of temperature monitoring in the medication room refrigerator, one for out of date items in the medication room, two for unclean or not defrosted refrigerator, three related to hand washing, one related to giving a medication early, one related to an unclean medication room, and one to opened food items not labeled with date. These results were in sharp contrast to the description above of the medication pass observed by the monitoring team. Medication error data were presented, including Medication Errors FY 2010 Rolling Trends, Medication Error Committee meeting minutes, and the Medication Error Synopses through June 2010. For June 2010, errors were related to (a) wrong drug and dosage administration of controlled substance schedule IV drugs clonazepam and lorazepam and (b) administering to the wrong person were identified as recurrent. The errors related to clonazepam and lorazepam were identified as being related to the similar spellings of the drugs. Scheduled drugs in the various dosages were maintained separately from medications specifically labeled for each individual. As was observed and described by nursing staff, separate baggies were used to store each drug at a	

#	Provision	Assessment of Status	Compliance
		specific dosage (e.g., a baggie of unit dose 1.0 mg clonazepam tablets). Nurses then located the baggie with the appropriate drug and dosage, removed the dosage prescribed for the individual in a unit dose pack, and the nurse signed for each dose administered indicating the individual to whom it was administered. The procedure previously implemented to prevent confusion related to these two medications specifically was to use color-coded baggies that were to be reused. The solution was to re-inservice nursing staff on use of the baggie system. There was no follow-up monitoring and observation or re-evaluation of the system for storing and administering scheduled drugs. There were 16 wrong drug and nine wrong dose errors for the rolling 12 month period ending June 2010 with five wrong dose and six wrong drug errors in the most recent quarter ending May 2010. Further evaluation was needed. The second area related to administration to the wrong person. The error in May 2010 was addressed with re-inservicing of the nurse involved. The March 2010 error was not described fully other than requiring vital sign monitoring of the individual. The action taken was to notify the nurse involved of the error and "the importance of following the medication administration policy and procedure was stressed." There were four wrong person errors for the rolling 12 month period ending June 2010 with two occurring in the most recent quarter ending May 2010. Further evaluation was needed.	

Recommendations:

1. The facility should continue its efforts to develop the processes necessary for the generating data that can be accurately interpreted, analyzed, and are reflective of the practices being measured (i.e., quality assurance processes as they related to this provision of the Settlement Agreement).

2. The facility should re-evaluate the current healthcare planning approach including the reliance on standard plans. The facility's system for health management plan development and implementation need to be revised to provide person-centered goals as well as individualized and specific interventions with a clear direction for data collection and analysis.

3. As required by Sections G and F of the Settlement Agreement, the Nursing Department should collaborate with other disciplines regarding care, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans.

4. The facility should develop and implement clinically sound competency-based training for nursing assessment, health management planning, and documenting implementation Once training is completed, the facility should provide on-going proficiency monitoring and job coaching to nursing staff as required to ensure levels of performance that are consistent with professional standards of care and state policy.

5. The facility should provide proficiency-based practice on the appropriate and consistent implementation of flow sheets for tracking specific health problems or issues to resolution. Completed models of flow sheets at each nurses' station with instructions for use should be readily

available to nursing staff. Note that this recommendation is directed at there being adequate and consistent implementation of the system recently initiated at SASSLC (i.e., the flow sheets), as well as to consider more organized and complete tracking sheets.

6. As is recommended with regard to Section I of the SA, standardized risk assessments with established reliability and validity should be used by all the facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.

7. The facility should revise and/or implement policies, procedures, and protocols with regard to medication administration in order to ensure consistent administration of PRN medications, including appropriate and complete notations of the reason for and response to the medication given. Audits of PRN medication administration should be included in daily RN MAR audits.

8. The facility should re-evaluate the medication administration process for inclusion of more person-centered approaches.

9. The facility should revise and/or implement policies, procedures, and protocols with regard to medication administration monitoring to ensure current medication administration policies and procedures are fully and consistently implemented. The nursing department should provide observation of complete medication passes during implementation of the Medication Administration Competency Checklists. The data should be aggregated and analyzed to facilitate corrective action.

10. The facility should re-evaluate of the system for storing and administering controlled substances.

11. The scoring key to the Braden Scale should be included on the nursing assessment form, the scoring key included next to the total score (i.e., 12 or less high risk, 13-15 moderate risk, $\geq$ 16 minimum risk).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix: Pharmacy and Therapeutics Guidelines o SASSLC Pharmacy and Therapeutic Committee Meeting Minutes, 7/14/10 o State Supported Living Centers Procedure: Medication Errors/Incidents, dated 11/09 o San Antonio State Hospital-(SASH) Pharmacy and Therapeutic Committee Meeting Minutes, 3/10/10, 4/14/10, 5/12/10, 6/9/10, 7/14/10 o Medication Error Committee Meeting Notes o SASH Pharmacy Policy and Procedure Manual o SASSLC Adverse Drug Reactions (eight examples) o Records for the individuals listed in Section L • Quarterly Drug Regimen Reviews • MOSES and Discus Scales Interviews and Meetings Held: o Sharon Tramonte, Pharm.D., Clinical Pharmacist o Ann L. Richards, Pharm.D D., Director of Pharmacy Services, San Antonio State Hospital o Carmen Mascarenhas, M.D., Medical Director o David Hazlett, M.D., Staff Physician o Albert Thomason, M.D., Staff Physician o Janet Adams, R.N., Chief Nursing Executive Observations Conducted: o Tour of San Antonio State Hospital pharmacy o Informal observations of medication administration
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The facility had implemented several processes to ensure safe medication use. Several of the processes were either newly, or incompletely, implemented. Other requirements of the provision had not been addressed. SASSLC was found to be in noncompliance with this provision. Medication orders for individuals supported by the facility were dispensed from the San Antonio State

	Hospital and delivered directly to the residences. Prospective reviews of medications were, therefore, completed at the state hospital. The facility did not maintain a policy and procedure manual. The monitoring team request for the policy and procedure manual was met by the facility providing a copy of the pharmacy manual of the San Antonio State Hospital. At the time of the onsite review, the sole employee of the SASSLC pharmacy department was the clinical pharmacist who reported that a second clinical pharmacist was scheduled to start 9/1/10. The clinical pharmacist reported to the chief nurse executive and was responsible for administration of the medication error system. The clinical pharmacist also appeared to be involved in duties that normally do not fall under the purview of the pharmacy department, such as responsibility for programming all of the facilities defibrillators. Systems were in place for tracking medication errors, but not all errors were being recorded. Adverse drug reactions were reported over the past six months through the use of the WORx software. The ADRs reported were detected during the process of completing the drug regimen reviews. The facility had not developed a comprehensive ADR reporting and monitoring system. The facility had not completed any drug use evaluations. The function of the facility's Pharmacy and Therapeutics Committee (P&T) was integrated into the P&T Committee of the San Antonio State Hospital. A review of the last five committee meeting minutes indicated that participation by facility staff was cursory and information was frequently reported as not available. The facility recently formed a Pharmacy and Therapeutics Committee that met for the first time in July 2010. The composition and function of this committee was not defined in policy and procedure.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing	There was no documentary evidence of a formal process for conducting a prospective review of an individual's medication regimen and, therefore, this provision item was rated as being in noncompliance. The state hospital pharmacy director described the process for dispensing medications from the pharmacy. This process, which included the prospective medication review, could not be verified based on documents provided. There was also no documentation in the record that verified this process. The dispensing process is described below: • Orders are faxed from the facility to the state hospital. • The orders are then entered into the WORx software. • The software checks for therapeutic duplication, drug interactions, allergies, and other issues upon entering a new medication, and alerts are generated for the pharmacist when problems arise. • When issues or problems arise, the pharmacist contacts the MD for resolution • The pharmacist documents on the order sheet any corrections required.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 WORx software had the ability to record the pharmacist-MD interactions as a patient intervention report, but this capability was not routinely utilized. There was evidence that reviews of medication regimens occurred retrospectively. A Drug Regimen Review (DRR) was found in all of the records reviewed. They are discussed in detail below in provision N2.	
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.	Drug Regimen Reviews were completed on all of the records reviewed. The reports were completed consistently on a quarterly basis and provided detailed information. More work was needed in this area and, therefore, this provision item was rated as being in noncompliance. The Drug Regimen Reviews included a summary of findings and provided recommendations to the PCP and psychiatrist when appropriate. The summary of findings included information on: • Presence of polypharmacy • Delivery device, dose, frequency, and route of administration • Potential drug interactions • Monitoring and evaluation of drug effectiveness, side effects, toxicity and adverse effects • Appropriateness of pharmacotherapy and consistency with psychotropic prescribing guidelines Recommendations were given related to therapeutic duplication, ordering of lab studies, dosage schedules, and appropriateness of indications. There were some general and individual specific issues identified with the DRRs in the record sample. General issues are listed immediately below. • The DRR form contained a place for signatures of the clinical pharmacist, psychiatrist, and PCP. The form was not designed for the reviewing physicians to indicate agreement or disagreement with the recommendations. • The decision to implement the recommendations, or clinically justify a decision not to implement the recommendations, was not evident on the form. • There was no policy providing a timeframe for physicians to sign and return the document. Signatures were frequently not dated. • There did not appear to be any oversight of this process by the medical director. In monitoring of the AEDs, laboratory values were reported. Other important monitoring parameters were not included, such as the need for checking bone mineral density, monitoring for complications of metabolic acidosis, such as kidney stones, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		measurement of intraocular pressures. The following are examples of problems found with the DRRs for specific individuals: • Individual #245 had DRRs completed quarterly. The individual was on clozaril and had an order for monthly CBCs (these were done). The DRR completed on 2/25/10, had the most recent CBC dated as 9/3/09. The psychiatrist and PCP both signed the DRRs with no comments. The DRR completed on 5/27/10 was signed on 6/20/10 by the clinical pharmacist, and on 6/28/10 by the PCP. • Individual #218: The DRR completed 2/20/10 indicated that clonidine was used for aggression. The psychiatrist noted that clonidine was used for hypertension and not for aggression. There was no PCP signature on the document. The DRR completed on 3/17/10 continued to list clonidine for aggression. This document was signed by the PCP on 5/11/10, but the issue was not addressed. The DRR completed 6/23/10 was signed by the PCP who indicated the diagnosis was changed. • Individual #317: The DRR was completed on 4/30/10 and signed by the clinical pharmacist on 5/24/10. The PCPs signature was not dated. • Individual #218: The DRR completed 11/9/09 had the indication for calcium and vitamin D recorded as osteoporosis prevention. The clinical pharmacist recommended that the diagnosis be changed to osteoporosis. The PCP changed to osteomalacia prevention. The individual had a diagnosis of osteoporosis by DEXA. • Individual #336: All DRRs completed noted hyponatremia most likely secondary to the use of carbamazepine and anemia most likely exacerbated by the chronic use of anticonvulsants. Both of these issues could have been reported as suspected adverse drug reactions.	
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	The facility reported that no stat medications or chemical restraints were used. There was no process in place to meet this provision. The quarterly drug regimen reviews provided some information on polypharmacy, benzodiazepine use, and anticholinergic load. That process did not reflect any collaboration between practitioners and pharmacists, nor did it provide adequate clinical justification for the use of benzodiazepines and polypharmacy. This provision is rated as being in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Recommendations were made by the clinical pharmacist through the drug regimen reviews. The form required a signature only. There was no manner to easily identify if the practitioner agreed or disagreed with the recommendations. If the practitioner agreed with the recommendations, it was difficult to determine if the recommendations were implemented. There was no oversight of this process by the medical director. This provision item is rated as being in noncompliance.	Noncompliance
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.	The MOSES and DISCUS rating scales were completed in the records reviewed. There was little evidence that these tools were utilized in clinical decision-making. This provision item is, therefore, rated as being in noncompliance. In some instances, the tools provided valuable information to practitioners. There was little evidence, however, that the results of the rating scales were utilized in the therapeutic decision making of the various disciplines such as medical, psychiatry, and neurology. The following are three examples of abnormal findings documented on the MOSES instrument, both increased and decreased weights were scored as 0 where indicated: • Individual #24 6/21/10: wt. 173 lbs., weight scored as 0 (no change) 3/10/10: wt 160 lbs., weight scored as 0 (no change) 12/4/10: wt 150 lbs., weight scored as 0 (no change) 9/7/09: wt 139 lbs., weight scored as 0 (no change) IBWR 124-155	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #336 6/25/10: wt. 148.9 lbs., weight scored as 0 (no change) 3/8/10: wt 142 lbs., weight scored as 0 (no change) 12/3/10: wt 139 lbs., weight scored as 0 (no change) 9/15/09: wt 136 lbs., weight scored as 0 (no change) IBWR 106-132 • Individual #284 7/9/10: wt. 119 lbs., weight scored as 0 (no change) 4/2/10: wt. 132 lbs., weight scored as 0 (no change) 1/28/10:wt. 136.5 lbs., weight scored as 0 (no change) 10/6/09: wt. 139 lbs., weight decreased scored as 1 (minimal) IBWR 109-136 The rater failed to properly score the changes in weight. The psychiatrist signed all of the documents cited above. No side effects and no action necessary were checked.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility reported eight adverse drug reactions, which occurred from March 2010 through August 2010. These reports were not timely since they were detected as part of the drug regimen reviews and not at the time of event occurrence. The ADRs were discussed in the July 2010 P&T Committee meeting. The San Antonio State Hospital Pharmacy and Therapeutics Committee meeting minutes did not document any discussion of adverse drug reactions (ADRs) reported by the facility. Although reports were generated, an ADR reporting and monitoring system did not exist, resulting in a rating of noncompliance for this provision. The clinical pharmacist indicated that the ADRs were generated from the drug regimen reviews and copies of eight reports generated by the WORx software were provided. The reports were labeled as Single Patient Intervention Report and Single ADE Report. The content of the two reports varied, did not contain essential ADR data and for each event the forms were incomplete. The P&T Committee notes (7/14/10) documented six ADRs. Each ADR was addressed at the person-specific level. The ADR process at SASSLC lacked several key components recommended by professional organizations, such as the American Society of Hospital Pharmacists. Key requirements include: • A program that is ongoing and concurrent with reporting of suspected ADRs by pharmacists, physicians, nurses and patients	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Identification and monitoring of drugs likely to cause ADRs • Use of a probability scale to categorize each ADR • Investigation of suspected ADRs to determine the probability that the drug caused the symptoms. • Severity established by a ranking system • Review of all ADRs by a designated committee, such as the P&T • Dissemination of information to health care professionals for educational purposes • Data collection, analysis and trending both aggregate and individual data with results being incorporated into the agency's quality improvement program	
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.	No drug utilizations evaluations were reported and the facility had not implemented a procedure to comply with this provision. The provision is therefore rated as being in noncompliance.	Noncompliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility had a process in place for reporting errors, collecting and analyzing data, and implementing corrective actions. The system was designed to be non-punitive and to encourage self-reporting. There were several areas of weakness associated with the system and, therefore, this provision was rated as being in noncompliance. The Medication Error Review Committee met monthly for the past year to review medication errors. Participants included the chief nursing executive, clinical pharmacist, medical director, staff physician, QE nurse, and other members of nursing management. Medication error data were collected by the clinical pharmacist and reported at the MERC meeting. The clinical pharmacist was responsible for data collection and reporting and chaired the MERC. The chief nursing executive, assistant director of the nursing department, and clinical pharmacist all agreed that omissions were the greatest problem. Discussions with the medical director, chief nurse executive, and clinical pharmacist all	Noncompliance

#	Provision	Assessment of Status	Compliance
		indicated a low level of error reporting for physician errors. Potential errors did not appear to be reported. It was also reported by the state hospital pharmacy director and the clinical pharmacist that medications were sometimes found in the bins upon return to the state hospital pharmacy. These occurrences were reported when it seemed "unusual." These data were not tracked on a routine basis. The true extent of this problem was unknown. This was particularly problematic because it was documented in MERC meeting notes that blanks were found on the MARs, as this also has the potential to be indicative of a medication omission. As documented in the MERC meeting notes, there were several errors reported that involved the wrong patient, the wrong drug, and the wrong dose. Giving lorazepam (LZP) for clonazepam (CZP) was an error that was repeated monthly. Corrective actions were implemented by placing the drugs in baggies with visual cues. Subsequent MERC minutes documented that the process was not maintained and, therefore, this particular error continued. The following errors involved look-alike, sound-alike drugs, and/or the wrong individuals: • 8/09 Gave CZP instead of LZP • 9/09 LZP 2mg instead of LZP 3.4mg • 11/09 CZP given for LZP • 2/10 CZP 1mg for LZP 1mg • 3/10 LZP for CZP • 3/10 LZP for alprazolam • 3/10 Two doses of CZP .25mg given • 3/10 CZP 2mg given instead of .5 mg • 3/10 CZP 1mg given instead of .5mg • 6/10 CZP .5mg given instead of LZP .5mg • 6/10 LZP given instead of CZP • 6/10 LZP given instead of CZP • 9/09 Individual grabbed another individual's meds • 11/09 One individual was given another individual's meds • 1/10 Wrong individual • 3/10 Medication given to incorrect individual • 5/10 Wrong individual January 2010 MARs were found mixed up with December2009 MARs, and some doses were omitted. MERC meeting notes documented on a monthly basis that the root causes of each error were discussed. The actual root causes were never mentioned within the documented	

#	Provision	Assessment of Status	Compliance
		MERC notes. The facility's July 2010 P&T meeting did include discussion of medication errors, but no root causes were discussed. The meeting notes documented some issues that warranted further explanation or action but no documentation was found: • The June 2010 MERC notes documented that, "The issue of blanks on the MARs was discussed. A plan was discussed for implementation by the nursing management." Previous and subsequent notes did not provide information on this issue. This was a significant issue related to medication administration and documentation that required further explanation. • The January 2010 notes discussed systemic issues, including "One source of medication errors is in the copying/transcription/writing of medication orders. Properly written medication orders should facilitate the reduction of medication errors." This statement was likely made in response to the prescribing and transcribing errors reported in prior months, yet no definite plan for corrective action and responsible persons were identified. The facility medical director, chief nurse executive, and infection control nurse were designated to participate in the San Antonio State Hospital P&T Committee meetings. Minutes reviewed indicated that the SASSLC medication error report was included on the agenda of every meeting, however, all but one of the meeting minutes documented that information was not available. The meeting minutes dated 6/9/10 contained a report of the second quarter total error numbers. There was no additional documentation of discussion. Medication errors were discussed at the first facility P&T meeting. The P&T Committee is the appropriate forum for discussing medication variances with professionals not included in the MERC discussions. The committee also bears the responsibility of forwarding data to the facility's director and quality improvement department. Errors related to look-alike, sound-alike drugs, and other errors of omission are very often the result of faulty processes. Errors that fail to correct with interventions warrant intense evaluation, such as that seen in performance improvement methodology. This methodology requires understanding the problem, mapping out the processes, identifying potential causes, data collection and analysis, identifying root causes, and selecting a solution for implementation. Observations of the medication packaging, as well as observations in the homes during medication administration, demonstrated a cumbersome system that was prone to error.	

#	Provision	Assessment of Status	Compliance
		While there may be quick fixes of process gaps, it is likely that major changes are needed in the current system to improve efficiency and resolve faulty processes.	

Recommendations:

1. The facility needs to implement systems to adequately document the requirement of a prospective review. Further investigation should be made into utilizing the current WORx software to accomplish this goal.

2. An ADR reporting and monitoring system should be developed.
    a. This is a comprehensive program that requires reporting by all healthcare practitioners, not just pharmacy staff.
    b. A data collection tool is needed to assist staff in detecting and reporting suspected ADRs. The tool should include a probability scale, a severity scale, and individual outcome thresholds.
    c. The outcome thresholds should be used to conduct intense case analysis.
    d. All data should be reviewed by the P&T Committee and submitted to the facility's quality department.

3. Additional work is needed in the area of medication errors.
    a. All errors, potential and actual, must be reported.
    b. All medications that are returned to the state hospital pharmacy must be reconciled.
    c. If no explanation is found for the returned medication, it should be considered an omission.
    d. Data should be analyzed for trends and corrective actions taken.
    e. Data should be provided to the facility's quality department for analysis.
    f. Performance improvement projects should be charted for problems that are not amenable to appropriate corrective actions.
    g. The medical director should assume an active role in this process.

4. The Drug Use Evaluation system must be developed to fulfill the requirements of the Health Care Guidelines. Oversight for the system should be provided by the P&T Committee.

5. Physicians should review the Drug Regimen Reviews more thoughtfully. The form should be revised so that practitioners can indicate agreement or disagreement with recommendations. Guidelines should be established for review and returning the document. The medical director should provide oversight for the process.

6. The results of the side effect rating tools should be incorporated into the evaluation and treatment decisions for medical, psychiatry, and neurology practices.

7. Meeting minutes for the Medication Error Review Committee and for the P&T Committee should provide adequate details of the relevant topics. The actions steps required, responsible persons, and target dates should be recorded when corrective actions are needed.

8. Staff responsible for quality improvement and performance improvement initiatives should be provided appropriate training on data integrity, data analysis, and performance improvement methodology.

9. The current structure of the pharmacy department should be re-evaluated. The supervision of the SASSLC pharmacy and its staff is more appropriately aligned under medical services.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Nutritional Management Committee Screening tools o Health Status Team Screening tools o PNMP clinic notes o PNMP monitoring sheets o PNMP Monitoring Schedules o Meal Observation Sheets o Nutritional Management Committee meeting sign-in sheets o Individuals with PNM Needs list o Health Status Team Health Risk Ratings o HST-HAB Info spreadsheet o Pneumonia Diagnosis list o Fractures Injuries Requiring Sutures/Dermabond 1/1/10-6/30/10 o Individuals Experiencing Falls-Past 12 Months 7/1/09-6/30/10 o Individuals with BMI <20 o Enteral Feeding Information spreadsheet o ER Visits list o Hospitalizations 1/1/10-6/30/10 o PST Summary Interim Meeting (4/5/10) for Individual #304 o Wheelchairs/Ambulation lists o New Employee and Lifting Refresher Sessions o Dining Plan Training checklists o Transfer Training Checklists o PNM Training curriculum o PNMPs submitted o Dining Plans submitted o Individuals on Modified Diets/Thickened Liquids o Texture Changes in last 12 months o Wheelchair Shop Maintenance Log o Personal Record documents (PSP and all addendums, PSP Quarterly Reviews, Annual Medical Summary, Annual Medical Evaluation, Health Risk Assessment Rating Tool, X-ray section, GI consults, orthopedic consults, nursing assessments, Habilitation Therapy section including OT, PT, SLP assessments, consults, other, nutrition assessments) for the following individuals: • Individual #123, Individual #74, Individual #66, Individual #197, Individual #126, Individual #198, 146, Individual #4, Individual #211, Individual #341, Individual #308, Individual #312, Individual #254, Individual #135, Individual #288, Individual #302,

Individual #324, Individual #65, Individual #236, Individual #1.

- Also requested for these individuals, but information was not submitted by the facility to the monitoring team: Individual #301, Individual #213, and Individual #20.

Interviews and Meetings Held:

- Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director
- Retha Skinner, MOT, OTR
- Kelly Patrick, OTR
- Patricia Hajny, OTR
- Allison Block-Trammell, MA, CCC-SLP
- Various PNMP Coordinators
- Discussion with various supervisors and direct support staff
- Meeting with Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director, Janet Adams, Director of Nursing, Allison Block-Trammel, MS, CCC-SLP, Dr. Carmen Mascarenhas, MD
-

Observations Conducted:

- Mealtimes
- Living Areas
- PNMP clinic

Facility Self-Assessment:

Please see the Executive Summary section of this report.

Summary of Monitor's Assessment:

SASSLC continued to implement a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. This team (NMC), however, still did not include critical team members, such as the physician, physician assistant, nurse practitioner, or PT. The only registered dietitian and the dietary technician attended the meetings as well. These meetings were well attended by the SLP acting as chairperson and one OT, as well as two to three registered nurses. The Habilitation Therapies team members had attended PNM-related continuing education, but no evidence of further clinical instruction for other team members was submitted. While there was not a meeting scheduled for the week of this onsite review, a group of clinicians and the Medical Director met to discuss the recently developed policy (draft) for a new Physical Nutritional Management Team process that was to be implemented in the upcoming months. Concerns for the continued lack of a strong health risk assessment and the continued lack of integration between the NMC and the HST systems were also discussed.

Mealtime observations in a number of homes demonstrated that great effort and attention had been directed toward improvement staff training, monitoring, and support for home managers and direct support staff. Fewer errors in implementation were noted, though issues related to liquid consistencies continued to pose challenges for staff. Use of a new product to thicken liquids was expected to be

	implemented after the onsite visit and it was expected that this would help to resolve this. Positioning continued to be inconsistently implemented by staff with limited attention to detail for alignment and support of those in wheelchairs. In a number of cases, pictures with the PNMP to assist staff with this were missing from the individual books. The PNMP coordinators had been trained and, though there had been some turnover in these staff, they had stood out as leaders during mealtimes. Direct support staff and home managers looked to them for information and validation. They will require continued oversight and coaching by clinical staff to ensure their continued competence in these new roles. Strategies that were used to heighten awareness of mealtime issues should also be applied to address positioning of individuals to promote improved precision and performance.

#	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	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** The Nutritional Management Committee (NMC) members included an SLP (Margaret Delgado-Gaitan), an OT (Patricia Hajny), nurses (two to three attended each meeting), dietitian (Leona Bludau), and diet technician (Geraldine Grant). There were no PT members or ancillary members such as physicians. The meeting minutes were forwarded to the physicians routinely. Based on a review of NMC meeting documentation from 1/27/10 to 6/24/10, each of these members attended each of the monthly meetings held. There were always two to three nurses who attended. There was no evidence that there were any other attendees or participants at any meeting. Meeting minutes were consistently maintained by the Committee Chairperson, Margaret Delgado-Gaitan, MA, CCC-SLP who was also the Habilitation Therapies Director. Meetings were held on 1/27/10, 2/24/10, 3/25/10, 4/28/10, 5/26/10, and 6/24/10. The format of the minutes was consistent across each meeting and listed those individuals with upcoming PSPs due for their PNMP reviews, those requiring follow-up from a previous meeting or based on assigned risk level, and individuals with aspiration pneumonia, texture referrals, modified barium swallow study (MBS), choking incidents or significant weight issues. The number of individuals reviewed related to one of these issues averaged 39, ranging from 25 to 49 at any one meeting. The meetings were held for two hours and 45 minutes or three hours regardless of the number of individuals reviewed. Approximately 236 individuals were reviewed by the NMC during this six month period. Discussion of individuals related to each of these categories was as follows:	Noncompliance

#	Provision	Assessment of Status	Compliance
	physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• PSP review: 18% • Follow-up from previous meeting: 27% • Aspiration pneumonia: 6% • Review based on Risk Screens: >1% • Texture referrals: 24% • MBS: 5% • Choking: >1% • Weight: 20% It was not possible to verify the qualifications of members based on the documentation submitted. Licenses for nurses or the dietitian were not submitted, though licenses for the OT and SLP were current. No CVs were submitted for committee members, so it was not possible to verify experience or continuing education of team members other than the OT and SLP members. It was documented that there had been no changes in staffing, so CVs were not submitted, however, the CVs for nurses and the dietitian were not submitted for the previous review either. Ms. Gaitan had attended the following PNM-related continuing education courses during 2010 for a total of approximately 10 hours : • Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management • Issues in Nutritional Management • DASI- Dysphagia Management System Ms. Hajny had attended the following PNM-related continuing education courses during 2010 for a total of approximately 15 hours: • Motor Activities Training Program for Students with severe Disabilities • PNMP and Wheelchair Clinic Teleconferences (5) • Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management • DASI- Dysphagia Management System While this was excellent for these two NMC members, there was no evidence that other members had similar opportunities. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to	

#	Provision	Assessment of Status	Compliance
		address follow-up activities, and at any phase in the Nutritional Management process. Based on a review of NMC meeting documentation, it was noted that this group had met one time monthly for the last six months. There was no evidence that the team convened for any additional meetings to address other issues that came up in the interim.	
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.	**Standard: A process is in place that identifies individuals with PNM concerns.** The process used to establish health risks was inconsistent across the HST and NMC. Different screening tools were used and there was little to no integration across these two systems. By report, the NMC had begun to utilize the HST ratings, but there was no evidence of this practice contained in the minutes submitted. This system, as used statewide, was ineffective and did little to heighten the awareness of potential harm to those individuals with complex and serious health risk concerns or to enhance the intensity and frequency of intervention, review, and monitoring. There was reference early in the week of this onsite review that there was a plan to integrate these two systems together and that a new draft policy had been provided to the SSLCs for implementation by September 1st. A meeting of several monitoring team members with the Medical Director, Carmen Mascarenhas, MD; Nursing Director; HST Coordinator; and Habilitation Therapies Director, Margaret Delgado-Gaitan was held to discuss this. The draft policy, however, did not appear to address this issue but rather was intended to change the focus of the NMC and changed the name to PNMT to be consistent with terminology in the Settlement Agreement. The monitoring team did not review this policy. Instead Ms. Delgado-Gaitan briefly summarized some of the proposed content and indicated that an assessment format had also been developed. The discussion focused on the need to establish a strong system to identify health risk indicators statewide. Further review of this area will be needed as this system evolves. **Standard: Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.** Individuals who received direct and indirect PNM and OT/PT supports received annual OT/PT assessments in addition to medical, nursing, and nutritional assessments provided annually to each individual. Assessment was not specifically driven by level of health risks. These were discipline-specific assessments with the exception of the OT/PT assessments, and little collaboration at the time of assessment was noted among professional staff for any individual, and certainly not for those at highest risk.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Prior to the NMC meeting there was to be a thorough record review to gather data necessary to guide the discussion during these meeting for individuals scheduled for review based on the categories described above. At this time, these appeared to be completed predominately by Habilitation Therapies staff for all health related issues.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 248 individuals who were listed with PNM needs but approximately 278 PNMPs were submitted from Homes 665, 668, 688, 670, 671, 672,673, 674, and 766 . These corresponded to the homes listed in the document Individuals with PNM Needs, dated 7/14/10 (with the exception of home 688) and it was presumed these were an error. It appeared that individuals who required PNM supports had not been included on the list submitted. The PNMP contained information related to the focus, assistive equipment, communication, mobility, transfers, and positioning as well as the dining position, diet texture and liquid consistency, dining instructions, and precautions. Criteria used to develop a comprehensive individual record sample of 23 individuals at risk included: • Emergency Room visits • Hospitalizations • PNMP Committee meeting documentation • Individuals with active pressure ulcer within the last 6 months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last six months • Individuals with unexplained weight loss or BMI ≤ 20 • Individuals ≥ BMI of 30 • Individuals who experienced a choking incident which required abdominal thrust within the last six months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or ambulation • Individuals with chronic respiratory infections • Individuals with chronic dehydration • Individuals with a diagnosis of osteoporosis and/or osteopenia • Individuals who experienced a fracture • Reviewer observations of mealtime, positioning, transfers, medication	Noncompliance

#	Provision	Assessment of Status	Compliance
		administration, tooth brushing, personal care and functional communication • Individuals who had been recently admitted Two of these 23 individuals were not listed as having PNM needs, including Individual #66 and Individual #308. There was no PNMP submitted for Individual #66, but a PNMP for Individual #308 was noted. Other individuals listed with PNM needs did not have a PNMP, including Individual #302 and Individual #254. Other personal record information requested was submitted for each of the 23 individuals included in the sample with the exception of Individual #301, Individual #213, and Individual #20. There was no explanation why these were not submitted. • In 20 of 20 of PNMPs reviewed (100%), mobility was addressed. In 12 of the 20 PNMPs reviewed (60%), positioning instructions for wheelchair and/or alternate positions instructions were included. Five of the 20 PNMPs reviewed (25%) identified that the individual was independent with ambulation and transfers. Another three individuals required some limited assistance by staff. • In 20 of 20 PNMPs reviewed (100%), the type of transfer and, in some cases, transfer instructions were included. • In 20 of 20 PNMPs reviewed (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks. Five of the 20 individuals (25%) received all of their nutrition via gastrostomy tube and nothing by mouth, so oral intake instructions were not indicated. • In four of 20 PNMPs reviewed (20%), the mealtime/dining plan included liquid consistencies. Five of the 20 individuals (25%) received all their nutrition via gastrostomy tube and nothing by mouth, so food texture was not indicated. While others without a liquid consistency specification likely received regular thin liquids, it was not clear if this was intended or was an omission. Each of the plans made reference to food texture even when there was no modification ("solid"), so it was not clear why this information was not provided related to liquids as well. • In 0 of 20 PNMPs reviewed (0%), strategies for medication administration were included. • In 0 of 20 PNMPs reviewed (0%), strategies for oral hygiene were included. • In 19 of 20 PNMPs reviewed (100%), individual assistive equipment was included. One individual was listed with dining equipment only. • In 20 of 20 PNMPs reviewed (100%), individual dining equipment was addressed in the plan. Four individuals were listed with regular dinnerware. One of these individuals required a regular dining chair, though with armrests, to reduce risk of falls secondary to seizures or he was able to use a wheelchair. • In 20 of 20 PNMPs reviewed (100%), individual dining positioning was addressed in the plan.	

#	Provision	Assessment of Status	Compliance
		• In 7 of 20 records reviewed (35%), bathing/showering positioning and, in some cases, additional instructions were included. No bathing equipment or instructions were provided for five others, but they were independently mobile for ambulation in familiar settings, transferred independently, and did not require any bathing equipment. For six others (Individual #146, Individual #324, Individual #65, Individual #135, Individual #126, and Individual #288), bathing/showering equipment was listed, but no specific instructions were offered. In two other cases (Individual #211 and Individual #301), no bathing/showering equipment was listed, but they required some level of assistance from staff with regard to ambulation and/or transfers. • In 20 of 20 PNMPs reviewed (100%), a section related to communication was included, however, in most cases, this identified only how the individual communicated and no strategies for staff to use were outlined. Only seven plans (35%), provided any communication strategies that could be used by staff. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** PNMP information was typed into the PSP in the form of a General Discussion Record that addressed review of the PNMP "for accuracy/changes." Three of the PSPs made a brief reference to the PNMP and indicated that no changes were needed (Individual #254, Individual #236, and Individual #65). In seven other cases, there was slightly more evidence that the PST had reviewed the plan and, in some cases, changes were indicated (Individual #1, Individual #74, Individual #302, Individual #211, Individual #197, Individual #4, and Individual #308). In the remainder of the records reviewed, there was no evidence of review of the PNMP by the PST based on the PSP submitted (Individual #135, Individual #66, Individual #146, Individual #312, Individual #123, Individual #324, Individual #198 and Individual #126). The PNMP Clinic was held prior to the PSP and involved a review of the PNMP by Habilitation Therapy staff, but did not involve the entire PSP. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Health status was reviewed by the NMC in the month prior to the annual PSP meeting to address revisions, and PNMPs were reviewed during the PNMP Clinic. By report, further discussion and review were conducted during the PSP meeting with other team members though, as reported above, this was not consistently documented in the PSP. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.**	

#	Provision	Assessment of Status	Compliance
		In 10 of the 20 PSPs for the sample individuals reviewed, there was a section that was described as review of the PNMP. As described above, the review documentation was very limited.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** Based on observations of individuals during a meal across Homes 668, 670, 671, 673, 674, there had been a significant improvement in staff implementation of interventions and recommendations outlined in mealtime plan portion of the PNMP. Implementation of other aspects related to position, alignment, and transfers outside of mealtime were implemented with less precision and accuracy per the PNMPs and the generally accepted professional standard of care. There continued to be issues with regard to thickening liquids. By report, a different thickening product had been obtained that should make it easier for staff to thicken liquids with greater accuracy and consistency in the future. This new product was to be introduced after this onsite visit. While less in number, there continued to be some issues related to mealtime supports. Some examples are presented below. • Individual #311 was observed eating his dinner and was noted to be coughing. He was being served liquids that were pudding thick, though his dining plan prescribed honey-thick liquids. Individual #311 was never given the opportunity to drink from a cup, but rather was spoon-fed liquids only. When asked, the direct care staff assisting him argued that he was correct. The monitoring tem contacted a supervisor in the home to check on the consistency being offered and she identified that they were "too thick" and instructed the staff to correct them. This direct care staff person indicated that he had been employed at SASSLC for seven years and in Home 671 for one year. He also indicated that he was "familiar" with Individual #311 and had worked with him regularly. It was further noted that he was "coaching" a new staff person on the home with another individual. Later in the meal, Individual #311 continued to cough. The assistant did not consistently alternate bites of food with sips of fluid. The individual vomited approximately a quarter of a cup of liquid. The meal was discontinued, the nurse was contacted, and she arrived for her assessment. • A direct support staff was responsible for reading the dining plan for Individual #185 prior to serving him to ensure that everything was correct. She read the entire plan, but never looked at the food or utensils to see if they were correct. She was prompted to do this by the monitoring team and found no errors. When asked about the fact that he had not been served milk, she indicated that he wanted a soda and could not have both. As she explained the diet card to the	Noncompliance

#	Provision	Assessment of Status	Compliance
		monitoring team, she incorrectly identified the "S" as snack rather than supper. Further, he was reported to be independent, but was being assisted to eat by staff. His sister was there visiting to try to encourage him to eat as he had been refusing meals and had lost weight, per her report. • Three individuals in Home 671 were seated at one table with only three open sides (the fourth side was against the wall) and each required direct support staff to sit with him to provide assistance. This created a very tight and crowded environment space for three staff and three individuals. Three larger tables were elevated to accommodate taller wheelchairs, but there were only one or two individuals seated at each of these tables. • Individual #234 was observed to be assisted to eat and drink by staff, though her dining plan (12/31/09) indicated that she should be encouraged to eat and drink independently. When the therapist was asked about this, she reported that this was "my error" and that the individual generally now refused to hold her spoon due to arthritis pain. She indicated that the dining plan and PNMP should be revised to reflect this but had not yet been done. • Individual #190 was served chopped spaghetti on her chopped diet, however, other foods (vegetables and salad) served appeared to be over-processed and were consistent with ground foods. She was eating rapidly and staff prompted her to slow down. She was also encouraged to take a drink, but her mouth was full of food at the time. • Individual #149 was observed to take large bites of her pureed food at a fast pace. Staff did not prompt her to slow down until she attempted to drink from a bowl, then they intervened. She was noted to cough to clear two times. • The "orientation mat" prescribed for Individual #324 was missing during her meal. • Individual #242 was assisted by her mother to eat. It was noted that her liquids were prescribed to be nectar thick, but she was being served pudding-thick liquids. She was also to be served with a plastisol-coated spoon, but her mother was using a regular metal teaspoon. The pureed meat being served to her was extremely runny. • The pureed meat being served to Individual #136 was extremely runny and was not corrected. • The liquids served to Individual #110 were thinner than honey as prescribed in her dining plan. • Individual #280 was noted to be coughing while drinking liquids. It was noted that his dining plan listed that he was to receive honey-thick liquids, yet they were thinner than prescribed. This was not noted by the direct support staff or PNMPC present at the meal. It was corrected when it was brought to their attention.	

#	Provision	Assessment of Status	Compliance
		• A direct support staff had opened a bottle of supplement beverage and loosely replaced it. Individual #280 removed the top and began to drink from the bottle before it was correctly thickened. Staff intervened. • Individual #301 was observed to be coughing. His dining plan instructed that he should be offered small bites and assisted at a slow pace. The staff assisting him was offering large bites and presenting another bite before he had swallowed the bite before. Staff were to moisten dry foods per the dining plan, but this was not done. • Staff were observed to use a cup of water to thin mashed potatoes that were too thick and sticky. Water tends to flatten the flavor of foods. Milk, broth, gravy or butter could be used to enhance flavor when the diet order permitted. • Individual #156 was taking huge bites of mashed potatoes. Staff intervened numerous times. The dining plan instructed that staff should offer verbal prompts only and, clearly, physical prompts were also required. Skills training to take smaller bites or to put his spoon down between bites could be also considered. • Individual #123 was noted to cough repeatedly while drinking fluids following his meal. Wheelchair positioning instructions were not specific. Limited instructions identified that individuals should remain upright, described the angle of recline, and the type of transfer to be used. General practice guidelines with regard to transfers, seatbelt use, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation. Inappropriate position, alignment and support inconsistent with the PNMP were noted for the following individuals: • Individual #70, Individual #345, Individual #228, Individual #24, Individual #343, Individual #145, Individual #124, Individual #293, Individual #247, Individual #165, and Individual #306, among others. Primary concerns were related to not positioning the pelvis back in the seat, posterior tilt of pelvis, and inadequate foot support. There was no precision with regard to position and alignment and staff did not appear to be as tuned into this as they had been for mealtime issues. Alternate positioning was not observed other than seating in a recliner. Medication administration and tooth brushing instructions were not included in the PNMP. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.**	

#	Provision	Assessment of Status	Compliance
		All dining plans were out on the tables during the meals. When asked, all staff were able to locate the PNMPs as requested. Staff were generally able to verbalize why they were required to implement specific strategies as described above.	
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.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** Review of the Facility's training curricula revealed that with the exception of transfer training, much of it was knowledge-based training with little to no skills-based training. With the exception of transfer training, there were no skill competencies established. By report, there was a statewide effort to address this in the early stages only. The clinicians had recently identified competencies for training the PNMPCs and validation of their skills was also initiated. **Standard: Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable.** Training was not competency-based at this time. **Standard: All foundational trainings are updated annually**. Only transfer training was updated after initial NEO training, but only on an every two year basis at this time. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Initial staff training was conducted by professional staff and PNMPCs. PNMPCs provided routine ongoing coaching and re-training based on observation and monitoring conducted in their assigned homes. In addition, home supervisors also were responsible for direct support staff training, but none of it was competency-based at this time. **Standard: PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.** Staff training was not currently competency-based, so, while staff may have received some	Noncompliance

#	Provision	Assessment of Status	Compliance
		level of training for implementation of PNMPs for those at high risk, it was not performance-based, requiring successful performance of clearly established competencies. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** See above.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no policy that related to the process of monitoring. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring was conducted to address mealtimes, as well as communication, transfers, and positioning in the homes. Bathing/showering and toileting equipment was reviewed for condition and cleanliness, there was evidence of routine monitoring of transfers, positioning, and support in these. There was no evidence that monitoring of position and aspiration risk was monitored during medication administration or tooth brushing. Mealtime monitoring conducted was noted on the mealtime observation forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. There were approximately 104 PNMP monitoring forms for approximately 57 individuals submitted. This was an increase in PNMP monitoring conducted since the baseline onsite visit in February 2010. Monitoring forms submitted included: January (1), April (2), May (6), June (27), July (57), and August (11). There were two individuals monitored eight times, one monitored five times, nine individuals monitored three times, two monitored nine times and 36 individuals monitored once during the period for which forms were submitted. The frequency of monitoring did not correspond with the level of risk. There were 303 Mealtime Observation Sheets submitted. This was a significant increase in mealtime monitoring conducted since the baseline onsite visit in February 2010. It was clear that the staff time commitment had paid off with the improvement noted in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		implementation of dining plans. These were general mealtime observation and did not target a specific individual and were completed by PNMPCs and therapy staff. There was no clear method to track the frequency of observation conducted for specific individuals who were considered to be at highest risk. There were 24 observations sheets submitted for August, two for April, three for May and the remaining observations were conducted in June 2010 and July 2010. **Standard: All members of the PNM team conduct monitoring.** Habilitation Therapies staff were responsible for conducting monitoring in addition to the PNMP Coordinators. In June 2010, a system was initiated whereby therapy clinicians reviewed individuals at highest risk monthly. Nurses, dietitians, and QMRPs conducted some level of review relative to assessment and progress notes, however, there was no other integrated and coordinated system of monitoring. The current system was not clearly based on specific risk levels. The NMC monitored individuals they reviewed during the monthly meetings. **Standard: Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.** The PNM committee did not utilize PNMP monitoring information in their reviews. Meal observation information was used occasionally. The NMC did not specifically review aggregated findings across homes for trend analysis to drive system change and training. Record review was conducted by Habilitation Therapies staff for use during NMC meetings. By report, there were instances when actions were deferred due to lack of information at the time of the meeting. There was no mechanism to track data for system analysis in order to focus training and coaching. There was no system in place to conduct trend analysis to consistently review if interventions had a positive outcome on an individual's health status. They also did not review incidence of health concerns such as aspiration pneumonia, use of bowel management aides, weight loss/gain, falls, fractures, and so forth over time to address system outcomes as a result of interventions and supports. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when a person was determined to be at risk of harm. Supervisors, PNMPCs, and habilitation therapy staff were observed to intervene in any instance that the PNMP, particularly the dining plans, were not properly	

#	Provision	Assessment of Status	Compliance
		implemented by direct support staff. Monitoring forms documented coaching and retraining of staff in some cases. The system of PNMPCs was still new and these staff were still learning their roles and responsibilities and continued to need coaching and oversight themselves to ensure they intervened and addressed issues that came up in a timely and appropriate manner.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** The NMC screening Tool was completed annually for all individuals, and the HST screening was completed every six months. The PST was to meet monthly on those deemed to be at highest risk. Some individuals were reviewed annually prior to their PSP to go over the PNMP and recommend changes to it prior to the annual meeting. Others were reviewed related to incidence of aspiration pneumonia, texture referrals, modified barium studies, choking, and weight related concerns. The NMC Screen Risk Rating was reported for each individual reviewed with the exception of those reviewed for texture referrals or weight issues. This screening tool was completed, but, generally, the risk factors checked and the risk level assigned did not seem consistent with the format outlined. For example, an individual who had lost more than five pounds in three months was considered to be High Risk per this form and was to be reviewed by the NMC at the next scheduled meeting. Individuals identified with weight loss were designated to be medium or low risk rather than high. There was no NMC Screening Tool for Individual #304 who had experienced a choking event when she choked on a Jolly Rancher candy at work. The screening tool indicated that any choking incident warranted a High Risk designation and a subsequent review at the next NMC meeting, yet no screening had been completed for her after this incident on 4/5/10. Following the incident, she was observed at her lunch meal that same day. Her diet was downgraded to soft for three days because she complained of pain in her throat, neck, and chest. No further follow-up by the NMC was documented in the meeting minutes. The HST screening system also reviewed a variety of health risk concerns. These two systems were not integrated and were inconsistent. While it was reported that the NMC had begun to use the HST risk ratings, there was no documentary evidence of this practice noted in the meeting minutes. No additional meetings were scheduled to address pressing or urgent concerns but rather they waited until the next monthly meeting of the Committee. None of these were related to a system of risk management that was facility-wide. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.**	Noncompliance

#	Provision	Assessment of Status	Compliance
		Unless an individual participated in direct therapy, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators. Recently an initiative for therapy clinicians to conduct monthly monitoring of those considered to be at highest risk. It was not clear how this was determined, however, because the system of risk identification was inconsistent facility-wide.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** A process to ensure that all individuals who received enteral nutrition would be reviewed annually by the NMC. While all individuals had not yet been reviewed, it was anticipated that this would be completed by the end of the year. The following individuals included in the sample for review received enteral nutrition and had received the following assessments by Habilitation Therapy professionals : • Individual #197: OT/PT Annual Update (9/24/09) • Individual #236: OT/PT/ST Annual Update (10/20/09) • Individual #126: OT/PT comprehensive Evaluation (7/14/10) • Individual #288: OT/PT Annual Update (5/4/10) • Individual #312: OT/PT/ST Annual Update (4/7/09) Each of these individuals had PNMPs as follows: • Individual #197: 7/1/10 • Individual #236: 5/27/10 • Individual #126: 7/9/10 • Individual #288: 5/25/10 • Individual #312: 6/11/10 Examples of content are presented below: • Individual #312 did not have an assessment current within the last 12 months. Two of the five assessments merely stated that the individual received enteral nutrition with no analysis of findings to address whether this continued to be appropriate. • In the case of Individual #126, health history was reviewed and NPO status was recommended, but there was no analysis to justify why this was indicated. • In the case of Individual #288, the assessment outlined specific findings that should be considered and recommended that the PST consult with the physician	Noncompliance

#	Provision	Assessment of Status	Compliance
		as to whether a follow-up MBSs may be indicated as a diagnostic for possible oral dining/pleasure dining, but did not weigh in on this issue themselves. • Per his Annual Update, Individual #236 had a PEG tube placement in 2006 due to weight loss. By report, he ate orally for all meals and received enteral nutrition only when he ate 50% or less. It was reported that he usually ate 100% of his meals and had gained weight since March 2009. The clinicians addressed his continued texture modification with a recommendation for pureed, and stated that an upgrade was not indicated due to decreased oral control. According to his PNMP dated 5/27/10, he received nothing by mouth (NPO) at that time. Integrated Progress Notes submitted from 2/13/10 through 7/13/10 were reviewed. A nursing note dated 5/17/10 indicated that his oral intake had been discontinued, but no rationale was documented. This was post discharge from the hospital after removal of a colon mass and colostomy in April 2010. There were no interim PST meeting minutes to reflect discussion of this change in status. The NMC had reviewed him on 2/24/10 and 3/25/10 to address a change in liquid consistency after a mealtime observation on 2/16/10. The same information was documented in each review. He was reviewed on 4/28/10 due to referral for increased emesis after meals. He was evaluated with no etiology identified, though he had a 14.5 pound weight loss and he received supplement via gastrostomy tube with resulting weight gain of 5.5 pounds since then. He was not reviewed again until 6/24/10 again with regard to weight loss, but no review was documented related to his significant change in health and intake status. There were no interim PSP meeting meetings or addendums submitted to reflect that the PST met to discuss his change in status. Individuals who received enteral nutrition were reported to be reviewed at least annually by the NMC to assess whether non-oral intake continued to be most appropriate for them. • Individual #312 was reviewed for a May PNMP/PSP on 4/28/10 and though this was not listed as an enteral review, the NMC recommended consideration of reinstating oral intake within the next three months with subsequent review again in July 2010. An MBS on 1/9/07 had recommended oral intake of pureed foods and nectar thick liquids. It was not known why that recommendation had not been implemented at that time. It was also not known whether this current recommendation by the NMC was implemented as minutes from the July NMC meeting were not submitted. • Individual #288 was listed as reviewed on 5/26/10 for a June PNMP/PSP. This was identified as an enteral review. Though she had an earlier history of choking, coughing and weight loss in 1988 and 1991, she had not had a episode of pneumonia since 1997. An MBS conducted in 1991 did not report aspiration. It was recommended that the PST discuss and document whether oral intake	

#	Provision	Assessment of Status	Compliance
		should be considered at this time. The nutrition assessment section of her PSP dated 6/17/10 outlined her current enteral feeding order and there was a statement that the PST agreed but there was no evidence of any discussion of this issue and no rationale was documented as to why consideration of oral intake should not be investigated. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake had been provided a PNMP and included the same elements described above. **The need for continued enteral nutrition is integrated into the PSP.** Based on a review of 20 PSPs in the individual record sample, there were five individuals who received enteral nutrition. These individual's PSPs did not document the rationale for the continued need for enteral nutrition. **Standard: When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used.** Though recommendations had been made for consideration of oral intake for Individual #312 and Individual #288, there was no evidence that this had been implemented or even discussed by the PSP. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** There were no facility policies that defined the frequency and depth of evaluations related to an individual receiving enteral nutrition. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking. In the case of Individual #236, he had eaten orally until sometime in 2010 he became NPO and his existing PEG tube was used exclusively for all nutritional intake, hydration, and	

#	Provision	Assessment of Status	Compliance
		medications. It could not be discerned from the documentation why this occurred, though he had returned from the hospital post-removal of colon mass and colostomy. There was evidence in the integrated progress notes that he had previously been observed by therapy staff at meals on 2/16/10, 3/1/10, 4/5/10, and 4/6/10. Per a nursing note on 5/17/10, it was reported that his oral intake had been discontinued, but there was no rationale as to why his status had changed. There was no evidence of further review or assessment of this issue since that time in the progress notes, PSP, or NMC meeting minutes.	

Recommendations:

1. There was limited participation of additional professional staff in the NMC process, including no participation by physicians. Participation should be improved.

2. All Committee members must bring information related to their professional expertise to each meeting in order to effectively review each individual included on the agenda each month. This information should then be discussed in detail to permit the appropriate design of interventions and supports as well as thoughtful recommendations for those reviewed. This will permit action-oriented steps, rather than the current volleying of suggestions back to the PST.

3. The statewide system of risk assignment must be established in order to more clearly identify the roles of committees and the PST in the review and management of individual risk indicators.

4. Apply a similar approach used to reduce the implementation errors around mealtimes to the implementation of other aspects of the PNMPs, particularly related to position and alignment.

5. Ensure that a system of mealtime monitoring is implemented for individuals and that it is based on level of risk rather than only the general dining room monitoring currently in place.

6. Incorporate findings from monitoring into the reviews to bring greater depth of information necessary for decision-making and problem solving.

7. Ensure that the NMC review process is not merely a paper trail, but rather a meaningful discussion and problem solving of health status as well as an examination of the supports and services provided to ensure that they effectively address the primary presenting issues. Follow-up and feedback must be a critical aspect of the review, and follow-up must continue until the problem is resolved or effectively stabilized. Risk levels should drive frequency of review, monitoring, and training efforts.

8. PNMP Coordinators continue to require specialized training, competency-based performance check offs, monitoring and review. Establish a system to routinely validate continued competency and understanding.

9. Establish a tracking system to permit analysis and review of monitoring data.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o PNMP clinic notes o PNMP monitoring sheets o PNMP Monitoring Schedules o Meal Observation Sheets o Individuals with PNM Needs list o Pneumonia Diagnosis list o Individuals Experiencing Falls-Past 12 Months 7/1/09-6/30/10 o Wheelchairs/Ambulation lists o New Employee and Lifting Refresher Sessions o Transfer Training Checklists o PNM Training curriculum o PNMPs submitted o Dining Plans submitted o HST-HAB Info spreadsheet o Fractures Injuries Requiring Sutures/Demabond 1/1/10-6/30/10 o Individuals Experiencing Falls-Past 12 Months 7/1/09-6/30/10 o Wheelchair Shop Maintenance Log o Adaptive Equipment spreadsheet o OT/PT Evaluation templates o List of Physical Therapy treatment o PT progress notes o Personal Record documents (PSP and all addendums, PSP Quarterly Reviews, Annual Medical Summary, Annual Medical Evaluation, Health Risk Assessment Rating Tool, X-ray section, GI consults, orthopedic consults, nursing assessments, Habilitation Therapy section including OT, PT, SLP assessments, consults, other, nutrition assessments) for the following individuals: • Individual #123, Individual #74, Individual #66, Individual #197, Individual #126, Individual #198, 146, Individual #4, Individual #211, Individual #341, Individual #308, Individual #312, Individual #254, Individual #135, Individual #288, Individual #302, Individual #324, Individual #65, Individual #236, Individual #1. • Also requested, but not submitted to the monitoring team: Individual #301, Individual #213, and Individual #20. o PSPs for the following individuals: • Individual #336, Individual #168, Individual #91, Individual #62, Individual #23, Individual #248, Individual #157, Individual #164, Individual #35, Individual #225,

	Individual #293, Individual #199, Individual #106l, Individual #189, Individual #268, Individual #331, Individual #323, and Individual #215 o Assessments and Screens for the following individuals: • Individual #66, Individual #50, Individual #211, Individual #123, Individual #4, Individual #74, Individual #254, Individual #35, Individual #308, Individual #168, Individual #213, Individual #157, Individual #302, Individual #164, Individual #324, Individual #65, Individual #341, Individual #31, Individual #198, Individual #135, Individual #62, Individual #151, Individual #248, Individual #197, Individual #112, Individual #225, Individual #242, Individual #23, and Individual #149 <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director o Retha Skinner, MOT, OTR o Kelly Patrick, OTR o Patricia Hajny, OTR o Raelynn Stowlowski, PT o PNMP Coordinators o Discussion with various home supervisors and direct support staff <u>Observations Conducted</u>: o Mealtimes o Living Areas o PNMP clinic
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: SASSLC continued to implement a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. This team (NMC), however, still did not include critical team members, such as the physician, physician assistant, nurse practitioner, or PT. The only registered dietitian and the dietary technician, however, attended the meetings. These meetings were attended by the SLP (acting as chairperson), one OT, and two to three registered nurses. The Habilitation Therapies team members had attended PNM-related continuing education, but no evidence of further clinical instruction for other team members was submitted. While there was not a meeting scheduled for the week of this onsite review, a group of clinicians and the Medical Director met to discuss the recently developed policy (draft) for a new Physical Nutritional Management Team process that was to be implemented in the upcoming months. Concerns for the continued lack of a strong health risk assessment and the continued lack of

	integration between the NMC and the HST systems were also discussed. Mealtime observations in a number of homes demonstrated that great effort and attention had been directed toward improvement staff training, monitoring, and support for home managers and direct support staff. Fewer errors in implementation were noted, though issues related to liquid consistencies continued to pose challenges for staff. Use of a new product to thicken liquids was expected to be implemented after the onsite visit and it was expected that this would help to resolve this. Positioning continued to be inconsistently implemented by staff with limited attention to detail for alignment and support of those in wheelchairs. In a number of cases, pictures with the PNMP to assist staff with this were missing from the individual books. The PNMP coordinators had been trained and, though there had been some turnover in these staff, they had stood out as leaders during mealtimes. Direct support staff and home managers looked to them for information and validation. They will require continued oversight and coaching by clinical staff to ensure their continued competence in these new roles. Strategies that were used to heighten awareness of mealtime issues should also be applied to address positioning of individuals to promote improved precision and performance.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** The census at SASSLC was approximately 282 at the time of this baseline review. The department director, Margaret Gaitan, MA, CCC-SLP was a speech-language pathologist. There were seven positions for PNMP monitors and all had been filled, though there had been turn over since the last review and only three of the original Coordinators were still in those positions. OT services were provided by three full-time occupational therapists: Kelly Patrick, OTR, Retha Morgan-Skinner, MOT, OTR and Patricia Hajny, OTR. This was unchanged since the previous review. Evidence of current licenses was submitted for each OT. Given the census of 282 at the time of this review, average caseloads for each OTR included approximately 94 individuals. This was essentially unchanged since the previous review. There was one OT position approved, but unfilled at the time of this review. There were no COTAs employed at SASSLC. There was one OT technician. PT services were provided by three physical therapists, working part-time. Edward Harris, PT, worked four days per week at the time of this onsite review. A prior plan to	Noncompliance

#	Provision	Assessment of Status	Compliance
		move him from contract to employee status was unsuccessful and he remained in contract status. He focused predominately on direct PT treatment. Additionally, one other PT worked part-time, a couple of mornings a week (Raelynn Stowlowski, PT). Ms. Stowlowski participated in the PNMP clinics, wheelchair assessments, and annual OT/PT assessments. No evidence of professional license or credentials was submitted for Ms. Stowlowski. The other part-time physical therapist was no longer contracting with the department. There were one to two full time positions vacant at the time of this review. Efforts to recruit additional clinicians have been unsuccessful due to the salary differences between that offered at SASSLC and what is offered to therapists in other settings locally. There were no PTAs employed at SASSLC, though there was one vacant position available. There was one PT technician. Fabrication of seating systems occurred onsite. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at SASSLC, fabricating custom components, and completing repairs and modifications. At the time of this review, there were two full-time fabricators, though one was out on medical leave. Certificates from continuing education were submitted for each of the three OTs, but none were submitted for either of the PTs. The courses attended since the previous review by OTs were related to wheelchair seating, evaluation and treatment of individuals with developmental disabilities, and included: • PNMP and Wheelchair Clinic Teleconference o Kelly Patrick, OTR (6.00 hours) o Retha Morgan-Skinner, MOT, OTR (6.50 hours) o Patricia Hajny, OTR (6.70 hours) • Motor Activities Training Program for Students with Severe Disabilities o Kelly Patrick, OTR (3.00 hours) o Patricia Hajny, OTR (3.00 hours) **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** There were at least 23 of the 33 records reviewed (70%) that described individuals with movement disorders, and limitations in self-care and/or functional skills. There were 16 individuals listed as receiving physical therapy treatment with a focus on interventions, such as gait stability training, endurance training, range of motion, and therapeutic exercise. There was no list submitted identifying that any individuals received direct OT services. By report and record review, each individual had received a screening and/or an OT/PT assessment, though a number of these submitted to the monitoring team were not current. OT/PT assessments were requested for a sample of individuals selected by	

#	Provision	Assessment of Status	Compliance
		the monitoring team (19) as well as five most current assessments for each therapist (14). Assessments and screenings submitted included the following: • Individual #213 Individual #213 (10/18/07) • Individual #211 (7/28/09, 7/22/10) • Individual #164 (5/4/10) • Individual #198 (5/17/10) • Individual #31 (2/18/03, 1/15/10) • Individual #308 (1/22/10) • Individual #302 (12/17/03, no date) • Individual #248 (5/12/10) • Individual #341 (8/25/09) • Individual #254 (10/24/95) • Individual #65 (3/29/95, 6/22/06, 6/9/10) • Individual #112 (9/4/90, 9/14/94, 9/10/96, 8/5/09) • Individual #288 (5/4/10) • Individual #168 (6/14/10) • Individual #135 (3/11/85, 3/26/85, 4/6/04, 4/12/05, 2/17/06, 2/4/10) • Individual #74 (10/2/95) • Individual #50 (6/16/10) • Individual #66 (12/23/08, 12/15/09) • Individual #324 (5/14/01, 12/6/05, 3/19/08, 4/8/08, 3/19/10) • Individual #4 (9/19/95) • Individual #35 (6/30/10) • Individual #312 (4/7/09) • Individual #157 (no date) • Individual #242 (5/12/10) • Individual #126 (7/14/10) • Individual #62 (6/23/10) • Individual #197 (8/13/92, 9/24/09) • Individual #151 (5/12/10) • Individual #23 (5/4/10) • Individual #225 (5/27/10) • Individual #236 (10/20/09) • Individual #149 (5/26/10) • Individual #123 (10/13/94) There were a variety of assessments/screenings submitted including: • Occupational/Physical Therapy Comprehensive Evaluation (four, dated 2003-2010)	

#	Provision	Assessment of Status	Compliance
		• Habilitation Therapies (OT/PT) Comprehensive Evaluation (six, dated 2010) • Habilitation Therapies (OT/PT) Annual Update (15, dated 2007-2010) • Habilitation Therapy (OT/PT) Update (1, dated 2010) • Occupational/Physical Therapy Comprehensive Evaluation (8, dated 1992-2003) • Occupational/Physical Therapy Update Evaluation (2, dated 2010) • Addendum to Occupational/Physical Therapy Comprehensive Evaluation (one, dated 2006) • Occupational Therapy Comprehensive Evaluation (two, dated 1985-1990) • Addendum to Occupational Therapy Evaluation (five , dated 2004-2008) • Physical Therapy Comprehensive Evaluation (one, dated 1994) • Physical Therapy Evaluation (one, dated 1985) • Physical Therapy Update Evaluation (one, dated 1996). The POI stated that there were "older" assessments titled as screens, but that the therapists completed assessments rather than screens. There were five Habilitation Therapy (OT/PT) Screens recently completed: Individual #168 (6/14/10), Individual #211 (7/28/09), Individual #308 (1/22/10), Individual #66 (12/23/08), and Individual #50 (6/16/10). Individual #168 and Individual #308 were new admissions and their screenings had been completed within 30 days of their admissions to SASSLC. It was not clear why Individual #50, Individual #211, and Individual #66 received screens. Individual #50 had no other OT/PT assessment while Individual #66 had received an Annual Update on 12/15/09, and Individual #211 had received an Update on 7/22/10. There were seven individuals who did not have a current assessment, some of which were 15 years old. While these individuals (Individual #123, Individual #4, Individual #74, and Individual #254) did not appear to have significant motor skill or self-care deficits, it would be anticipated that they would have had a more current assessment to ensure that no changes had occurred in that time. On the other hand, the other three did have functional motor skill concerns (Individual #312, Individual #213, and Individual #112), and an annual assessment would be anticipated. Annual Updates for Individual #157 and Individual #302 were undated, but appeared to have been completed for a PSP held in within the last 12 months. Though the monitoring team had requested all OT/PT-related spreadsheets, there was no data tracking completion of assessments submitted. Other than the actual assessments submitted, it was not possible to verify reports that all individuals had received an assessment. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.**	

#	Provision	Assessment of Status	Compliance
		The monitoring team requested the PSPs, PT assessments, PT-related SPOs, and progress notes for the last six months for 16 individuals who were listed as receiving direct physical therapy. The following individuals were listed as receiving PT. A PSP was submitted, but no assessment or progress notes were provided: Individual #323, Individual #331, and Individual #227. There was no current PT evaluation for the following individuals though, they also were listed as receiving direct PT services: Individual #336 (2/3/94), Individual #106 (11/17/86), and Individual #189 (5/7/96). Assessments were not consistently present in the personal records for individuals with indirect needs as well. In the case of Individual #227, he had received hip surgery (post-surgery discharge to SASSLC on 5/17/10) due to a fracture secondary to a fall from his bed on 5/10/10 and later gastrostomy tube placement due to weight loss. He weighed 101 pounds on 3/23/10 prior to the hip fracture, below his Ideal Body Weight Range (IBWR) of 113-141 pounds. On 7/10/10, it was reported that he weighed 92 pounds. By 7/16/10, he weighed 85 pounds and the PST recommended that the physician consider enteral PEG tube placement. A PSP Addendum on 8/3/10 reported that he had returned from the hospital on 7/31/10 after PEG placement. There was no evidence of a comprehensive assessment submitted secondary to change in status related to either of these events. PST Interim meeting notes on 05/11/10 stated that the previous OT/PT assessment was 6/29/09. While the PNMP was reported to have been revised, there was no current assessment or progress notes in the record. **Standard: If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.** Each individual living at SASSLC received some level of direct and/or indirect OT/PT supports and services. For example, each individual had a PNMP and a dining plan. It was not possible to determine if the individuals who received annual updates had previously received a comprehensive assessment that was being updated. If that was the case, clearly the comprehensive assessment was not maintained in the record. As stated above, not everyone had a current assessment in his or her personal record. There did not appear to be any discernible difference in content between the Habilitation Therapies Update and the Comprehensive Evaluation; the distinction was not clear. The template submitted had headings for both the comprehensive and update evaluations and it was not possible to determine the differences. Many of these were not comprehensive in that they lacked information regarding health risk indicators and no clinical analysis with rationale for recommendations.	

#	Provision	Assessment of Status	Compliance
		There was an extensive review of "health status" and "relevant consults and diagnostics." This was accomplished via extensive record review by the clinicians, however, content with regard to review of supports and services provided over the previous year, and rationale for the provision of those supports, including assistive equipment, was not consistently provided. Assessment detail and clinical reasoning also varied greatly from report to report. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. Neither an analysis of findings nor a rationale was provided as a foundation for the recommendations identified. Specific risk indicators were not listed. There was only a statement regarding that the individual had a PNMP, but nothing related to the contents, if it had been modified over the course of the last year, or if it continued to meet their needs. There was no correlation with the health risk indicators identified by the NMC, HST, and/or interventions recommended by the clinicians. There was no clear correlation between interventions, supports, services, and risk identification via analysis of findings for each individual who received and OT/PT evaluation or update. Recommendations were generally rote in nature and pertained primarily to the provision of plans to continue the PNMP or review by the NMC, for example. The reference to the PNMP, however, usually highlighted a focus, but this had not been clearly established in the presentation of the data or evaluation findings. These assessments were conducted with OT and PT together, so collaboration was evident in the process. Generally, each of the following areas were addressed in both the Comprehensive Assessment and Assessment Update, though content was often limited: • Movement; • Mobility; • Range of motion; • Independence; and • Functional Status across each of these areas (HCG VIII.B.2) As described above, Individual #227 had received hip surgery (post-surgery discharge to SASSLC on 5/17/10) due to a fracture secondary to a fall from his bed on 5/10/10 and later gastrostomy tube placement due to weight loss. There was no evidence of a comprehensive assessment submitted secondary to change in status related to either of these events. The following individuals received direct PT and there was no evidence in their record that they had received a current OT/PT assessment to justify direct services:	

#	Provision	Assessment of Status	Compliance
		• Individual #336**:** There were progress notes from 2/10 to 07/10 related to a walking program for weight loss. None of the progress notes documented any data related to weight loss, but merely the distance walked. No action steps related to PT goals were noted in the PSP dated 10/9/09. The most current assessment was a Physical Therapy Comprehensive Assessment dated 2/3/94. • Individual #106**:** There were progress notes from 03/10 to 06/10 related to "restore Individual #106's ability to be a safe, functional ambulatory." His PSP indicated that no direct PT was indicated. There was no rationale as to why PT was initiated. The most current assessment was a Physical Therapy Evaluation dated 11/17/86. • Individual #189**:** He was listed as receiving direct physical therapy related to cervical range of motion, however, there were no assessment or progress notes in his personal record. • Individual #236**:** He was listed as receiving direct physical therapy related to extremity range of motion. He had a current Habilitation Therapies Annual Update (10/20/09), but it was stated that direct PT was not indicated at that time. There was no additional assessment or other documentation related to the rationale for direct PT and there were no progress notes in the record submitted. **Standard: Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.** Per the POI, this was not accomplished consistently. An example was described above when Individual #227 experienced a hip fracture and surgery after a fall from his bed in May 2010 as well as PEG tube placement due to weight loss in July 2010. He had not received an OT/PT assessment since June 2009 per his PSP Addendum, but there was no assessment in his personal record. **Standard: Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment.** Most of the assessments described the seating system, a rationale for the properties, and a statement of the fit and function. The clarity and thoroughness of this varied from report to report. A mat evaluation and review of the wheelchair was an aspect of each annual assessment. In many cases, simple repairs or modifications were possible at the time of the review and, in the case that more extensive work was required, this was scheduled for completion at a different time. **Standard: Medical issues and health risk indicators are included in the assessment**	

#	Provision	Assessment of Status	Compliance
		process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. There was an extensive review of diagnoses and health status as well as a description of relevant consults and diagnostics over the last year. Medications and their purpose and a review of nutritional management related health status was included in the assessment as indicated. There was no clear identification of risk indicators from the NMC or HST screening tools. Interventions and supports were not clearly linked to these concerns. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** Each of the current assessments were signed by both the OT and PT. In some cases, there was limited participation by the SLP when swallowing concerns, or issues related to AAC were of note, and when input was indicated for review of the individual's seating system. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.** PSP Addendums were generally not conducted to justify the addition of therapy services. In some cases, however, changes to the PNMP were included as an aspect of discussion in interim PST meetings for events warranting these meetings. Treatment plans were not generally developed by therapists or were not included in the personal record. The specific outcomes for PT intervention were limited to a statement in the progress notes, though these were not always in the record and were not generally measurable. There was no evidence of OT intervention submitted as requested. Therapy supports provided and integrated into the PSPs were generally limited to the equipment provided. Actions related to the actual provision of therapeutic intervention were not addressed in the majority of the records reviewed. While there were 16 individuals who received PT, the need for PT, or the expected outcomes and objectives of PT intervention, was not typically noted in the PSP. In one case, there was an action step related to physical therapy, but it did not match that included in the assessment. • Individual #199 had a current Habilitation Therapy Comprehensive Evaluation dated 3/9/10 with recommendations to continue direct PT to provide passive range of motion and stretching of his lower extremities for contracture management. The OT/PT section of his PSP (4/12/10) stated that he had not	Noncompliance

#	Provision	Assessment of Status	Compliance
		ambulated for two years, yet an action step stated that "Individual #199 will have safety during all transfers during ambulation skills training (provided by PT) by using a gait belt during the next 12 months." He was described as needing a two person mechanical lift or two (or more) person stand pivot transfer. There was no mention of ambulation training in the OT/PT evaluation. There were no progress notes in the record. • As described above, Individual #227 experienced a hip fracture and surgery after a fall from his bed in May 2010 as well as PEG tube placement due to weight loss in July 2010. He had not received an OT/PT assessment since June 2009 per his PSP Addendum, but there was no assessment in his personal record. He was reported to have a diagnosis of osteoporosis. His most current PNMP was dated 6/17/10. There was no reference to osteoporosis, fracture risk, fall risk, enteral nutrition, weight loss or other health risk issues. The focus of his plan was to only to "support mobility and safety with equipment and promote safe dining with modified textures." No more current plan had been put in place in a timely manner to ensure his health and safety. • Individual #215 had a current Habilitation Therapy Update Evaluation dated 2/23/10. There was a recommendation to continue his walking program until it could be turned over to direct support staff in his home and at work. Progress notes were present in the record for June and July 2010 only. His goal was to ambulate at least two times weekly with PT and a gait belt. He was discharged as of 8/4/10 because he averaged 1000 feet and had reached his "treatment plateau." In June 2010, the goal was listed as being able to perform sit to stand transfers with minimal assistance of one staff, and walk with minimal assistance of one staff on even surfaces. There was no measureable functional goal stated in the July 2010 note, but rather a service objective related to frequency of service only. There was no mention of his progress related to sit to stand transfers and insufficient rationale stated for discharge from treatment. His PNMP was dated 4/20/10. Staff were instructed that "Individual #215 should not walk until further notice" and that he used a two person transfer with a gait belt." This plan had not been revised to reflect the reported gains he had made with regard to ambulation skills and related to the original recommendation in his OT/PT assessment in February 2010. There were no PSP Addendums submitted to reflect any changes in his plan. **Standard: Within 30 days of development of the plan, it was implemented.** As no plan had been developed to address change in status for Individual #227 and Individual #215, for example, it was unclear what interventions had been implemented and within what timeframe following these significant changes in their health status.	

#	Provision	Assessment of Status	Compliance
		Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. There was no evidence of SPOs for OT or PT in the PSPs submitted. Direct PT was provided to 16 individuals but, as described above, intervention plans were not developed, progress notes were not always present in the record, and many did not have current assessments. In most cases, the purpose of the intervention was stated on the progress notes, but there were no measureable goals or objectives. Emphasis on progress related to a specific measurable objective should be clearly and consistently stated. Clear rationale to discharge from or continue therapy should be tied to progress related to established measurable objectives. PNMPs were the primary intervention plan and while a focus was identified in the rationale for the plan, the assessment did not provide a clear rationale for the specific selection of interventions for that individual. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. There was a poverty of intervention plans beyond the PNMP. These plans included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and bed and other positioning, in addition to listing assistive equipment, communication, and the dining plan. There was little information that identified how the individual was able to participate or ways in which skill acquisition and practice could be incorporated into the individual's daily routine. These strategies promote teachable moments throughout the day and should be included in training, monitoring, coaching and modeling conducted by the therapy staff. This greatly enhances opportunities for learning and independence. Many of these may be as subtle as allowing sufficient time for the individual to give a signal that he or she was ready for a transfer (e.g., 1-2-3-GO) in that the individual may be able to blink, vocalize, or nod head on "GO." Or, the individual may be able to look in the direction of the transfer, for example, by looking over to the bed right before the transfer from the wheelchair. Other examples include the individual may be able to hold his or her foot up for placement of shoes and socks; during mealtimes when an individual who received hand over hand assistance had the ability to bring the spoon to his or her mouth and only required assistance to scoop; or that an individual could hold a second toothbrush or hairbrush in his or her hand or	

#	Provision	Assessment of Status	Compliance
		on lap while being assisted to have teeth or hair brushed. These subtle abilities or potentials for skill acquisition often go unnoticed by direct support staff as they hurry to get everything done across their day. These types of activities would require that a baseline be established with regard to the individual's ability at the time of the OT/PT assessment, and then supports would be established to provide opportunities for practice of existing skills or for learning new ones. The clinicians appeared to recognize that more work was needed in this area, but believed that the staffing shortage was a barrier. The assessment format did not address potential for skill acquisition. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The rationale offered in the assessment, however, was generally insufficient. The assessment should provide a clear analysis and rationale for equipment, rather than a rote assignment of these systems without clear and well documented need in regards to functional abilities, potentials, and health risk indicators. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** Measureable goals were uncommon in the design of most of the plans and, as a result, there was little in the documentation to quantify progress or regression. It was noted that the clinicians generally did a good job of verbalizing their clinical thinking throughout the process of mat evaluation to problem solve and identify concerns. This was observed with Individual #146 and Individual #230, however, in their discussion related to Individual #341, it was stated that her wheelchair was difficult to push. They discussed moving the seat back to address this. Despite the fact that she had received a new custom molded seating insert with added lumbar support, the team did not thoroughly evaluate whether that continued to meet her needs. The therapists reported that they had expanded their observations for the assessments to include more environments including eating and toileting. Further assessment of additional environments for day program and work will increase the functional approach to the design and implementation of interventions and supports. **Standard: On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the**	

#	Provision	Assessment of Status	Compliance
		person's status, transition (change in setting), or as dictated by monitoring results. In some cases in which direct PT was provided, there was a progress note written monthly intended to document progress. The note identified attendance and the therapeutic activities provided. The clinician checked whether to continue the therapy or recommended changes. A changes/comments section included a very brief narrative and usually made objective statements of performance, but rarely actually pertained to the stated objective and, as described above, provided little clinical analysis as to why therapy should continue or why discharge was indicated. Individuals were not otherwise reviewed on a monthly basis, but PNMPs were reviewed and changed on an as needed basis only. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP. Some examples included the following: • Individual #70 was observed seated in her wheelchair. Her pelvis was forward in the seat and posteriorly tilted. Her trunk was laterally tilted. The seat belt and chest strap were too loose to provide adequate support and stability. The chest strap was not listed in her PNMP. There were no pictures available for her PNMP. • Individual #345 was also not back in her wheelchair seat and was in a posterior tilt. She did not have a picture for her PNMP. • Individual #228 had a pelvic strap attached over two aprons (large clothing protectors), but this did not provide adequate support and stability to her pelvis. The aprons covered her entire trunk from her nose to below her knees. Her chin was covered and so were both arms as well. There were no specific instructions related to this practice in her PNMP. There were no pictures for her PNMP to guide staff. • Individual #24 was not wearing elbow protectors as prescribed in her PNMP. Again, there were no pictures for PNMP implementation. • Individual #343 was observed to be transferred by staff. When asked about the large sling being used, staff stated that there were only two red ones and the large one was the only one available. Her PNMP specified that the small sling should be used for transfers. She was positioned flat on the changing surface even though her PNMP specified that she should be elevated to 30 degrees at all times due to PEG placement and reflux precautions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The footrest for Individual #273 was positioned too low to provide appropriate support to his feet and legs. There were not pictures with his PNMP. • There were no pictures for the PNMP for Individual #145. • The PNMP for Individual #124 showed a black wheelchair frame while she was seated in a teal frame at the time of this review by the monitoring team. Her knees were approximately eight inches forward of the seat front and her hips were not fully back in the seat. She mobilized her chair with her right hand and foot, by report. It was not clear if she was positioned as intended because the picture did not match her current seating system. • Individual #293 was not seated in the center of his wheelchair and the cushion appeared to be bottomed out somewhat in the center. His pelvis was oblique and in a posterior tilt. His knees were significantly adducted and internally rotated. His right leg was extended. He was wearing a gait belt while in the wheelchair. Staff reported that he only got out of his chair for meals and leisure. He was not wearing a seat belt. It was secured after the monitoring team brought this to staff attention. The seat belt was very loose and staff did not correct his alignment before securing it. He was not positioned as pictured in his PNMP. • Individual #247 was observed in a posterior tilt and his feet were not supported on the footrests. It was further noted that his seat cushion was unzipped with the metal air nozzle exposed. This was brought to staff attention who stated that she probably put air in it and forgot to zip it, but she did not attempt to correct this herself. He had a gait belt tightly secured around his abdomen while seated in his wheelchair. The picture for his PNMP showed him in poor alignment as well. • Individual #165 was observed being transferred to his wheelchair. Staff did not align his pelvis before the secured the seatbelt. His seat belt was too loose to properly stabilize his pelvis and the gait belt was too tight around his abdomen. Staff were observed to lift him under his armpits and by the gait belt to scoot him further back in the seat. • Individual #65 was transferred by staff using a stand pivot transfer from his wheelchair to the dining chair. Staff did not move her feet, but rather twisted her back and this placed her at risk for injury. Though this staff member had been employed at SASSLC for five months, per her report, she required verbal prompts and cues for two different transfers. In the other transfer, she did not remove the footrests and required a verbal prompt to do so prior to the transfer. While it was great that the supervisor provided coaching, it was of concern that a five-month tenured employee would require prompts for two transfers within 10 minutes. • Individual #306's seat depth appeared to be too long and her feet were dangling	

#	Provision	Assessment of Status	Compliance
		unsupported. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The only competency-based OT/PT training aspect of New Employee Orientation (NEO) was provided related to transfers and this was the only area for which re-training as provided. Per the Lifting/Transfer of Consumers handout submitted, this was required every two years for all direct support staff. Both NEO Physical Management and Lifting training, and the lifting refresher training, were offered two times monthly. There were specific checklists used for this process, though it was unclear as to the actual standards of performance for skills required. A number of the transfers observed were poorly executed by staff and suggested that the original training and annual re-training were inadequate, and that monitoring did not effectively identify the need for further training and coaching. As described above, a supervisor was observed providing excellent oversight and coaching to her staff. She had previously been a PNMPC and had been promoted to the supervisor position recently. Clearly her training had provided her with a strong foundation for her role as supervisor and suggested that other supervisors would benefit from similar learning opportunities. By report, most of the additional training required for implementation of PNMPs and other support plans related to OT/PT were predominately completed by the home supervisors and by informal coaching by the PNMP coordinators, rather than specifically by the therapy clinicians. Clinicians and PNMP coordinators provided person-specific training for transfers and positioning or other interventions (e.g., orthotics, gait trainers, gait belt, mealtime chairs, bathing trolleys, toileting chairs and seats) that varied from that taught in NEO to Supervisors, Director of Pre-Vocational Services, Director of Recreation, the QMRP, and, at times, nursing staff. Supervisors and Directors then in turn, trained their staff. There was a plan to be implemented by Habilitation Therapies that treatment plans requiring training would include specific competencies as part of their training with the expectation that supervisors would use the same competencies to check off the performance of their staff as well. At this time, however, evidence of training was limited to sign in sheets that did not outline the skills or performance criteria expected and, as such, would not be considered to be competency-based. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff clearly were not able to recognize the rationale behind recommended interventions. Rationale for interventions and supports were not consistently included in the PNMP. This would be an important aspect of staff training as well as monitoring and coaching.	

#	Provision	Assessment of Status	Compliance
		Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement.	
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.	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The current system of PNMP monitoring was generally limited to availability and condition, rather than function and fit. Function and fit were consistently reviewed on an at least an annual basis via evaluation, at the request of the PST, and upon referral when a problem was identified. Proactive review of staff performance was conducted on an informal basis by therapy clinicians and PNMPCs. Tracking and documentation were not yet in place, however, the PNMPCs were more consistently providing staff training when issues and concerns were identified, both on the spot and with inservices. The wheelchair fabricators conducted maintenance checks on a quarterly basis for wheelchairs only. Direct support staff were responsible for conducting daily maintenance checks and cleaning of all equipment. Direct support staff were reported to be reliable in bringing the individual and his or her equipment to the wheelchair shop and reporting needs for repair, maintenance, or modification. When needs were identified, the priority was assessed and assigned a number. This did not appear to impact the fact that most needs were met that same day, per the tracking list submitted that outlined the many maintenance, repair, and modification activities conducted in the shop. Others were completed in two to three days, and longer completion times were more the exception. (One of the longest time frames was nearly six weeks for a tilt cylinder for Individual #295 labeled as a Priority 3.) The consistency of the turnaround time was excellent and was clearly evident due to this work order tracking system. Likewise, if review of this tracking system revealed that task completion was not done in a timely manner, this would be readily identified and intervention steps taken to correct the problem. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** As stated above, monitoring typically was primarily limited to availability and condition of equipment by the PNMPCs, rather than efficacy of the interventions. By report, however, the therapists had just recently initiated monitoring and documentation for those individuals who were deemed to be at highest physical and nutritional risk on a monthly basis.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were 248 individuals identified with PNM needs, representing approximately 88% of the current census at SASSLC. The identification of those at greatest risk is discussed in Section O above. It would be anticipated as the system of risk identification was further developed and integrated, this system would drive the frequency of monitoring by the clinicians. As described in this section P, above, there also appeared to be monthly review of direct therapy interventions, but documentation of this was not consistent and only a limited amount was submitted in the documents requested by the monitoring team. **Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. An outline for the PNMPCs of monitoring activities that were to be conducted and the frequency with which they were to be done, however, was submitted. The schedule of bathing observations was outlined to cover both AM and PM bathing. Safety checks for position and maintenance needs were generally to be conducted twice daily in the assigned homes in addition to PNMP equipment checks for 10 individuals daily. Mealtime monitoring was also included as discussed in Section O above. The monitoring team requested PNM monitoring forms completed in the last quarter. There were approximately 104 forms for approximately 57 individuals submitted. This was an increase in PNMP monitoring conducted since the baseline onsite visit in February 2010. Monitoring forms submitted included: January (1), April (2), May (6), June (27), July (57), August (11). There were two individuals monitored eight times, one monitored five times, nine individuals monitored three times, two monitored nine times, and 36 individuals monitored once during the period for which forms were submitted. General findings were as follows: • No concerns noted: 56% • Partial concerns noted: 14% • Lap belt not snug: 5% • Staff were not following schedules per the PNMP: 3% • PNMP not readily available: 4% • Individual not positioned correctly or according the PNMP: 7% • Head not correctly positioned on headrest: 2% • Feet not on the footrest: 4%	

#	Provision	Assessment of Status	Compliance
		• Wheelchair not clean and in good condition: 11% • Assistive equipment not clean or in god condition: 6% • Equipment was not available or used correctly: 5% • Correct lifting procedures not used: 25% • Enteral or oral eating position not correct: 1% It was unclear how the partial designation was to be used. For example, in one case, the wheelchair was noted to need cleaning, yet the monitor marked partial. Another case documented that staff retraining was necessary on the spot to correctly do a two person stand pivot transfer, yet partial was marked for that item. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** The system of monitoring was relatively new and there had been significant turnover in the original staff hired and trained as PNMP Coordinators (PNMPCs). These Coordinators were involved in ongoing on-the-job training and there was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated. Validation of the PNMPCs had been completed by the therapy clinicians. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** See above. **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff .** This was reported to be true by therapy clinicians, however, because training was not competency-based, there was no assurance that those who were most at risk were assisted by competent and well-trained direct support staff. A number of stand pivot transfers were observed to be unsafe and/or did not promote individual participation or skill development. The system that employed the PNMPCs had been effective to modify staff performance related to mealtimes and, as such, would likely improve staff performance related to implementation of positioning plans and transfer. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.**	

#	Provision	Assessment of Status	Compliance
		There was no documentary evidence that issues identified during monitoring had been remedied or that home supervisors were notified of the findings. There was no tracking system to enable systemic analysis of findings or to track follow-up. **Standard: Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.** By report there was back up equipment in both the homes and Habilitation Therapies to ensure that, in most cases, items were available as needed at all times. **Standard: Data collection method is validated by the program's author(s).** There were no plans implemented, other than the PNMPs, at this time, and no data collection was occurring, so validation was not indicated. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement.	

Recommendations:

1. OT and PT staffing was inadequate and aggressive recruitment was needed to ensure adequate supports and services were available to those with therapy needs.

2. Ensure that the most current assessments and other documentation were present in each individual's record at all times. If the system is adopted to complete comprehensive assessments every three years with interim updates, the comprehensive assessment should remain in the record for three years with the interim updates until a new comprehensive assessment is completed to replace it. Updates should make reference to the comprehensive assessment and provide analysis of changes from the baseline findings in that report.

3. PNMP Coordinators continue to require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.

4. The focus of training and monitoring should include improving staff precision with regard to position and alignment. Ensure that pictures that accurately reflect the intended position are available with the PNMPs for staff reference. If PNMPCs are responsible for the photography, ensure that they understand and can produce accurate positioning and alignment of body segments and that they take photos from angles that will permit staff to evaluate whether or not they have the individual correctly positioned and aligned.

5. Develop a more clear definition of direct and indirect therapy so as to determine who would require a comprehensive assessment every three years.

6. Review the current system of comprehensive assessments and updates to create a distinction between them without sacrificing sufficient findings for the design of appropriate interventions and supports. Focus should be on guidelines to conduct the analysis of findings, as well as providing consistent documentation of the rationale for the interventions and supports recommended by the clinicians. The updates should include a health status update, review of supports and services over the previous year, individual response to the supports, and progress.

7. Additional focus for the development of improved assessments should address health risk indicators and clear relationship of interventions selected to address them.

8. Develop treatment plans that have specific measurable and functional goals. Ensure that documentation relates to those goals. Consider integration of these into the PSP process as SPOs. Interventions should begin to shift to skill acquisition rather than foundational supports via assistive equipment and the PNMPs. These may be accomplished via direct service as well as collaboration in the development of training plans in other areas including the home and day/work programs.

9. Ensure that performance competencies are clearly defined for staff training that is skills based. Additional training of supervisors and PNMPCs may be needed to ensure that they have the skills they need to train others and understand how to establish competent skill performance.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o Dental Policy and Procedure Manual, undated draft o SASSLC Dental Data (1/1/10 - 7/22/10) o Individuals who completed annual exam o Individuals who missed clinic o Individuals who refused clinic o Dental records for the individuals listed in Section L Interviews and Meetings Held: o Carmen Mascarenhas, M.D., Medical Director o Carol Willborn, DDS, SASH Contract Dentist Observations Conducted: o Dental clinic o Informal observations of individuals' oral hygiene in homes
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: This provision is rated noncompliance for the following reasons: • Individuals did not receive care in compliance with the requirement for annual evaluations. • There was frequent use of sedating medications and restraints with little documentation from the Personal Support Teams (PST) on strategies to prevent use. In most instances, the personal support plans documented team agreement with the dental plan, including the use of restraints. • Desensitization plans were not noted in any of the records reviewed. • In the case of individuals who refused, the PSTs did not have a clear strategy to overcome barriers. • Policies and procedures for the provision of dental services had not been implemented. The policy and procedure manual provided was a draft version that had not been approved. • The majority of the records reviewed indicated that the individuals had a hygiene status of poor or fair. • The facility had not implemented a dental quality improvement program and data for key dental process and outcome indicators was lacking.

#	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.	The facility did not meet the requirements for annual assessments and did not maintain data on restorative and emergency treatments provided. The dental supports provided in the homes relative to oral hygiene appeared lacking resulting in a large percentage of individuals having poor and fair hygiene ratings. This provision is therefore rated as being in noncompliance. Dental services were in a transitional stage at the time of the onsite review. Services were historically provided by the dental clinic of the state hospital. A full time dental director was hired on 5/1/10. A full-time dental hygienist was hired 6/1/10. At the time of the onsite review, the dental director was not available for interview. The dental director and dental hygienist had started evaluating and treating individuals in the SASH dental clinic. A temporary dental clinic (bridge clinic) was scheduled to open on 9/1/10. The use of the state hospital was scheduled to be discontinued on 8/31/10. The state hospital dentist reported that the clinic followed the American Dental Association pediatric guidelines in the treatment of individuals living at SASSLC. She cited concerns about oral hygiene, stating that, in her opinion, very little hygiene was provided once the individuals left the clinic. This opinion was based on the fact that individuals who had through cleanings in clinic returned three to four months later with heavy tartar and calculus build-up. She also expressed concern over the discontinuation of sedation for individuals, stating that it was difficult and unsafe to treat individuals who could not cooperate. Comments regarding oral hygiene care at the facility are also found in section M3 of this report. Data provided by the facility showed that 38 individuals had completed their annual assessments as of 7/22/10. Fifty-four individuals missed clinic appointments and 13 individuals refused treatment. The reasons for missed appointments varied and included individuals being off grounds, sick and hospitalized individuals, lack of staff, lack of sedation, and PCP cancellation. Data on restorative treatments and emergency dental care was requested by the monitoring team, but was reported as being non-available.	Noncompliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	The transition to a facility dental clinic and hiring of a dental director and hygienist were all evidence of progress in the provision of dental services. These programs had not been fully implemented. Additionally, strategies to address the use of restraints and sedation were in the development stage at the time of the onsite visit. For these reasons, this	Noncompliance

#	Provision	Assessment of Status	Compliance
	and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	provision was rated as being in noncompliance. The dental records were comprised of multiple documents including: • SASSLC Dental Treatment • Initial Examination Report • Dental Treatment Record • Dental/Oral Hygiene Evaluation/Individual Behavior and Recommendation form The individual behavior recommendation form documented issues, including the effectiveness of sedation, us of restraints, behavior classification, behavior recommendations, oral tissue examination, future treatments, request for consent, oral hygiene classification, treatment rendered, recall for cleaning, and recommendations for improved oral health. Dental documentation of 20 records was reviewed. All of the records contained evidence of dental treatment. Many individuals were seen in dental clinic every three to four months for exam and prophylaxis. Most of the individuals required sedation and/or restraint. Review of the most recent hygiene status showed 11 individuals with poor oral hygiene, six fair, and two good. One individual was edentulous. Review of the personal support plans verified that the teams received the information contained in the records and reviewed it. Other documents, such as the minutes from the Nutritional Management Committee meeting made detailed note of oral hygiene status. In the majority of cases, the teams agreed with the treatment recommendations and use of restraints. There was little evidence that the teams considered strategies to minimize the use of restraints. No formal desensitization plans or reference to plans were found in the records reviewed. The newly hired dental director had requested that all sedation for dental clinic be suspended so that each individual could be evaluated to determine the need for chemical and mechanical restraints. The records contained evidence that this had been implemented.	

Recommendations:

1. The facility must move quickly in establishing the bridge clinic to prevent lapses in dental care.
2. The facility should make every effort to ensure that all individuals receive timely treatment including the comprehensive annual assessments.
3. The facility should ensure appropriate coordination between services in order to minimize missed appointments due to lack of transportation, lack of staff, and individuals being off grounds.
4. The types of services provided should be expanded such that those individuals who can benefit may do so.
5. The facility should continue its efforts to assess the need of each individual for the use of sedation and restraints.
6. Every individual who requires the use of sedation or restraint should, at a minimum, be assessed for the need of a desensitization program.
7. Any individual with a poor hygiene rating, or deterioration in hygiene status, should have an individualized dental plan of care implemented.
8. Staff should be trained on the dental plan of care and it should be verified that staff understand and have implemented the plan.
9. The dental clinic should develop a quality improvement program in conjunction with the overall facility quality efforts.

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 SASSLC Plan of Improvement o Speech assessments including: • Individual #65, Individual #112, Individual #123, Individual #75, Individual #293, Individual #333, Individual #135, Individual #74, Individual #93, Individual #268, Individual #50, Individual #308, Individual #198, Individual #324, Individual #4, Individual #254, Individual #146, Individual #302, Individual #168, Individual #211, Individual #197, Individual #312, Individual #66, Individual #31, Individual #256, Individual #24, Individual #334, Individual #91, Individual #126, Individual #341, Individual #288, and Individual #323 o List of individuals with Psychology Department Caseloads o List of individuals with Communication Devices o Communication Tracking Sheet (two versions, both undated) o PSPs including: • Individual #112, Individual #31, Individual #123, Individual #254, Individual #146, Individual #324, Individual #198, Individual #74, Individual #66, Individual #197, Individual #126, Individual #4, Individual #211, Individual #341, Individual #196, Individual #312, Individual #135, Individual #302, Individual #91, Individual #268, Individual #334, Individual #236, Individual #1, Individual #75, Individual #333, Individual #50, Individual #168, Individual #288 and Individual #323, Individual #256 o Progress notes: • Individual #112 and Individual #31 o Communication Audit form o Augmentative/Alternative Communication Priority Screen o Assessment formats o PNMP monitoring forms Interviews and Meetings Held: o Margaret Delgado-Gaitan, MA, CCC-SLP, Habilitation Therapies Director o Allison Block-Trammell, MA, CCC-SLP o Roland Hoffmann, III, MS, CCC-SLP Observations Conducted: o Living areas o Dining rooms o Day programs

	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: As was the case during the baseline monitoring tour, there were still only two speech clinicians to provide supports and services in the area of communication. Each of them also had responsibilities in the area of mealtimes and dysphagia assessment. Of the 32 assessments reviewed, approximately 82% identified individuals with significant expressive and/or receptive language deficits. There were 14 of these individuals who were recommended for some type of AAC system beyond the communication dictionary provided. It continued to be a concern that so few individuals were actually receiving communication supports. Much time and energy were focused on two individuals with higher tech devices, as they were receiving direct therapy with communication-related SPOs. Many others, however, continued to wait for these supports. During an interview with the SLP clinicians, they discussed that they had made an error regarding the development of a plan for completion of comprehensive assessments. In a number of cases, assessments for those who had been identified with highest needs for AAC had in fact been deferred until the next PSP year due to the existing staff's inability complete them. In some cases, assessments for individuals with a less urgent need had assessments completed prior to these Priority 1 individuals. The therapists indicated, however, that the assessments for the "1's" that remained could be completed by the end of this calendar year and agreed to do so. A number of individuals were determined not to be candidates for AAC systems based on a very limited assessment of their potentials to benefit from this supports. Collaboration with other disciplines outside of the Habilitation Therapies department continued to be limited and impacted the relevance and integration of communication supports across environments. The foundation of communication skills must be well integrated within the home, work, and leisure settings. SLPs must be able to lend their expertise to others in order to ensure that staff can capitalize on communication opportunities, appropriately reinforce communicative intent in a timely and effective manner, and promote communication-based skill acquisition integrated into all activities throughout the day.

#	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	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** At the time of the onsite monitoring tour, there were two full time SLPs employed at	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	SASSLC (Allison Block-Trammell, MA, CCC-SLP and Roland Hoffmann, III, MS, CCC-SLP) in addition to the Habilitation Therapies Director, Margaret Delgado-Gaitan, MA, CCC-SLP who was also an SLP, but did not carry an active communication caseload. Copies of current licenses were submitted for Ms. Gaitan and Mr. Hoffmann, however, the license submitted for Ms. Trammel was under the name of Allison Block and was expired on 07/31/10 at the time of this onsite review. Her license was presumed to be current at the time the original document request was submitted in July 2010, but a more current license was not submitted for this SLP. Each of these clinicians had attended the Texas Assistive Technology Network Statewide Conference in June 2010 for a total of 15 hours each. Per staff report, the two SLP clinicians were not currently able to provide supports and services based on individual needs at this time due to inadequate staffing. Each clinician had primary duties related to dysphagia and mealtime, in addition to those related to the provision of communication supports. With a census of 282, each speech clinician was responsible for a caseload of 141 individuals in both of these areas. This was a reduction in caseload from the previous review of only 150 individuals per clinician. Again, given this ratio, it would not be possible to adequately meet the needs of the individuals living at SASSLC in these two critical service area, communication and mealtimes. By report there was a position for an SLP posted. There were no CVs submitted for any SLPs as per the monitoring team's document request regarding CVs for PNMT. It was, however, documented that, "There have been no changes to CVs for PNMT members." It was reported that all three SLPs had attended the Texas Assistive Technology Network Statewide Conference in June 2010, though no documentary evidence of this was submitted. Based on interview and review of the POI submitted, the SASSLC concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant.** Of the 32 assessments reviewed, approximately 82% identified individuals with significant expressive and/or receptive language deficits. Only Individual #31 and Individual #112 received direct communication intervention. There were 14 of these individuals who were recommended for some type of AAC system beyond the communication dictionary provided for some. Individual #74 and Individual #341 were not listed with a communication device or system per the Communication Devices list,	

#	Provision	Assessment of Status	Compliance
		though this had been recommended in the assessments submitted. Neither of these individuals had a current assessment as a part of their personal record. Some of the systems provided for the other 12 individuals were personal and available throughout their day, while others were only available in certain locations, such as the dining room or living area. A number of homes had devices available to everyone in the home including 665, 668, 670, 672, 672, 673, 674, and 766. Each individual had been previously screened and ranked based on need for AAC. The priorities were outlined as follows: • Priority 1 = ≥70%, Nonverbal with good potential for immediate use of AT • Priority 2 = <70%, Nonverbal with likely need for training in use of AT • Priority 3 = Limited verbal, but may benefit from AT • Priority 4 = Verbal, no need for AT A three-year plan had been developed whereby those with a Priority 1 were provided comprehensive communication assessments as possible per the PSP schedule in Year One. Year Two consisted of the "1's" the clinicians "didn't get to" in Year One and any "2's" they had time for per the PSP schedule. Year Three consisted of any other "1's" the clinicians "didn't get to" in Year One or Two and any "2's" they had time for per the PSP schedule. During the interview with the SLP clinicians, they discussed that they had made an error regarding this plan and understood that it did not in fact provide supports to those they identified at highest need in the most timely manner. They indicated, however, that the assessments for the "1's" that remained could be completed by the end of this calendar year, and they agreed to do so. As there were only two speech clinicians, they were limited as to the number of new comprehensive assessments they were able to complete as those who were recommended for communication supports were also provided a new communication update assessment annually per the PSP schedule following the initial comprehensive assessment provided based upon the above schedule. Upon review of the Communication Tracking Sheet submitted (undated), rankings were listed as follows | | Priority 4* | Priority 3 | Priority 2 | Priority 1 | | --- | --- | --- | --- | --- | | Screening | 90 | 31 | 115 | 42 | | Evaluation Completed | 20 | 14 | 52 | 41 | | Evaluation Needed | 0 | 5 | 62 | 1 | | No designation | 70 | 12 | 1 | 0 | *previously Priority 0	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
There were several individuals listed who did not have a screening rank listed. This list was not consistent with the numbers reported during the interview with the speech clinicians. They indicated that there were eight individuals with a Priority 1 rank who still required assessment and 45 with a Priority 2 rank.

Another list, the Communication Tracking Sheet that presented data more consistent with their report.

<table>
<tr><th></th><th>Priority 4*</th><th>Priority 3</th><th>Priority 2</th><th>Priority 1</th></tr>
<tr><td>Screening</td><td>82</td><td>38</td><td>112</td><td>46</td></tr>
<tr><td>Evaluation Completed</td><td>14</td><td>18</td><td>64</td><td>36</td></tr>
<tr><td>Evaluation Needed</td><td>68</td><td>20</td><td>48</td><td>10</td></tr>
</table>

This list identified that Individual #130, Individual #293, Individual #246, and Individual #255 each needed an assessment but they had no priority rank. Individual #168 had no priority rank and no indication as to whether an assessment was needed. Three of these were known to be new admissions.

Based on interview and review of the POI submitted, the SASSLC concurred that they were not in compliance with this provision item of the Settlement Agreement.
</td><td></td></tr>
<tr><td>R2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a 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.</td><td>
Standard: All individuals in need of AAC were identified as being in need of AAC.

Per the current system outlined by the clinicians, they planned to complete annual assessments for individuals who received direct services or were provided “personalized” communication equipment. They had begun to provide comprehensive assessments for some, and interim updates for others, based on discussion during the baseline review by the monitoring team. This system did not appear to be consistently implemented at this time however.

Documents requested by the monitoring team included that the five most current assessments be submitted for each clinician along with the current PSP for those individuals.

Comprehensive Communication Evaluations were submitted for Individual #333 (5/28/10), Individual #323 (7/13/10), Individual #293 (7/13/10), Individual #65 (7/12/10), and Individual #168 (6/11/10).
Interim Communication Updates were submitted for Individual #256 (6/10/10), Individual #24 (8/8/10), Individual #75 (6/14/10), Individual #50 (6/23/10),

</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		and Individual #93 (7/15/10). These had been completed by the two speech clinicians as follows: Allison Trammell, MA, CCC-SLP • Individual #333 • Individual #256 • Individual #24 • Individual #50 • Individual #323 Ron Hoffmann, MS, CCC-SLP • Individual #293 • Individual #75 • Individual #93 • Individual #65 • Individual #168 Individual #65, Individual #168, Individual #293, Individual #323 and Individual #333 had been provided current Comprehensive Communication Evaluations. Findings included the following: • Individual #333's last assessment had been in 1997 at the time of his admission to SASSLC and his skills remain unchanged since that time. He was 44 years of age and was essentially nonverbal, communicating with behavioral changes, eye contact, facial expressions, imitation, vocalizations, one to two word phrases and the single sign "eat." AAC was not recommended because he was, generally, understood by others. His PSP described a training objective for him to label the three pictures in his communication folder. Though not stated, it would appear he would not be provided an annual assessment. • Individual #323's previous assessment had been in 2008 at the time of his admission to SASSLC. A re-evaluation was requested by his PSP secondary to noted observations of frustration related to his communication efforts. It was documented in the recent assessment that there had been a regression in his overall communication skills. It was recommended that he be provided a portable card with 12 pictures labeled in Spanish and English for use in natural contexts, and that the team should obtain one or two small voice output devices to attach to his walker. It did not appear that the SLP was to be involved in this and it was not clear if an annual assessment would be required in this case per the assessment schedule in place. Nothing was listed for Individual #323 in the Communication Devices list submitted.	

#	Provision	Assessment of Status	Compliance
		• Individual #65 had been provided a speech-language evaluation in 1995 upon his admission to SASSLC. His recent comprehensive assessment on 7/12/10 did not recommend AAC or other communication supports other than an object ring that included items, such as a cup, spoon, block and toothbrush. It was further stated that he would not require subsequent assessment unless there was a change in his status. No PSP was submitted, so it could not be verified that the object ring had been provided for his use. • Individual #168 had recently been admitted to SASSLC and had received his comprehensive assessment with 30 days. As he was described as demonstrating functional verbal skills and speaking in complete sentences, no communication supports were recommended. While it was not stated, it would appear he would not be provided an annual assessment. • A previous assessment for Individual #293 was reported to be in 1980 and a Functional Communication Profile was provided at another SSLC in 2008. The recent comprehensive assessment was completed within 30 days of his admission to SASSLC. The clinician did not recommend AAC or other communication supports though he presented with significant communication deficits. It was further stated that he would not require subsequent assessment unless there was a change in his status. No PSP was submitted for Individual #293. In the cases of Individual #256, Individual #24, Individual #75 and Individual #50, there was reference to findings of a previous assessment of language skills within the previous two years, though specific reference to a comprehensive communication assessment was not noted. With the exception of Individual #50, each had been provided some type of AAC system, and an annual assessment would be expected based on the system described by the clinicians. It was recommended for Individual #50 that a home-based training objective targeting sign language production be implemented with a personal picture card for use in the dining room. A training objective in his PSP stated that he would say or sign "eat" before he was served his meals. There was, however, no reference to a picture card available for his use. It was not clear if he would be provided an annual assessment by a speech clinician according to the system described above. In the case of Individual #93, it was reported that his most recent communication assessment had been in 1999, though there was also reference to a speech-language assessment that had been completed on 7/21/09. It was unclear whether or not this was a comprehensive communication assessment. An Interim Communication Update was completed on 7/15/10 and was current within the last 12 months. Individual #93 had been provided communication folders and a simple message voice output device and as such an annual assessment would be expected per the system outlined by the clinicians.	

#	Provision	Assessment of Status	Compliance
		Current PSPs were submitted for five of these 10 assessments. An admission PSP for Individual #168 was dated 5/26/10, the actual date of his admission, that included a list of necessary assessments, however, a completed PSP with assessment findings and training objectives was not submitted. PSPs were not submitted as requested for Individual #24, Individual #293, Individual #93, and Individual #65. Additional assessments were submitted with PSPs for Individual #268, Individual #91, and Individual #334. These were dated 2/8/10, 2/24/10, and 10/30/09 respectively. The assessments for Individual #268 and Individual #91 were Speech and Language Updates, while the one submitted for Individual #334 was an Augmentative Communication Review. Individual #334's review in 2009 referred to a speech-language evaluation completed in 2008. He had been provided a Small Talk Sequencer with a leaf switch listed as available to him in the Communication Devices list submitted. Individual #268's and Individual #91's updates referred to previous assessments in 1992. Neither appeared to have had a received a comprehensive assessment since that time. It was reported that Individual #268 contacted a switch to activate the message. Though it was recommended that he have access to this in the dining room, it was not listed as available to him on the Communication Devices list submitted. In Individual #91's update, there was a brief reference on page three to an "evaluation last year" in which skills needed for AAC were assessed and a voice output device was provided to him for trial. A Cheap Talk device was listed as available to him in the Forever Young program and in his home. PSPs were submitted for Individual #268 and Individual #91 only. Both Individual #334 and Individual #91 received some level of indirect service via the equipment provided and, as such, an annual assessment would be provided per the plan described above. It was not clear whether an annual assessment would be provided to Individual #268. Assessments for the only two individuals who received direct speech services included Individual #31 and Individual #112. Individual #31 had received an Interim Communication Update on 2/12/10 and Individual #112 had received a Speech and Language Update on 8/11/09 that was not current at the time of this onsite review. A variety of documents from the personal records including the SLP assessments of a sample of 23 individuals selected by the monitoring team were requested including: • Individual #123, Individual #74, Individual #66, Individual #197, Individual #126, Individual #198, Individual #146, Individual #4, Individual #211, Individual #341, Individual #308, Individual #312, Individual #254, Individual #135, Individual #288, Individual #302, Individual #324, Individual #65, Individual #301, Individual #236, Individual #1, Individual #213, and Individual #20.	

#	Provision	Assessment of Status	Compliance
		Of the 23 records requested, only 20 were received. No records for Individual #301, Individual #213, or Individual #20 were submitted as requested. Other personal records submitted, though not included in the sample, included Individual #255, Individual #31, and Individual #112. SLP assessments from the active records were submitted as follows with the date of the assessment(s) in parentheses: • Individual #123 (11/4/94, 8/6/09, and only 2/3 pages for an update dated 8/4/10) • Individual #74 (10/12/95, 12/8/95, 6/24/09) • Individual #66 (12/18/08, addendum dated 3/4/10) • Individual #197 (8/14/98 and 10/29/01 • Individual #126 (8/3/94) • Individual #198 (8/2/89 and 6/17/92) • Individual #146 (9/21/05) • Individual #4 (9/18/95) • Individual #211 (8/5/10) • Individual #341 (9/17/01) • Individual #308 (1/28/10) • Individual #312 (5/28/09 and 4/13/10) • Individual #254 (11/2/95) • Individual #135 (4/6/90, 1/29/09 and 2/19/09) • Individual #288 (5/30/01) • Individual #302 (1/27/92 and 1/12/09) • Individual #324 (4/19, 5/4, 5/21/01, new admission on 4/18/01) • Individual #65 (7/12/10) • Individual #1 (no assessment submitted) • Individual #236 (no assessment submitted) • Individual #255 (no assessment submitted) • Individual #31 (2/2/09) • Individual #112 (8/11/09) Of these 23 assessments reviewed, only four had SLP assessments current within the last 12 months (Individual #65, Individual #312, Individual #308, and Individual #211). Individual #65 and Individual #308 had received comprehensive assessments while Individual #312 and Individual #211 had been provided Interim Communication Updates. Individual #211's update (8/5/10) made reference to an evaluation completed at the time of his admission to SASSLC the previous year. He used sign language and a picture wallet and voice output devices located around his home. By report (4/13/10), Individual #312 had been formally assessed in 1989. There was reference to an "informal" assessment in August 2008, but that would not qualify as a comprehensive	

#	Provision	Assessment of Status	Compliance
		assessment. Though it was recommended that he be provided two button devices at his bed or in the hallway, the communication devices list identified that he had lap tray pictures and "pain pictures" in his wheelchair bag. Only the first two pages of a three page assessment update were submitted for Individual #123 and dated 8/4/10. His previous assessment was reported to have been provided the previous year. It was not clear if this had been a comprehensive assessment or update. He had been provided a four message voice output device. It would appear that each of these individuals would receive an annual communication assessment. Updates would be appropriate if there had been a recent comprehensive assessment completed. None of the 23 assessments listed above indicated that the individual did not require further communication assessments, though some of those individuals with assessments completed within the last two years were recommended for AAC or environmental control devices. Yet only "addendums" had been provided, rather than assessment updates including Individual #135 (2/19/09) and Individual #66 (3/4/10). These did not qualify as an annual assessment, but rather were clarifications of modifications to their existing speech-language recommendations. No specific communication recommendations were made for Individual #74 or Individual #302. It was not clear if an annual assessment would be provided because this was not stated in the updates submitted, dated 6/24/09 and 1/12/09 respectively, though a more current assessment was not submitted for 2010. It was not clear if they were not completed or not indicated. No assessments were submitted as requested for Individual #1, Individual #236, or Individual #255. In total, there were 19 individuals for whom current communication assessments were not submitted. Six individuals were reported to have had verbal communication skills in Spanish, English, or both per their communication assessments (Individual #254, Individual #308, Individual #4**,** Individual #168, Individual #146, and Individual #324). While they each presented with expressive and receptive language delays, their verbal communication appeared to be functional. As stated above, only Individual #308 and Individual #168 had communication assessments current with the last 12 months. Each of them had received an assessment within 30 days of their admission to SASSLC. The communication assessment for Individual #146 had been completed five years ago, while the assessment for Individual #324 had been completed over nine years ago. Both Individual #4 and Individual #254 had communication assessments that were 15 years old. Each of the current assessments contained a section related to Augmentative Communication and Environmental Access, though these were brief and a number did not report specific findings of actual observation, assessment of AAC use, or trials. Some examples included:	

#	Provision	Assessment of Status	Compliance
		• Individual #91 (2/24/10) was provided an Attainment Express One to provide a touch picture and voice output to allow him to make a simple request. It was paired with a preferred activity, playing with a keyboard. This was provided two weeks prior to the assessment, but no report of how this worked for him was noted. Further, he had previously had a four button device and "was not too successful," but "did somewhat better" with a two-button device. It was stated that he had required verbal and gestural prompting to reach out and contact the switch to generate the voice-output devices at that time. There was no objective data reported related to his baseline performance or progress. Though a new device appeared to have been provided, no baseline was established and no objective measure for determining his success was outlined. • Individual #334 (10/30/09) was provided a Small Talk Sequencer with a leaf-type switch activated by head movements. There was no report as to how long this device had been available to Individual #334. The switch activates the device, social phrases, questions, and parts of songs are played. Again, no baseline was established and no description of how well Individual #334 did with this system was reported. There was not an objective measure for determining his success outlined. It was stated that the device was appropriate for his needs, though there was no evidence of how that was determined. • Individual #93 (7/1/10) was to have "access to a simple message speech output device" to gain attention or request paper or markers. It was not clear how long this device had been available to Individual #93 and there was no description as to his baseline performance, current performance, or objective measure of successful use of this device. There was no description as to how he accessed it, what his level of independence was, or his reaction to the device. It was only determined to be appropriate for his needs and in good condition, though there was no evidence of how that was determined. • Individual #256 (6/10/10) had been provided a four-message voice output device mounted in the living area of his home. The assessment listed the messages and indicated that it was to "augment his expressive communication" and was a "tool to facilitate acquisition of new communication skills." It was noted that there was no description as to his baseline performance, current performance or objective measure of successful use of this device. There was no description as to how he accessed it, what his level of independence was or his reaction to the device. It again was not clear as to how long he has had access to this device. • Individual #293 (7/13/10) was described to "not exhibit skills needed for augmentative communication." This determination appeared to be based on his lack of visual attention to pictures (books or wallets), or to the examiner's signs.	

#	Provision	Assessment of Status	Compliance
		By report, he resisted physical prompts to produce signs. He was not deemed capable of using objects to represent actions because he did not inspect or manipulate objects presented. He required physical prompts to operate a switch and showed "no interest in the switch or radio." He was reported to bring a cup to his mouth when asked to "show me what you do with this." By report, he looked toward objects and reached or gestured toward an object that he wanted. An example of an action he performed requiring staff acknowledgment and reinforcement included pouring a glass of tea from a pitcher, a higher level motor skill with a clear function. Each of these was very situation-specific. His PNMP indicated that he propelled his wheelchair in his home and he participated in stand pivot transfers though was "fed by staff." A more complete picture of Individual #293's functional skills was not available because the PSP requested was not submitted. It was of concern that the assessment of Individual #293's response to AAC was very narrow and was not an assessment over time, but only within the context of observations on one date. It did not appear that the clinician had considered other options which may have been more meaningful or functional for him. Further, it was stated that Individual #293 would not require further assessment unless there was a change in status. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** It appeared that communication assessments for those individuals newly admitted to SASSLC were generally provided within 30 days of their admission. Examples included Individual #308, Individual #168, and Individual #293. It was noted however, that a current communication assessment was not submitted for Individual #255. There was no indication that individuals were re-evaluated upon change in status. The SASSLC POI indicated that additional SLPs were needed to ensure that this was consistently done. **Standard: Communication Assessment addresses:** • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and** • **The need for further assessment in Augmentative Communication.** The majority of the assessments reviewed (current assessments only were reviewed for these elements) generally addressed both verbal and nonverbal skills. In some cases,	

#	Provision	Assessment of Status	Compliance
		there was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also often not clear as to how effective the current methods used by each individual were within their daily routine. The clinicians reported what system the individual had and that it met their needs, but not how it was used and whether or not it was effective. Recommendations for further assessment related to AAC were not noted in any case. In most cases, the assessment addressed expansion of current abilities or the development of new skills generally only as they related to suggestions for staff. While these were excellent, there was little to suggest that there was a specific effort to expand current skills or develop new ones via specific goals for supports and interventions. Only the two individuals receiving direct speech therapy had specific goals established. Individual #31 had eight clearly stated goals with a description of his progress on each over the previous year, though there was no comparative analysis to illustrate his success. Unfortunately, however, there was no description as to how Individual #31 used his Mighty Mo device on an everyday basis with communication partners other than the speech clinician. An additional six measurable goals were stated for the upcoming year, some of which had been modified from the previous year to better meet his needs. Though it was not stated in his assessment, it was reported by the SLP that Individual #31 participated in direct speech therapy only one and a half hours per month. In the case of Individual #112, the goal for the previous year of therapy was not identified and there was no clear description of her progress. Though it was stated that she "continues to make steady progress," the clinician only reported that she was independent 60% of the time, required verbal prompts 25% of the time, and gestural prompts 14% of the time. It was not clear as to what she needed these prompts for and what she accomplished independently 60% of the time. There was no comparative analysis to support the statement that she had made steady progress. She had two established goal for the upcoming year in direct speech therapy, the second contingent on the first, though each was related to the "identification" of pages or phrases rather than related to functional communicative exchange. This was recommended for active treatment in a Senior's program and at home. A PSP service objective was written to ensure that she would have daily access to her device. It was of concern that this was necessary because availability of an AAC device should be considered as routine as having a wheelchair available and, as such, it would be unusual to need to write a service objective to ensure this. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured**	

#	Provision	Assessment of Status	Compliance
		relevance and appropriateness of goals. Per report by the clinicians, only two individuals received direct speech intervention. Individual #112 participated in therapy two times a month; while Individual #31 was reported to participate in direct therapy approximately one and a half hours per month and, as such, an annual assessment would be expected. Others received indirect supports via the provision of an AAC system and an annual assessment would also be anticipated. As described above, all individuals had not yet received a comprehensive assessment and their current needs for AAC or other communication supports had not been identified. There were a number of individuals in the sample who had assessments that were up to 15 years old. The current system in place would provide an annual interim update and comprehensive assessment every three years for any of those individuals identified with a need for AAC or other communication supports based on a comprehensive assessment. In the cases of Individual #65 and Individual #293, the clinician indicated that further communication assessment would not be indicated unless there was a change in their status. In the case of Individual #293, this was a concern because he was newly admitted and the assessment of his AAC needs and potential for communication had not been fully explored. In the case of Individual #65, he was described as able to respond to simple routine commands such as "sit up" or "find the spoon" without physical prompts, and produced a few intelligible words and phrases (e.g., "good," "go work," "stop it"), though he was reported to not use them functionally. It was stated that he might benefit from a simple object ring as he attended to and manipulated a few common objects in daily activities. He was also reported to respond to hand-over-hand assistance to use a switch to activate a radio at work and occasionally reached to turn on the music spontaneously. As he did not "react to any voice output devices around his home," nothing else was recommended beyond the object ring and access to the switch at work. It was of concern that this clinician recommended that no further assessment was necessary despite his identified potentials for communicative growth. Speech-language therapy was not recommended for Individual #308 or Individual #168, both newly admitted in the last seven months, as they presented with functional verbal communication skills to effectively express themselves. There was no statement as to the need for further assessment, however, in either report. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.** The initial screening did not specifically include those individuals with behavioral concerns, but since the baseline review by the monitoring team in February 2010, these	

#	Provision	Assessment of Status	Compliance
		individuals have been considered a priority and assessments were completed according to the plan described above. **Standard: Communication programs were integrated into the BSP as indicated.** By report, information from the PBSPs was included in the communication assessments and communication dictionaries. Conversely, it was also reported that Communication dictionaries and recommended communication strategies were included in the PBSPs. In review of the list of PBSPs it was noted that there were 208 individuals listed with a plan. The following communication assessments made note of a PBSP: • Individual #168, Individual #211, Individual #123, Individual #293, Individual #65, Individual #333, Individual #135, Individual #74, Individual #93, Individual #268, Individual #50, and Individual #75. While a number of these directed staff to refer to the PBSP in the individual's communication dictionary, there was little to no documented evidence of actual collaboration with psychology to determine if specific communication strategies may impact target behaviors. For example, Individual #123 was identified with a PBSP and the speech clinician recommended that he be provided a voice output device to enable him to request alternate activities when he became agitated. It was recommended that this device be available to him in his home and possibly in the Senior's program that he attended. There was no evidence that speech and psychology had plans for collaboration to assess if this strategy was effective for him. Care in implementation of these strategies is critical to ensure that staff were not inadvertently reinforcing his agitation by offering preferred activities upon observation of these behaviors, and that the communication being noted was that of requesting the activity and not his behavioral demonstration of agitation, including stomping his feet and loud vocalizations as described in his communication dictionary. Integrated staff training would be essential by both speech and psychology. In another example, Individual #302 was listed with a PBSP, but there was no reference to this in his communication assessment dated 1/12/09. He had not received a more current communication assessment in 2010. The following individuals did not have a current communication assessment despite the fact that they each were listed with a PBSP: • Individual #198, Individual #146, Individual #4, Individual #324, Individual #254.	

#	Provision	Assessment of Status	Compliance
		By report, there was informal collaboration with psychology and the speech clinicians had begun to attend the Behavior Therapy Committee meetings as of 6/5/10. While these were all excellent first steps, it was far from actual integration of assessments, supports, and services to address communication deficits as they relate to behavioral concerns. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to prioritize assessments and services based on need. The assessment plan in use at SASSLC was based on the completed screenings and the resulting rankings based on need for AAC. As stated above, however, completion of assessments was not based only on need, but also on the clinicians' ability to "get to" the evaluations in a given year. As they reported, they attempted to complete assessments for those ranked Level 1, or highest need, though these were postponed until a subsequent year if the clinicians were not able to complete them. This was essentially a three-year plan and based on the PSP schedule rather than predominately on need. During the interview with the SLP clinicians, they discussed that they had made an error regarding this plan and understood that it did not in fact provide supports to those they identified at highest need in the most timely manner. They indicated, however, that the assessments for the "1's" that remained could be completed by the end of this calendar year, and they agreed to do so. There were only two speech clinicians and, therefore, they were limited as to the number of new comprehensive assessments they were able to complete as those who were recommended for communication supports were also provided a new communication update assessment annually per the PSP schedule following the initial comprehensive assessment provided based upon the above schedule. Per the current system outlined by the clinicians, they planned to complete annual assessments for individuals who received direct services or were provided "personalized" communication equipment. They had begun to provide comprehensive assessments for some and interim updates for others based on discussion during the baseline review by the monitoring team. This system did not appear to be consistently implemented at this time, however. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision item of the Settlement Agreement.	
R3	Commencing within six months of	**Standard: Rationales and descriptions of interventions regarding use and benefit**	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**from AAC were clearly integrated into the PSP.** The current PSP format did not provide a holistic picture of the individual complete with a description of their communication methods and abilities of their ability to understand what others communicated to them. The manner in which communication was addressed within that also varied from team to team. Some examples from PSPs included the following: • The description of Individual #333's communication skills was limited to a summary of the communication assessment recommendations and a training objective was outlined for him to "label the 3 pictures from his communication folder." (6/2/10). • Individual #323 was described as able to understand and reply to simple requests and questions and that he generally understood Spanish better than English. (9/11/09) • The description of Individual #75's communication skills was limited to an outline of the recommendations from the communication assessment. It was stated that he had a communication dictionary. In the living options section, he was described as unable to speak and made his needs known with facial expressions and crying to indicate his likes and dislikes. • The description of Individual #256's communication skills was limited to an outline of the recommendations from the communication assessment. It was stated that he had a communication dictionary and that his would be provided a "personal communication device mounted in the living room of his home." There was no description as to how he used the device and how effective it was for him. There were no communication-related training objectives. **Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** As stated above, the PSP offered very limited descriptions of how a person communicated with others and even more limited instructions as to how staff would best communicate with them. The most descriptive information was included in the "specific communication strategies" section of the communication assessments completed by the SLPs, but this information was not translated to the PSPs, but, instead, only recommendations were listed. The provision of an AAC device was noted within the PSP in some cases, but how it was used by the individual was not. As noted above, Individual #123 was identified with a PBSP and he was provided a voice output device to enable him to request alternate activities when he became agitated. It was recommended that this device be available to him in his home and possibly in the	

#	Provision	Assessment of Status	Compliance
		Senior's program that he attended. His PSP, dated 8/21/09, stated that his target behaviors were "agitated behavior and smearing" and that he communicated with "limited gestures and sounds." Further information regarding his behaviors and communication skills were not evident in the PSP. A training objective was listed that he would "activate a speech output device with gestural/verbal prompting 3 of 4 trials per month for 3 consecutive months." This was to be implemented by vocational staff. The training objective was very non-specific and there was also no evidence of collaboration with psychology and speech to assess the effectiveness of this strategy on the frequency or intensity of his agitation and did not reflect integration as intended by the Settlement Agreement. There were two individuals who received direct communication intervention from a speech-language pathologist: Individual #112 and Individual #31. As reported above, Individual #112's most current assessment was dated 8/11/09. At the time of her assessment, the speech clinician recommended that she receive direct therapy to work on a training objective related to her use of the Gus Multimedia Speech system. Her PSP dated 9/4/09 described that she accessed the device via a head switch connected to an adapted mouse. Voice output messages were produced when she selected a target phrase by scanning through pages, rows, and columns of message icons on a computer monitor. The head switch and computer were mounted on her wheelchair. She was described as communicating with eye gaze, facial expressions, yes/no gestures, and pointing. There were four training objectives intended to improve her communication skills with implementation dates of 9/4/09 through 9/4/10. Documentation regarding these was submitted only from 11/30/09 through 4/30/10. She appeared to be making progress during that time. The documentation indicated that she was seen weekly, but the clinician reported that she was seen two times a month only at the time of this onsite review. No implementation plan was submitted. Individual #31 was described in his PSP dated 2/22/10 as responding to both Spanish and English and that he used his behavioral changes, eye contact, eye gaze, gestures, vocalizations, speech, and pictures to communicate with others. Specific strategies for staff to use with him were outlined, though this was not typically noted in the PSPs for others. He had six training objectives. His most current assessment and PSP as submitted were both expired approximately six months at the time of this review. The implementation plan designated that he would be seen in direct therapy one and a half hours per month. Documentation was submitted for April 2010, May 2010, and July 2010 and the goals outlined did not match that contained in the outdated assessment. He generally appeared to be making progress during that period. **Standard: AAC devices were portable and functional in a variety of settings.**	

#	Provision	Assessment of Status	Compliance
		In general, it appeared that the existing AAC devices were functional, though a number of them were used only in a specific context, for example, at meals, in the nurse's station, or to make a specific request, such as "lotion" for one individual. As such, a number of them would not be considered portable. These context-specific devices appeared to be appropriate in many cases, however, and were excellent first steps in the consideration of communication systems for these individuals. **Standard: AAC devices were individualized and meaningful to the individual.** Some of the devices had the appearance of being individualized and meaningful, such as: • The two-message voice output device in the activity room for Individual #135 so she might request lotion or a massage because these were described as "motivating" for her. • The four-message voice output device for Individual #123 that included icons for "go for a walk," "ball," "draw," and "sit outside." Further, these icons were described as being integrated with his PBSP recommendation to encourage him to participate in activities he enjoyed when he became agitated. As noted above, however, care to ensure integration of intended outcomes is critical to ensure that the behavior that increased was his requesting an alternative activity via the message device versus his current agitation and associated behaviors. In most cases, however, the selection of a device and messages were not typically well-justified in the assessment. For example, in the case of Individual #93, he was provided a two-message device in the activity room to get attention from staff and to request paper or markers. There was no rationale described in his assessment to establish why this was selected for him versus other alternatives. **Standard: Staff were trained in the use of the AAC.** Staff received general training related to communication in new employee orientation, but further staff training in the area of communication strategies by speech staff was limited due to the many other responsibilities of the staff and, therefore, tended to occur on an "as needed" basis. The communication strategies listed in the assessments appeared to be useful, though as these generally did not get integrated into the PSP, it was not clear how that valuable information was shared with direct support staff who would need it. These strategies were also not included on the PNMP. **Standard: Communication strategies/devices were implemented and used.** Staff were observed to be communicative and interactive with individuals during a variety of activities including mealtimes and "wait" times prior to meals. It was not	

#	Provision	Assessment of Status	Compliance
		evident, though, that the specific strategies were used with individuals as outlined in their speech assessments. The strategies appeared to be similar across individuals in a group setting. An effort to use sign language was also noted for a number of individuals and it was not always clear that this was the most appropriate method for them. The methods used should be individualized when indicated. In the case of Individual #112, her device required set up by staff. They had been trained to do so but compliance was inconsistent by report and staff did not always notify speech when her switch was not working. Many of the individuals at SASSLC did not have even the most basic of language skills. Therefore, SASSLC should consider ways of developing these types of skills. One way is to consider teaching early language skills. As suggested in the baseline monitoring report, the facility might consider using an assessment tool called the ABLLS-R (Assessment of Basic Language and Learning Skills-Revised). Although the tool was designed for children with learning and language disorders, autism, and other disabilities, the facility might find the contents helpful, especially in designing an instructional curriculum with a focus on early communication and language skills for individuals with the most severe learning needs. **Standard: General AAC devices were available in common areas.** A number of community devices were available and observed to be used with some consistency. Each of these devices observed by the monitoring team appeared to be in working order, but use by individuals and staff was limited. In one case, however, during the observation of medication administration in home 668, staff assisted each individual to touch the switch with the message "time for medication" or encouraged the individual to touch the switch. In the case of Individual #54, he touched the switch that said he was "sick" rather than the one for medication. Staff asked if he was sick and he smiled and chuckled, as did the staff, all seeming to share in the joke. If in fact it was determined that he was not sick, the staff did not intervene or guide a correction in order to activate the other switch. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision item of the Settlement Agreement.	
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	**Standard: A monitoring system was in place that: tracked the presence of ACC; working condition of AAC; the implementation of the system; and effectiveness of the system.** Per the POI, monitoring of AAC systems was limited due to insufficient staffing and large	Noncompliance

#	Provision	Assessment of Status	Compliance
	ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	caseloads for the two speech clinicians. The condition and availability of the equipment itself was included in the PNMP monitoring conducted by the PNMP Coordinators, though effectiveness and actual implementation was limited. The communication plans for the two individuals who participated in direct therapy were routinely reviewed by speech clinicians but other communication-related plans were not. In fact, little consultation was provided in the development of these plans. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** By report, monitoring of AAC was conducted most often in the homes rather than across settings. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no system of validation of monitors established at SASSLC at the time of this onsite review by the monitoring team. Based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision item of the Settlement Agreement.	

Recommendations:

1. Examine current efforts to recruit new speech clinicians. The existing two SLPs cannot possibly meet all the needs of the individuals who live at SASSLC and the department is at great risk for problems with retention.

2. The current assessment schedule should be evaluated to ensure that those with the greatest needs are assessed with supports in priority order rather than according to what can be accomplished based on current staffing according to the PSP schedule. Ensure that target dates for completion are outlined in the plan.

3. Ensure that the most current assessment is present in the personal record for each individual. Consider documentation regarding the priority based on the screening that was done to justify why a more current assessment may not be available. For example, an individual who was considered to be a Priority 4 may continue to have an outdated assessment in the record.

4. Unless a strong and current comprehensive assessment has been completed, it is of concern that an individual with an update would be deemed to not require further assessment unless there was a change in his or her status. In the case that an update is completed, reference to the comprehensive assessment should be made in the update and the comprehensive assessment should not be purged until such time a new comprehensive assessment is completed. For example, the clinicians were considering that a comprehensive assessment for those receiving

direct and indirect communication supports would be completed every three years, with updates completed in the interim.

5. Many recommendations appeared to be left to the PST for the development and implementation of plans. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans. Communication goals can and should be addressed across the full gamut of training objective programming.

6. Clarify the intent of the "annual" assessment by SLPs. At the time of the onsite tour, it was limited to those who received direct services (two individuals only) and to those who were provided equipment. There appeared to be some inconsistencies as to who would be included as needing an assessment or update on an annual basis.

7. The communication assessments were inconsistent in the clinician's analysis related to the selection of AAC systems, need for direct service, and the decision to only make recommendations to the PST related to communication supports. Statements to specifically outline the rationale should be more fully addressed in the assessment reports.

8. Consider the use of a tool, such as the ABLLS-R, to assess and plan for instructional programming regarding the most basic language and communication skills.

9. The focus of monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the PNMP Coordinators.

10. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSP.

11. Ensure improved integration of assessment and methodology for communication-related plans both formal and informal, including sign language, picture exchange, assistive technology, and other AAC systems to include speech clinicians, psychology, and other staff responsible for program development. Selection should be bimodal, meaning that AAC should utilize the individual's full communication capabilities, including residual speech or vocalizations, gestures, signs, and communication aides. These should be based on what best matches each individual's skills and functional needs across environments and settings. The integration of effective communication strategies ensures that active treatment is engaging and more meaningful to the individual.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o List of Individuals Employed On/Off Campus o Personal Support Plans for: • Individual #166, Individual #327, Individual #85, Individual #167, Individual #273, Individual #245, Individual #108, Individual #50, Individual #159, Individual #13, Individual #269, Individual #36, Individual #215, Individual #78, Individual #248, Individual #30, Individual #57, Individual #219, Individual #304 o Specific Training Objectives (SPOs) for: • Individual #42, Individual #219, Individual #304, Individual #85, Individual #167, Individual #78, Individual #159, Individual #36, Individual #50, Individual #166, Individual #248, Individual #13, Individual #108, Individual #249, Individual #269, Individual #273, Individual #30, Individual #245, Individual #215 o Personal Support Plan (PSP) Quarterly Reviews for: • Individual #273, Individual #30, Individual #215, Individual #171, Individual #57, Individual #36, Individual #269, Individual #50, Individual #245 o Individual Education Plans (IEP); Admission, Review, and Dismissal (ARD) meeting forms; and IEP progress reports for: • Individual #113, Individual #297, Individual #327 Interviews and Meetings Held: o Gina Dobberstein, Coordinator of Leisure and Recreational Activities o Jane Dahlke, QMRP Coordinator, Michael Wong QMRP for 671 West, Rosella Kleiwer QMRP for 673 East, and Karla Baker QMRP for 674 East o Mark Boozer, psychologist; Andrea Blue, QMRP Observations Conducted: o Observations occurred in various day programs and residences at SASSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and Implementation of behavior support plans o Torrance Cheeves, DCP, while supervising individual's engagement in activities

	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Overall, the skill acquisition plans at SASSLC were not adequate to promote growth, development, and independence. The facility needs to better document that individual skill acquisition plans are chosen to address individual needs and preference. Additionally, the methodology used to teach individual SPOs was found to be inadequate to maximize learning. Finally, although skill acquisition plan progress was monitored, the DCPs implementation of plans was not monitored. Nevertheless, meetings with staff responsible for skill acquisition plans indicated that they recognized the need for an effective and improved process to determine and document how skill acquisition objectives were chosen. Additionally, they expressed a desire to incorporate evidence-based training procedures for training skills, and acknowledged the need for enhanced monitoring of progress. Despite staffs clear enthusiasm and shared goal for skill acquisition at SASSLC, it is not obvious that these changes can be effectively accomplished without an organizational change that would allow more time and focus for writing skill acquisition goals and monitoring implementation and progress. A good working relationship was described between SASSLC and the local public school district, however, the monitoring team raised questions regarding the adequacy of provision of an extended year educational program that included summer school. The monitoring team continues to be encouraged by the progress SASSLC demonstrates in the area of active treatment. The activities were well planned and some individual staff members were excellent at engaging groups of individuals in meaningful activities.

#	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	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SASSLC. As indicated below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	this provision. As a result, this provision is rated as being in noncompliance. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at SASSLC had multiple skill acquisition plans. These plans consisted of training objectives, referred to as specific program objectives (SPOs) that were written and monitored by the qualified mental retardation professionals (QMRP). SPOs were implemented by direct care professionals (DCPs). An important component of an effective skill acquisition plan is that it is based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological assessment. 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. Conversations with the Coordinator of Leisure and Recreational Activities, QMRP Coordinator, and several QMRPs indicated that the facility did attempt to incorporate preferences and needs in the development of each individual's SPOs. In reviewing 19 PSPs, however, it was not clear that SPOs were developed to address needs identified in each individual's assessments. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference. Once developed, 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	

#	Provision	Assessment of Status	Compliance
		A total of 76 SPOs were reviewed by the monitoring team. The SPOs at SASSLC consistently included some of these components, such as task analysis, behavioral objectives, operational definitions, and the use of consequences for correct responses. The quality of some of these components, however, was inadequate. The following examples were typical: • The task analysis for Individual #50's SPO for differentiating between coins and paper money listed four steps: present coin, identify coin, present paper money, and identify paper money. None of the steps, however, included comparing the coins and paper money as indicated in the training objective. • The training objective for Individual #273 stated, "When presented with four different tactile stimuli, Individual #273 will independently respond with a change in affect or motor pattern…" A change in affect and motor pattern are not objectively defined and therefore do not represent a good training objective, or one likely to be clear to the DCPs implementing the SPO. • The target behaviors for Individual #42's task analysis included, "gain better control over the medications he is taking, and understand he is taking medication." Neither gaining control, nor understanding his medications, is operationally defined and therefore it is unlikely that DCPs would implement this SPO with integrity. Finally, although all of the SPOs reviewed indicated that individuals should be reinforced and encouraged following a correct response, specific consequences for correct responses (e.g., positive reinforcers) were not consistently included in the plans. On the other hand, some of the critical components identified above were consistently missing from the SPOs reviewed. These components included the use of specific consequences for incorrect responses, relevant discriminative stimuli, and a plan for maintenance and generalization. Finally, SASSLC typically used total-task chaining and least-to-most training procedures to teach SPOs. There are many other procedures that can be used which would likely result in better outcomes for some individuals. For example, some individuals and target skills may be best acquired by training one step of the task at a time, or using most-to-least prompting or time delays. Therefore, it is recommended that the facility expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. No medical desensitization programs were found at the facility. These skill acquisition plans teach individuals to tolerate medical interventions (e.g., dental exams), and can result in a decrease in the use of sedating pre-exam medication. It is recommended that	

#	Provision	Assessment of Status	Compliance
		the psychology department begin to write and monitor these plans. In addition, the psychology department was already writing replacement plans that were included in each individual's PBSP, although there were varying degrees of teaching descriptions included in the PBSPs for teaching replacement behaviors (see K5 for a more detailed description). It is recommended that replacement behavior and desensitization training procedures be incorporated into the general training objective methodology, and conform to the standards of all skill acquisition programs listed below. Communication SPOs were written by speech pathologists and are reviewed in Section R of this report. Vocational SPOs were written by the QMRPs and implemented by the vocational staff. Finally, in addition to SPOs, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the QMRPs. The monitoring team did not review these plans. Overall, the SPOs reviewed did not promote growth, development, and independence. The monitoring team was encouraged, however, to learn that the facility was looking into purchasing new training curricula to learn more about evidence-based techniques for teaching skills to individuals with developmental disabilities. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at SPSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. The monitoring team was encouraged by the overall quality of the activities, and the generally positive and caring interactions between staff and individuals at SASSLC. The ability to maintain individual's attention and participation in the activities varied widely across staff and houses. For example in Home 665, a DCP , Torrance Cheeves, conducted a current events group that maintained the interest and involvement of all the individuals in that area of the house. It was clear that this staff understood and fully	

#	Provision	Assessment of Status	Compliance
		embraced active treatment, and his enthusiasm for his work resulted in a positive response from the individuals. On the other hand, in other homes (e.g., Home 671) the DCPs were less enthusiastic and comfortable with the process of active treatment, and the disinterest (and poor engagement) of the individuals reflected that discomfort. The table below documents this variability across settings. The average engagement level across the facility was 42%, about the same as noted during the baseline tour (i.e., 44%). An engagement level of 75% is a typical target in a facility like SASSLC, indicating that the engagement of the individuals at SASSLC continued to have considerable room to improve. In order to continue to improve engagement at SASSLC it is recommended that the facility develop a simple methodology to regularly collect engagement data in each setting, and establish specific engagement goals in each home and day program site. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
Vocational Workshop (B)	4/7	2:7
Vocational Workshop (B)	8/13	2:13
Vocational Workshop (B)	8/16	3:16
Seniors program	1/11	2:11
Vocational Workshop (A)	5/7	4:7
Vocational Workshop (A)	2/6	4:6
Vocational Workshop (A)	0/8	3:8
Home 670	3/15	5:15
Home 670	3/9	3:9
Home 670	3/7	3:7
Home 670	3/5	2:5
Home 670	2/7	2:7
Home 766	5/6	3:6
Home 766	1/1	1:1
Home 665	5 /5	2:5
Home 665	3/4	1:3
Home 665	2/2	1:2
Home 671	0/7	3:7
Home 671	4/4	3:4
Home 671	1/9	2:9
Home 671	0/7	1:7
Home 672	3/4	1:4
Home 674	2/16	2:16

#	Provision	Assessment of Status	Compliance

Home 668	1/9	2:9
Home 668	1/3	1:3
Home 668	1/8	1:8
Home 668	0/7	1:7
Cyber Cafe	4/4	2:4
Home 673	0/3	0:3
Home 673	0/1	0:1
Home 673	1/3	1:3

Educational Services

Approximately 15 of the individuals living at SASSLC were under age 22 and, therefore, were entitled to educational services. The local school district, the San Antonio Independent School District (SAISD) was responsible for providing educational services. To learn more about the educational services being provided to these individuals, the monitoring team was directed to talk with Mark Boozer, one of the psychologists, and Andrea Blue, one of the QMRPs. These professionals had primary responsibility for the residences in which these individuals lived. Both Mr. Boozer and Ms. Blue had frequent interactions with SAISD.

The monitoring team learned that SAISD school buses picked up the students every day. They attended four different public schools (three high schools and 1 middle school). Most of the SASSLC individuals attended the local high school. The variety of high schools, however, allowed for some individuality of service provision.

Overall, based upon the monitoring team's discussion with these two SASSLC professionals, it appeared that the SSLC and the school district had a good working relationship, frequent communication, and an attempt to coordinate programming across both environments. School was not in session during the week of the onsite tour, so a direct observation could not be conducted. Attempts will be made to do so during the week of the next onsite monitoring tour.

The psychologist and QMRP reported that most of the students seemed to enjoy going to school most of the time. One or both attended each student's annual ARD/IEP meeting. They both did observations at school and were in regular email and cell phone contact with the classroom teachers. Teachers and school paraprofessional aides were also reported to visit the SSLC from time to time. IEP progress reports were reviewed by the monitoring team. These reports contained little information indicating student performance other than a "W" to indicate a work in progress or an "M" to indicate that the objective was met. All of the objectives for Individual #113 and Individual #297

#	Provision	Assessment of Status	Compliance
		indicated that every objective was a work in progress, but didn't provide any other detail regarding progress or planned programming changes. On the other hand, all of the objectives for Individual #327 were given a rating of "M" to indicate that the objective was met. This individual had just graduated and perhaps the "M" rating was needed in order to allow the process of graduation to occur. The school district was described as always striving to have students attend full time at public school (as compared to part time and/or on the SASSLC campus). Therefore, it was surprising to see that none of the students attended any type of summer educational program. As a result, the students received no education from the last day of the school term (approximately 6/4/10) through the start of the new school term on 8/23/10. That is, 11 weeks (more than 20% of the calendar year). It is unlikely that regression did not occur in student academic and related skills during this period. SASSLC should explore whether the school district is failing to provide these students with educational programming to which they are entitled.	
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.	As documented in the PSPs, SASSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1 above, however, it was not clear that this information was used in any meaningful way to impact the type of instructional programming offered to the individual. Therefore, this item is rated as being in noncompliance. It is suggested that the facility incorporate the results from multiple assessments and evaluations (i.e., in addition to the PALS) to choose individual skills to be trained, and that this process be more clearly documented in the PSP. Additionally, while the PSP attempted to identify preferences, no evidence of systematic preference and reinforcement assessments were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
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:		

#	Provision	Assessment of Status	Compliance
	(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	The monitoring team did not observe the implementation of SPOs in any of the day or residential homes during the onsite tour, however SPO data sheets were reviewed to evaluate this provision item. This review of completed SPO data sheets indicated that plans were not consistently implemented in the homes and vocational sites and, therefore, this item is rated as being in noncompliance. It was difficult to assess if the skill acquisition plans at the facility were implemented as scheduled since the documentation schedule was typically not specified. Implementation was to occur daily, however documentation was requested 4-6 times a month (dates of documentation were not specified). Nevertheless the monitoring team concluded that SPOs were not consistently implemented as planned based the following observations: • In the vocational workshop, staff reported that all individuals have vocational SPOs. When the monitoring team attempted to review the SPOs for three individuals working in the workshop, the SPOs and accompanying data sheets could not be located for two of those individuals (i.e., Individual #303 and Individual #192). • In one of the homes, when DCPs were asked about the absence of SPO data collection for Individual #276, they responded that she had been noncompliant lately, and they planned to wait until she was in a better mood for the documentation sessions. • The monitoring team found SPO data for Individual #75 and Individual #104's SPO documented for two dates in the future. It is important that SPO implementation be more closely monitored to ensure that SPOs are implemented as intended. The skill acquisition plans appeared practical and functional for some individuals (e.g., teaching Individual #245 how to safely cross the street), however many individual's appeared to have similar goals (e.g., identifying coins), and as discussed in S1, it is unclear how or why the skill acquisition objectives were chosen. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., Individual #57 matching coins), but not for others (e.g., oral hygiene for Individual #108; teeth brushing for Individual #13). The monitors were encouraged that some plans were modified based on completion of goals (e.g., teeth brushing for Individual #215), or lack of progress (e.g., paper money identification for Individual #171), however for the majority of SPOs reviewed that did not show progress, no modifications in the plan or implementation was documented. SPO data were not graphed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		It is recommended that SPO data be graphed so as to improve the QMRP's ability to evaluate the effectiveness of the plan. Additionally it is recommended that that these graphed data summaries of individual SPO progress be used to make data-based decisions concerning the continuation, discontinuation, or modification of the skill acquisition plan.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SASSLC enjoyed various recreational activities in the community. It was not clear, however, if these community activities were developed to address specific individuals' needs for services or preference. Therefore this item was rated noncompliance. The facility is making progress on this item. At the time of the onsite tour, four individuals at SASSLC worked in the community. Additionally 18 individuals participated in vocational adjustment; a program where individuals are training to work in the community. As part of this training they do volunteer work in the community. The monitors observed several individuals from this group in a meeting with a member of the community about an opportunity to do volunteer work painting picnic tables in a local park. Subsequent tours to SASSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item.	Noncompliance

Recommendations:

1. The Psychology department should begin to write and monitor medical desensitization programs.

2. Replacement behavior and desensitization training procedures should be incorporated into the general training objective methodology, and conform to the standards of all skill acquisition programs.

3. The facility should clearly document how SPOs are based on individual needs and preference.

4. All skill acquisition plans (SPOs and replacement behaviors) should contain the following components for learning and skill development:
   - 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

5. The training methodology used to teach SPOs should be expanded to other procedures shown to be effective in developing new behavioral repertoires.

6. The facility should develop a simple methodology to collect engagement data in each setting, and establish specific engagement goals in each home and day program site.

7. Incorporate the results from multiple assessments and evaluations (i.e., in addition to the PALS) to choose individual skills to be trained, and to document that each individual's preferences, strengths, skills, needs, and barriers to successful community integration have been assessed.

8. The implementation of SPOs should be more closely monitored to ensure that they are implemented as intended.

9. SPO summary data should be graphed.

10. Graphed data summaries of individual SPO progress should be used to make data-based decisions concerning the continued use of specific SPOs.

11. The facility should continue to expand the number of individuals receiving training in the community.

12. SASSLC should explore whether summer educational programming is appropriate and needed for the individuals who may be entitled to this programming.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and five attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 o SASSLC Most Integrated Setting Policy, numbered SOP #300-21 o SASSLC POI and POI supplement, June 2010 o MRA training documentation for SASSLC PST members, 6/23/10, 47 staff signatures o List of individuals referred from 1/1/10 through 6/30/10 o List of 11 Individuals not referred who said they wanted to move to the community o List of individuals placed in the community during past six months o List of individuals for whom a CLDP existed o DADS feedback to APC on CLDP for Individual #329 o Job descriptions of PMM and APC o Living Options Discussion information page for Avatar system o Tours of provider agencies, 4/14/10 through 7/19/10 o Brochures and other written information from 25 community provider agencies that provided HCS residential and/or day services o List of family members who attended the provider fair o PSPs for: • Individual #11, Individual #270, Individual #286, Individual #85, Individual #219, Individual #167, Individual #304, Individual #113, Individual #297, Individual #327, Individual #198, Individual #293, Individual #199, Individual #302, Individual #146, Individual #4, Individual #65, Individual #1, Individual #91, Individual #236, Individual #189, Individual #112, Individual #168, Individual #31, Individual #323, Individual #308, Individual #135, Individual #227, Individual #162, Individual #221, Individual #329 o Draft PSPs for: • Individual #205, Individual #37 o CLDPs for: • Individual #162, Individual #221, Individual #329 o Post move monitoring checklists for: • Individual #153: 90 day • Individual #210: 90 day • Individual #202: 90 day • Individual #237: 90 day • Individual #44: 90 day

	• Individual #221: 7, 45, and 90 day • Individual #162: 7, 45, and 90 day • Individual #102: 7 and 45 day • Individual #76: 7 day • Individual #329:7 day Interviews and Meetings Held: o Carol Young, Admissions and Placement Coordinator o Anna Cruz, Post Move Monitor o Ralph Henry, Facility Director o Brian Malven, MRA staff member who conducted CLOIPs o Kelsey Hanson, QMRP o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted: o PSP Meeting for: • Individual #205, Individual #37, Individual #206, Individual #251 o Community group home visit, post-move monitoring for • Individual #329 o SASSLC Self-advocacy meeting o Many residences and day programs at SASSLC
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Overall, SASSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, very few individuals were in the referral process at SASSLC, however, progress was occurring. Individuals who were on the referral list during the time of the baseline tour had been placed, and new individuals had been referred for placement. Typical procedures for educating individuals and LARs were being conducted at SASSLC, but the effectiveness of these activities was in question. The facility should determine measureable outcomes for these activities (e.g., provider fair, CLOIP action). Further, An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various

	PSPs and documents at the facility. SASSLC had two staff who were dedicated to providing most integrated setting options to individuals. The Admissions and Placement Coordinator had many years of experience at the facility. The Post Move Monitor had many years of experience working with community providers and was knowledgeable about the community provider network. Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. This was evident in the three CLDPs that were reviewed and during the group home visit conducted by the monitoring team. The local area had a large number of community residential providers. The monitoring team had the opportunity to attend the provider fair and to talk with representatives from more than two dozen providers. These conversations, as well as reports from facility staff indicated that the providers appeared committed to providing quality service. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. All of the discussions appeared to be brief and/or done in a rote manner and only had minimal individualization. They did not refer to optimistic visions for the individual. All four annual PSP meetings held during the week of the onsite monitoring tour were observed by the monitoring team. The LOD occurred towards the end of these meetings. The LODs were brief, rote, and not all meaningful. There was little discussion among PST members. These LODs appeared to be representative of the LODs across the facility. The monitoring team was told that changes in the PSP process and the PSP meeting (including the LOD) were forthcoming. New training for QMRPs was being scheduled. More observations of PSP meetings will occur during the next onsite monitoring team visit. The CLOIP was implemented for every individual reviewed. As indicated below, it should not be considered an assessment for placement, and further work will need to be done to create an assessment for each individual. Further, it is possible that the CLOIP activities were not meeting their intended purpose, that is, educating individuals and LARs about relevant community options. This is discussed in detail below. The facility recently appointed a new facilitator of the self-advocacy group and meetings were going to be re-instated. This will provide the opportunity to add to the content of the self-advocacy group meetings to include community placement, decision-making, and problem solving as regular topics for discussion. The placement for one of the three individuals placed during the past six months was not successful. He was placed in an adult foster care home and was moved to a group home within his first month of placement. Although he was stable at the time of the onsite monitoring tour, the facility should examine the referral and placement activities that occurred for this individual to determine if improvements can be

	made to these processes. Comments in one individual's PSP document indicated that funding might be an obstacle to his placement. The facility should examine this case to determine if funding was an obstacle and if so, a plan should be put into place to address this obstacle. Modifications were recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

#	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.	SASSLC and the state engaged in activities to encourage and assist individuals to move to the most integrated setting. SASSLC activities to encourage and assist individuals to move to the most integrated setting were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. This provision item, however, cannot be considered to be in substantial compliance due to the need for further actions and activities to occur, including the implementation of revised policies, consideration of the opinions of professionals regarding appropriateness of community placement for each individual, and the monitoring and management of important referral-related outcome information. SASSLC activities in this area did not always appear to be consistent with the determinations of professionals that community placement was appropriate, and consistent with the individual's PSP. For example, in the sample of 31 PSPs reviewed by the monitoring team, a number of the Living Options Discussion (LOD) record pages indicated that there were no significant barriers that might prevent the individual from being successful in the community. These individuals, however, were not referred for placement, and there was no indication of consideration of their being referred for placement (e.g., Individual #91, Individual #31, Individual #219). In most of these cases, the individual was not referred due to LAR preference but this was not noted as an obstacle. The state and facility's policy was very clear in directing the PST to document this as an obstacle and then identify and implement strategies to overcome this obstacle (paragraph III.B.5). In addition, if applicable, the PST can notify the facility director that there was a lack of consensus among the team members as per paragraph III.B.7. The policy provided direction regarding how the facility should proceed. At SASSLC, these procedures were not followed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Moreover, facility management should be aware of: a. all individuals for whom the PST indicated that there were no significant barriers to referral and placement and whose LAR indicated a preference for SASSLC, b. all individuals for whom there was a lack of consensus among PST members regarding referral and placement, c. all individuals who had expressed a desire for referral and placement, but whose PST did not refer for placement, and d. any individuals for whom a cap on funding was the sole obstacle to their referral and placement. In order to do track and report on the above items, some sort of system to gather this information needs to be created that includes looking at the CLOIP worksheets and LOD records from the annual PSPs. A list for item c was maintained by the facility, however, there appeared to be some confusion at the facility regarding this list. That is, one list was given to the monitoring team as part of the document request (it had three names) and another list was given to the monitoring team during the onsite tour (it contained 11 names). The number of individuals placed (three) and the number of individuals on the active referral list (six) demonstrated progress at SASSLC compared to the facility's performance at the time of the baseline monitoring tour. Even so, these numbers were very small given the size of the facility and a review of the PSPs for many of the individuals who were not referred for placement. The three individuals who moved to the community during the past six months were Individual #162, Individual #221, and Individual #329. Two of these individuals moved to local group homes. The third individual went to live in an adult foster care arrangement, however, after one month, his placement was changed due to behavior problems and characteristics of the setting that turned out to be counter-therapeutic to his needs and preferences (e.g., opportunities for independence). The six individuals referred for placement were included in an updated referral list that was presented to the monitoring team during the week of the onsite tour. The status of these six individuals is listed below and indicates that most of these individuals were in the early stages of the placement process: • Individual #160: was referred in 3/10; the PST wanted to ensure that community employment would continue and, therefore, was working on	

#	Provision	Assessment of Status	Compliance
		securing employment that was in proximity to any of the potential residential providers. • Individual #192: visiting providers. • Individual #107: visiting providers. • Individual #245: visiting providers. • Individual #269: visiting providers. • Individual #159: recent referral, no activities had occurred yet. Note that all six of these individuals were referred within the last six months. During the baseline onsite monitoring tour, four individuals were on the referral list. Three of those four were placed (the fourth was rescinded due to the family's inability to provide the supports necessary to care for the individual). Thus, SASSLC demonstrated progress in meeting this provision item by developing referrals and in completing the placement of those individuals who had been referred. Eleven individuals were identified by SASSLC as having expressed a desire to move. The list was similar to the one reviewed for the facility's the baseline monitoring report. These individuals were not referred due to the following: • Individual #304: LAR preference • Individual #63: LAR preference • Individual #194: LAR preference • Individual #3: LAR preference • Individual #319: behavioral/psychiatric • Individual #276: behavior/psychiatric • Individual #22: medical • Individual #4: only wanted to live with her family, but this was not an option • Individual #1: legal issues • Individual #211: exploring community options • Individual #201: exploring community options Carol Young was the Admissions and Placement Coordinator (APC). She was assisted by Anna Cruz. She was the facility's Post-Move Monitor (PMM) and also had other duties related to most integrated setting practices. The monitoring team had the opportunity to meet with both of these professionals. They were knowledgeable about the placement process and experienced with local providers and families. They described some upcoming changes to the state (and thereby facility) policies and practices regarding most integrated setting practices. A review of the APC's other duties (e.g., admissions activities) is recommended to ensure that they don't compete with her ability to fully attend to supporting and shepherding the current (and future) referrals from PSTs for community placement.	

#	Provision	Assessment of Status	Compliance
		Overall, funding did not appear to be an obstacle to any individual's transition. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding and that there were plenty of slots available to individuals at SASSLC. Nevertheless, the monitoring team found an indication of a possible funding obstacle in the LOD record section in the PSP for Individual #167. The LOD page noted that no community options existed for this individual and that, "… his medical needs exceed the cap HCS providers are able to meet." It was unclear as to whether funding was the sole obstacle to placement and, if so, whether facility management and/or the APC were contacted by the PST to help support a referral for this individual. The PST should not refrain from making a referral based upon its assumption about available funding; its referral should be based upon its assessment of the individual. It appeared clear to the monitoring team that SASSLC senior management did not receive regular reports and updates regarding the referral status of each individual (as well as all of the ongoing activities related to most integrated setting practices, including, for example, educational activities, community tours, rescinded referrals, and obstacles to placement). This should occur regularly. One way to do so is to have referral information be part of the facility's quality assurance program that also included CAPs (but as noted above in section E of this report, SASSLC did not have a comprehensive QA program).	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. This provision item was found to be in noncompliance due to upcoming changes in the state and facility policies regarding most integrated setting practices, and the comments made below regarding all subsections of this provision T1b. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. SASSLC had adopted this policy in full and had named it as a facility policy, #SOP 300-21. The policy also detailed procedures for assisting individuals with movement to the most	Noncompliance

#	Provision	Assessment of Status	Compliance
		integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that SASSLC had adopted the state policy and was beginning to work under the policy, however, a number of revisions to policy and practice were in process and being updated. The revised policies were likely to include more involvement of the PST in the referral process and the post-referral process, PST involvement in visits to community providers, a review of post-move monitoring with the PST, and extra assurances and procedures regarding the determination of essential and nonessential supports in the CLDP. SASSLC should determine whether any additional facility-specific policies would be of benefit to the facility's operations in this area. If so, the facility should obtain some type of documentation of approval of these policies from the DADS central office discipline head. The monitoring team also looked to see if the policies and procedures were being implemented consistently. SASSLC staff were working towards implementing the DADS policy #018.1 and expected to modify facility practice based upon upcoming policy updates.	
	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	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles.	Noncompliance

#	Provision	Assessment of Status	Compliance
	adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The monitoring team was informed that new policies and procedures were being developed by DADS regarding the PSP process. These policies and procedures were to be taught to QMRPs sometime over the next few months and then implemented at each facility. Thirty-one annual PSPs were reviewed, for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. All of these individuals resided at SASSLC or had recently transitioned to community placements. The sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. Four annual PSP meetings were observed. These were all of the annual PSP meetings scheduled during the week of the onsite monitoring tour. <u>Protections, Services, and Supports</u> The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at SASSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion (LOD) section of the PSP. The PSP meeting, including the living options discussion (LOD) was led by the QMRP. The comprehensiveness of the discussion reported in the Living Options Discussion Record (LODR) pages was fairly consistent across the 31 PSPs reviewed. Overall, there appeared to be little, if any, discussion of an ideal, optimistic vision for the individual; characteristics and components of an ideal living arrangement; or individual considerations for community living. The LODRs were very brief, sometimes only a paragraph or so long (e.g., Individual #286, Individual #219, Individual #304, Individual #113, Individual #198), and in one case, did not exist at all (Individual #270). In one other example, the family and individual wanted to work towards the individual returning home, but the referral did not occur because the MRA staff member was not present (Individual #168). Comments in the LODRs reflected an absence of discussion, or reflected superficial discussion as evidenced by the following statements: • "the individual had lived at SASSLC for so long" (Individual #227). • "health monitoring will not be proper met in group home due to low frequency of nursing hours" (Individual #4). • families were "aware of what is available…, but have chosen not to expose themselves or [the individual] to community options" (Individual #65,	

#	Provision	Assessment of Status	Compliance
		Individual #91). In addition, the LODRs indicated little discussion of obstacles to movement to the community. At most, the LODR contained one short paragraph regarding obstacles and it was not clear as to how any identified obstacles would or would not affect a referral for placement. The LODRs also contained no indication of addressing obstacles and barriers. The monitoring team fully respects the experience and opinions of the PST members, as well as the opinions and preferences of the families and LARs of the individuals. The monitoring team looks forward to upcoming training of PSTs regarding this component of the PSP process and the effects it may have upon the LOD portion of the PSP. Four annual PSP meetings occurred during the week of the onsite monitoring tour. All four were observed by members of the monitoring team. The content of each of these LODs was inadequate to meet the requirements of this provision item (see below). The LOD at the PSP for Individual #205 occurred at the end of the PSP meeting, about an hour after the meeting had begun, and lasted for 15 minutes. Approximately 12 people attended the meeting, including the individual and her mother. The MRA staff member began by saying that he spoke with the individual's mother on the phone, and met with the individual. He reported that the mother told him that she liked having her daughter at SASSLC and that her daughter's home was at SASSLC. The QMRP then asked the team, "What would be optimal?" There was little response and the QMRP talked about the individual's preference for dancing and swimming. There was very little participation from any PST members for the majority of the LOD. The QMRP then described community living as likely offering a smaller, calmer home and that this might be a good thing for Individual #205 because she often became agitated when others in her current home became agitated. Then, the QMRP followed the pre-planned sections of the LOD format, including reading information from the sections that had been completed prior to this meeting. The QMRP stated that it would be a good idea for the mother to see what's available in the community and suggested that she visit one group home. Individual #205's mother agreed to do so. Overall, the QMRP was pleasant and active during the LOD, but there was little meaningful discussion regarding the optimal vision and setting for the individual. Similarly, the PSP meeting for Individual #37 was attended by her parents and her sister. The LOD occurred at the end of the meeting and began with the MRA staff member stating that the family was not interested in placement, that the family knew what it was like to care for the individual, and that given her medical needs, including a feeding tube and kidney tube, they were totally against placement. The QMRP then continued to follow the pre-planned sections of the LOD format, including reading directly from the	

#	Provision	Assessment of Status	Compliance
		sections that had been completed prior to the meeting. There was no discussion of any type of optimistic ideal setting and its characteristics. Moreover, the LOD was interrupted for about 15 minutes when the occupational therapist joined the meeting and the discussion turned to the individual's current status regarding positioning. The living options discussion should include discussion about the ideal optimistic vision of the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The post-move monitor sat in on approximately one PSP meeting each week, often taking notes and completing a checklist in order to monitor and provide feedback to the QMRP regarding the LOD section of the meeting. These notes and the checklists were sent directly to DADS central office and were not used by the facility's management staff or QE department. Completed forms were not submitted to the monitoring team. <u>Obstacles to Movement</u> There was no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility. Further, the facility did not maintain a record of the obstacles on an individual basis. SASSLC did not present the monitoring team with any information regarding obstacles or barriers to placement other than the information included in section T1a of this report and in the short sentence or two that was typical (and almost identical) in the LODR section of the annual PSP documents reviewed. The information in section T1a included the reasons 11 individuals were not referred for placement. It was not a comprehensive listing of obstacles and barriers across the entire SASSLC population. Strategies to overcome these obstacles did not appear to be in place at SASSLC. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary.	
	2. The Facility shall ensure the provision of adequate education about available community placements to	SASSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in, or was planning to engage in, each of the five activities listed in the DADS policy.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals and their families or guardians to enable them to make informed choices.	Detailed information, however, was not provided to the monitoring team regarding these five types of training and educational opportunities for individuals, families, and LARs. Instead, a description of the MRA's CLOIP process was submitted. This provision item is rated as being in noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. First, SASSLC had conducted a fair for all providers to present information to interested individuals, family members, LARs, staff, and families from the community. Coincidentally, the fair occurred during the onsite monitoring tour and, therefore, members of the monitoring team were able to attend the fair. Approximately 25 providers attended; each had a display table set up in the facility's gym. It appeared to be well attended by SASSLC staff, individuals who lived at SASSLC, and many family members of individuals who still lived at home. Family members of only three individuals who lived at SASSLC, however, attended. The low family member attendance may have been due, in part, to the MRA's own provider fair which occurred only a few days prior to this fair. As a result, many providers (and perhaps family members) did not attend SASSLC's fair. Most, if not all, of the providers were approved by DADS to provide HCS residential and day services. Most were small (e.g., four group homes), for-profit companies that had been in business for less than 10 years. Discussion with representatives of these providers, and a review of their promotional literature, indicated that they were community-based and committed to providing high quality services. Responsibility for oversight of these programs belonged to DADS. SASSLC should consider ways of making the provider fair more effective. One way to do so is to determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. In addition, the facility might focus on increasing attendance, providing family members with sufficient guidance before the fair and then escorting them during the fair to ensure that they have an opportunity to interact with providers who might best meet their family member's needs, and helping providers prepare to answer the types of questions most often raised by family members. Second, interactions occurred between the facility and the local MRA, such as a quarterly meeting with the APC, but it was unclear whether any type of annual community living options inservice occurred for family members and staff. Documentation, however, was provided showing that the MRA did a 90-minute training session for 47 SASSLC PST members regarding community placement processes.	

#	Provision	Assessment of Status	Compliance
		Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. A list of the most recent CLOIP meetings for all individuals at SASSLC was not provided to the monitoring team. The purpose of the CLOIP was to educate individuals and family members about community living options. Although the CLOIP was reported as being implemented by the MRA, an interaction with a family member of an individual at SASSLC raised questions about the adequacy and effectiveness of the CLOIP and is described below. The CLOIP worksheet for Individual #205 was quoted in the LODR of her proposed PSP. It noted that the parent "demonstrated to [the CLOIP worker] that she is has thorough awareness of [the individual's] options. She is familiar with group homes as well as foster homes. She has had discussions with other parents of consumers and has heard both sides of the issue." Following Individual #205's PSP meeting, the monitoring team had the opportunity to speak with her mother. The monitoring team commented that it was great to see that she was going to visit a group home to learn more about them (see section T1b1 above). The mother said that she had never been to a group home. She asked the monitoring team questions regarding life in a group home, such as whether her daughter would be transported to work, get to go to the mall, get to go shopping, and be supervised around the clock. These questions indicated that she was not knowledgeable about the basics regarding group home and community living. This indicated that the CLOIP procedures did not have the intended (and assumed) outcome as quoted in Individual #205's LODR. The next day, the monitoring team asked the MRA CLOIP staff member about this. He said that the mother had said no to considering placement. Although the above is only one example, it caused the monitoring team to question the reports of CLOIP outcomes in the other PSP LODRs reviewed. Some examples are listed below: • "[The parent] had no interest in viewing community living options for [the individual]…. In general she believes the community group homes are not adequate or efficient for consumers at the State Support Living Center…" (Individual #302) • "[The individual] and his family were provided with information as to their options regarding living options." (Individual #286) • "[The individual's] sisters were presented with living options by the service coordinator of the [MRA]/ Community Living Options Information Process. They are aware of what is available for [the individual] but have chosen not to expose themselves or [the individual] to community options." (Individual #219) • "[The] LAR is well aware of the options as [the individual] has been placed in several group homes in recent years and has been unsuccessful…" (Individual	

#	Provision	Assessment of Status	Compliance
		#304) • "[The] LAR was present and indicated that she is well-aware of other living options, but feels that at this time, [the individual] is more suitable at his current residence." (Individual #327) • "[The CLOIP worker] discussed living options with [the parent], and it did not seem that she had a good knowledge of his living choices. He offered to be of further assistance once she had a chance to read and review the literature he sent to her." (Individual #11) Fourth, the facility took individuals on visits to community providers. The only information provided to the monitoring team was from 4/14/10 through 7/19/10 (i.e., a three month period). During this period: • Only 10 individuals visited HCS homes • Only two individuals visited HCS day programs • Only one individual went on more than one tour (he went on two) • One parent visited an HCS home In addition, the information was not at all detailed (i.e., it did not contain any information regarding the individual's response). Further, there was no plan for addressing ways in which the facility's other 270 or so individuals might experience visiting community providers. To improve this process, some type of summary data or tracking database is needed to determine if all individuals who were supposed to have these opportunities were indeed presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work was needed to have these discussions be more comprehensive and meaningful. Finally, although not solely related to education about community placements and providers, SASSLC had a self-advocacy group. A new facilitator was assigned during the week of the onsite tour. This presents possible opportunities for education regarding community placement (also see section E above).	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least	This provision item required the facility to assess individuals for placement. A process or tool for doing so did not exist at SASSLC. The facility did not provide the monitoring team with any relevant information regarding assessing individuals for placement or a	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	listing of individuals who had been assessed for placement. The facility was awaiting guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. The CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The Monitoring Panel will discuss the expected criteria further, and would like to discuss this with DADS and DOJ in further detail. Ensuring adequate transition planning will require looking at the entire transition process from start to finish. Part of the problem at this time is that teams are only beginning to define important and critical supports and services (called essential and nonessential supports in the CLDP process) at the time the CLDP is developed. If this process started earlier, specifically when the PSP is developed (especially for those individuals who are referred during the annual PSP), then the CLDP would flow from the essential and nonessential supports that already had been identified. Generally, transition planning should start at least at the point of referral. This would allow for transition activities, such as visits to providers and the supports needed with that process, to be defined, and for individualization to occur with regard to numbers of visits to potential providers, training to the provider staff, and so forth. Finally, starting over in the CLDP process (in terms of defining needed supports) also means that supports and services that individuals need are likely being missed or not adequately defined.	Noncompliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST submit a current assessment and/or discharge summary for inclusion in the CLDP. Overall, processes were in place at SASSLC for this provision item. The limited number of cases (three CLDP documents, no CLDP meeting), combined with the upcoming revision to state policy, resulted in this provision item receiving a noncompliance rating. It is possible that this item will obtain substantial compliance following the policy update and implementation, and when additional examples of SASSLC's development and implementation of CLDPs are reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		At SASSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits, exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports. The CLDP activities were coordinated and managed by the APC. She gathered documents, put together a draft CLDP, and organized and ran the meeting. Unfortunately, a CLDP meeting could not be observed by the monitoring team because no CLDP meetings were scheduled during the week of the onsite tour. Recently, the CLDP was revised to include updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet, but the CLDP document itself now only included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. Three CLDPs were reviewed for the individuals listed under the "Documents Reviewed" list at the beginning of this section of the report. These were all of the CLDPs at SASSLC. At SASSLC, the CLDP document was an appropriate length and contained a great deal of information about the individual, including for example: • behavioral issues • adaptive equipment • diagnoses • medications • history • a summary of assessments (e.g., social, medical, psychological, daily living skills, vocational, leisure and recreation) • specific steps taken during the placement process, including individual, family, MRA, and SSLC involvement; other considerations; and homes considered • essential and nonessential supports • signatures from the SSLC, MRA, and Provider • a description of monitoring activities • agreements The three SASSLC CLDPs indicated that the individuals were fully involved in the process	

#	Provision	Assessment of Status	Compliance
		of visiting homes, selecting providers, and planning their transitions. It appeared that attempts were made to ensure that all relevant and important information was shared with the new providers and that support was provided to the individuals and their new providers by SASSLC during the transition period. The monitoring team was pleased to see that DADS central office had reviewed the most recent CLDP and had provided valid and useful comments and feedback to the APC. DADS central office had reviewed the CLDP for Individual #329 and provided a one-page listing of comments that addressed the need for additional information and a clearer writing style, as well as information addressing the individual's behavioral history. In addition, the note included many questions regarding the essential and nonessential supports section of the CLDP, that is, whether a number of different supports needed to be added to the list in the CLDP. After receiving these comments, the APC made changes as appropriate to the CLDP. The monitoring team hopes that this type of feedback can become a regular component of the training given to APCs, and a regular part of the quality assurance procedures for this provision.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and facility director had responsibility and had agreed to the contents of the CLDP. Each CLDP also referred to a specific date for moving to the new placement.	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.	Signatures indicated that guardians or LARs (when any existed or were appointed) were informed of the CLDP and participated in the process. A signature of the individual was included in each of the CLDPs.	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.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. In order for this item to be in substantial compliance, however, some sort of checklist or tracking tool needs to be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing. The assessment documents for the three individuals for whom CLDPs were developed were reviewed in detail. Although numerous assessments were included, it was not	Noncompliance

#	Provision	Assessment of Status	Compliance
		possible for the monitoring team to determine if these assessments represented the full set of assessments relevant for the individual, however, they appeared to be comprehensive and relevant. The APC reported that she knew which assessments were required and that discharge summaries were also required for all disciplines (this was a new requirement). That is, even if an assessment had been done within the past year, an updated summary was required, too.	
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.	It was the understanding of the monitoring team that upcoming changes in the policy on most integrated setting practices would include a focus on improving the process of identifying and following up on essential and nonessential supports. A review of the updated policy and procedure, and its implementation at SASSLC will be required before this provision item can be considered to be in substantial compliance. A key part of the community placement process was the identification of essential and nonessential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Nonessential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all nonessential supports needed to be in place and addressed. Nonessential did not mean not needed. The APC and the PMM described the facility's process for creating a list of essential and nonessential supports to be a work in progress. They described the process as occurring during the CLDP meeting. The APC reported that she also reviewed the individual's assessments in an attempt to ensure that the CLDP content was consistent with the assessments. The MRA was responsible for ensuring that all essential supports were in place prior to the day of the individual's move. This responsibility was to soon become the facility's. This is likely to be more beneficial for the individual and for the transition process because of the facility's extensive knowledge about the individual, and because the facility will continue to be responsible for the post move monitoring of these supports. Each of the three SASSLC CLDPs had a table that listed out essential and nonessential supports. Specific staff at SASSLC and at the provider agency were identified by name. The table included target dates for putting these supports in place. The table listed 10 areas of supports (e.g., residential, vocational, safety). These pages were completed similarly, but not identically, across all CLDPs. Some of the supports were the same in	Noncompliance

#	Provision	Assessment of Status	Compliance
		every CLDP (e.g., nurse to nurse contact, BSP inservice) and some referred to bureaucratic processes (e.g., site review by MRA, 30 days of medication). Even so, there was some individualization in these three lists of supports. Some of this individualization was in reference to personal preferences of the individuals. Other individualization was related to medical needs and staff training. Nevertheless, SASSLC should take steps to ensure that the list of essential and nonessential supports is comprehensive, clear, and complete. This is especially important because the essential and nonessential supports section of the CLDP provides the facility with its one chance to ensure that certain aspects of support will be provided to the individual. If an important support is left out this listing, the facility has no way of following up on it and requiring the provider to put the support in place. Therefore, this component of the CLDP is very critical to the ongoing success of each individual's placement. This will require a thorough reading of all assessments and assessment updates in addition to the current procedure of developing the list from CLDP meeting participants' discussion during the CLDP meeting. In addition, some supports were written in a way that made them difficult, if not impossible, to measure or observe. As a consequence, the ability of the post move monitor to objectively determine their presence or absence became similarly difficult and certainly unreliable (also see section T2a of this report). Improvements to this portion of the CLDP process might include a more detailed listing of essential and nonessential supports during the living options discussion at the PSP meeting for those individuals who have been, or are likely to be, referred for placement. It is expected that the essential/nonessential section of the CLDP process will be modified at SASSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or nonessential supports, • define each of these essential and nonessential supports in more detail, and • specify the support in a manner that can be measured or verified.	
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	There was no quality assurance process in place at SASSLC regarding this section T of the Settlement Agreement. Moreover, the data collected by the post-move monitor was sent to DADS central office and not used at the facility level (although it was unclear as to what data were sent because no examples were given to the monitoring team).	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans for which the Facility is responsible, consistent with the provisions of this Section T.		
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	SASSLC was not in compliance with this provision item. SASSLC was not gathering, and was not analyzing, information related to identified obstacles to individuals' movement to more integrated settings. Please also see the discussion in section T1b1 above. SASSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. At the time of the onsite monitoring visit and subsequent preparation of this report, DADS was in the process of developing an assessment and report to meet the requirements of this provision item. The monitoring team appreciated having had the opportunity to review a draft of this document and provide suggestions to DADS.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be	A community placement report was not issued to the monitoring team. No information or documents were submitted in response to the monitoring team's request regarding this provision item. Although not required by this provision item, the monitoring team recommends that the facility's placement report also include a listing of individuals whose PSTs indicated would be good candidates for placement, but were not referred, as well as individuals who themselves expressed a desire to move to the community, but were not referred (see section T1a above).	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		
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	SASSLC was implementing the post-move monitoring process, including the appointment of the post-move monitor approximately six months ago. The post-move monitor was knowledgeable about many of the individuals, the local providers, and the CLOIP process. Visits occurred regularly and checklist forms were completed. The post- move monitoring process, however, was relatively new at SASSLC and a number of the post-move monitoring visits were conducted beyond the 90-day deadline for individuals who were placed more than six months ago and, as a result, this item was rated as being in noncompliance. Individuals placed more recently had their post-move monitoring visits completed within the required timelines. Completed post move monitoring checklists were reviewed for a total of 10 individuals:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	the three individuals who moved within the past six months, five individuals placed more than six months ago, and two individuals placed from other SSLCs within the SASSLC post-move monitoring catchment area. Overall, the reports indicated that essential and nonessential supports were in place or there was a plan for them to be put in place. Each post-move monitoring visit included a visit to both the residence and day program of the individual, according to the PMM. This information was not, but should be, included on the post-move monitoring checklist. A review of the post-monitoring visit checklists indicated that the PMM follow up on items that were not yet in place. For example, the 7-day visit for Individual #102 indicated that his personal calendar was not in place. The PMM made a visit to the home a week or two later to ensure it was in place, rather than waiting until the 45 day visit was scheduled. Further, any items that were rated as not being in place included a description, albeit brief, of the follow up that was to occur. For the 7-day post-move monitoring checklist for Individual #329, the PMM added a target date for items that were not yet required to be in place, such as "Trust fund transfer 9/1/10." This was helpful information because it indicated that a "no" rating was really not accurate or reflective of the status of the item. Even so, the checklists did not contain much detail regarding the checklist items. Most items were checked as Yes, but no supportive or background information was provided. Further, evidence indicating that essential and nonessential supports were in place was not described, obtained, or attached to these checklists. The PMM indicated that she assessed evidence of presence of the supports by (a) obtaining documentation, (b) her own knowledge of its presence, or (c) observing documentation. The facility should consider having the CLDP process include a specification of the manner in which the PMM determines the presence of each essential and nonessential support and the type of evidence that must be provided by the PMM. The checklist had a column for NA. According to the key, this was to indicate "not a support identified in the CLDP." Many items, however, were scored NA, even for items that did not refer to specific CLDP supports, such as staff training. This appeared to the monitoring team to be a problem, that is, there are many areas for which NA cannot, and should not, apply. Staff training in all aspects of an individual's life is one of them (e.g., hygiene, mobility, communication, adaptive needs), even for individuals who are competent and capable. Consider that Individual #162 had a failed placement (described in more detail immediately below) that was due, in part, to his preference and ability to independently walk around the neighborhood (as far as was understood by the	

#	Provision	Assessment of Status	Compliance
		monitoring team). This related to mobility; an area that was marked NA on the checklist. Perhaps more consideration of this area would have led to better and more appropriate supports for this individual. There were no individuals who had returned to SASSLC after placement. One individual, however (Individual #162), moved out of his placement in an adult foster home and into a group home only one month after moving from SASSLC. The APC and PMM reported that characteristics of the foster home were not in line with some of preferences and skills (e.g., walking independently in the community). It was unclear to the monitoring team as to whether this could have been avoided with more detailed planning during the referral, CLDP, and post-move monitoring processes. Therefore, SASSLC should conduct a formal review of this failed placement to determine if other actions could have been taken, and to inform SASSLC regarding improving its referral and CLDP practices for future referrals. Fortunately, the individual was moved to a small group home (operated by the same provider who managed the foster home) and appeared to be stable at the time of the onsite monitoring tour. The PMM maintained contact with the individual and provider beyond the 90 days in order to help facilitate the individual's move into the group home. The monitoring team also recommends that the post move monitor have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. The PMM reported that she had a very good working relationship with the providers and had not needed to resort to notifying the MRA, DADS, or any regulatory agency in order to gain their compliance in providing any of the required supports.	
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	As noted above in section T2a, post-move monitoring visits were occurring at SASSLC. This item cannot be rated as in substantial compliance, however, until the monitoring team has had the opportunity to observe an actual post-move monitoring visit. The monitoring team hopes that the facility will be able to schedule a post-move monitoring visit during the next onsite monitoring tour. Nevertheless, the monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of an individual, Individual #329, who had moved to the community within the previous two weeks. The 7-day had already been completed, therefore, this was not an official post-move monitoring visit. The monitoring team thanks the post-move monitor and the community agency for making arrangements for this visit to occur and for talking with the monitoring team about the individual's transition. The purpose of this visit was to learn about the post-move monitoring	Not Rated

#	Provision	Assessment of Status	Compliance
	the 90th day following the move date.	process, see the community home, meet the individual, learn about the transition and services, and see the status of some of the essential and nonessential supports. The home was operated by CALAB, a local for-profit provider that had been providing HCS residential services since 1996. This home was opened on 7/1/10 and the individual lived with three others. The home was nicely furnished. The program director, house manager, and two new staff trainees were also present during this visit. Individual #329 appeared happy, gave a tour to the monitoring team, and described his activities at home and at work. He said he was happier at this home and could do more for himself than he could do at SASSLC. During the day, he went to work or to the agency's day habilitation program. The program director and PMM described how staff were trained on the individual's BSP, the counseling sessions that were to start the following week, and how his medical conditions were being monitored. The monitoring team observed that BSP data were being kept each day and were recorded right up to the time of this visit, and that daily notes were kept in a logbook. Overall, the transition appeared to have gone smoothly for the individual and the new provider. The PMM also reported that the individual seen during a group home visit during the baseline monitoring tour was also doing very well. The PMM reported that she exhibited few problem behaviors, went on frequent activities in the community, and attended a day habilitation center each day.	
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.	There were no individuals at SASSLC to whom this provision item applied. There were five individuals who were considered to be alleged offenders, but they had been admitted to the facility many years ago and, therefore, this provision item did not apply to them.	

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

Recommendations:

1. Implement updated policies and procedures when they are disseminated.

2. Consider whether to develop any facility-specific policies and procedures related to this provision of the Settlement Agreement. If any are developed, ensure the facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state

policies that add to, or supplement, state policies.

3. Ensure that the opinions of professionals (i.e., PST members) are considered when determining most integrated settings. Further, ensure that the PST follows state and facility policy regarding referrals, reporting of obstacles, and acting when there is a lack of team consensus.

4. Collect information regarding those individuals as indicated in section T1a, including those for whom the PST believes community placement might be appropriate, and those individuals who have requested referral, but were not referred. Consider conducting a thorough review of the CLOIP worksheets and the PSP LOD record. This information should then be used by SASSLC management, and by the APC.

5. Ensure that senior management at SASSLC is regularly informed of the status of referrals, move dates, CLDPs, rescinded referrals, and other actions of the APC and the admissions and placement department.

6. Develop a quality assurance process for this provision. Ensure that relevant information is submitted and monitored by the QE department. Ensure that quality assurance processes are applied for all of section T, including but not limited to T1g.

7. Review the job tasks of the APC to ensure that she is able to address the requirements of this provision, especially regarding the referral and placement activities for the individuals at SASSLC.

8. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community. Move LOD to the beginning of the meeting. Ensure that the LOD is thorough and meaningful. Ensure that the LODR is an accurate reflection of the LOD.

9. Identify and address the identified obstacles to individuals' movement to the most integrated setting:
    a. within the PSP meeting LOD for each individual,
    b. across the facility by conducting a comprehensive assessment, and
    c. by developing actions from DADS as required by provision item T1g..

10. Continue to work on education of individuals and LARs regarding most integrated setting practices.
    a. Determine measureable outcomes for the provider fair.
    b. Increase the number of individuals who go on tours to community providers. Track the individuals who go on specific tours to ensure that the tour is an appropriate one given the needs of each individual.
    c. Determine measureable outcomes for the CLOIP process to ensure it is achieving its stated purposes.

11. In the self-advocacy meetings, include discussion regarding choices, decision-making, and problem solving related to, at a minimum, rights and community placement. Consider doing the same, or similar, at home meetings.

12. Develop and implement a checklist to ensure that all required assessments have been submitted and included with the CLDP.

13. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Consider ways to begin developing the list of supports prior to the CLDP meeting.
    b. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.

i. define each support in observable and measureable terms.
ii. define the manner in which the presence of each support will be verified.

c. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.

14. Consider making DADS central office review, comment, and feedback on CLDPs a regular, ongoing practice.

15. Create an assessment for placement as required by this provision.

16. Utilize the data collected by the PMM regarding the living options discussion of the PSP meetings.

17. Revise the post-move monitoring checklist to include detail regarding (a) each of the sites visited, (b) how the presence or absence of supports was assessed, and (c) follow up activities for both essential and nonessential supports.

18. Provide opportunities for the post-move monitor to network with other post-move monitors at other facilities.

19. Create a Community Placement Report and consider including additional information as noted above in section T1h.

20. Examine whether funding is the sole obstacle to the placement of the individual described above.

21. Examine the failed placement of the individual described above to determine if any improvements should be made to the referral and transition processes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC Rights Assessment o Inventory for Client and Agency Planning o PSPs listed in Section F of this report Interviews and Meetings Held: o Laurence Algueseva, Rights Officer o Jane Dahlke, QMRP Coordinator o Rosella Kleiwer, QMRP o Karla Baker, QMRP Michael Wong, QMRP o Observations Conducted: o Observations at all residences o Observations at the onsite workshop, prevocational program, and Forever Young program o PSPA Meeting for Individual #276 o PSP Meeting for Individual #212 o Self Advocacy Meeting 8/16/10
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The facility had not begun to formalize a process for identifying individuals in need of LARs or identifying resources for finding guardians. A self-advocacy meeting was observed during the monitoring visit. The meeting was well attended and the individuals in attendance appeared to enjoy participating in the meeting. The staff person that assisted with facilitation of past meetings was no longer working at the facility and officers of the group had been recently elected, so the meeting had little focus. The new facility Rights Officer had just been appointed and planned to continue to assist the group.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility had not yet developed a list of individuals that needed LARs. A new Rights Officer was hired the week of the onsite monitoring visit. He will be responsible for the development of a process to address this provision item. A review of PSPs at the facility revealed that the PST teams discussed guardianship and made some initial efforts to obtain LARs for individuals, but the process had not been formalized. PSTs administered rights assessments for each individual and results of the rights assessment were summarized in the PSP. Any restriction of rights was reviewed by the facility Human Rights Committee (HRC). It was evident from a review of minutes of the HRC meetings that the committee did not automatically approve each request for restrictions. The HRC requested more information and made recommendations when appropriate.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities	This process had not yet been formalized at the time of the onsite monitoring visit.	Noncompliance

#	Provision	Assessment of Status	Compliance
	seeking to advance the rights of persons with disabilities.		

Recommendations:

1. Develop a prioritized list of individuals who need LARs
2. Develop a list of LAR providers in the area.
3. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.
4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SASSLC Consumer Record, Policies and Procedures Manual, dated 5/11/10, rev. 5/13/10 o SASSLC Master File Checklist, dated 8/26/10 o Packet of materials used for staff training regarding recordkeeping practices o Completed record audits done by Noemi Cardenas in July 2010 for five individuals o Active records of many individuals who lived at SASSLC o Review of active records and individual notebooks of: • Individual #349, Individual #15, Individuals listed in section M Interviews and Meetings Held: o Janet Prince Page, Coordinator of Consumer Records o Noemi Cardenas, Unified Records Coordinator o Larrie Collier, Director of Quality Enhancement o Records clerks for two homes: • Stephanie High, Josephine Tarin o Numerous staff and clinicians at all levels, including • Mary Ventura, Gevona Hill, Pam Walsh, Joyce Sanchez, Veronica Mata, Marc Suarez, Steve Trevino, Ali McHinda, Mark Boozer, Andrea Blue, Rose Martinez Observations Conducted: o Records storage areas in residences o Records storage areas in administration building
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: SASSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented for some, but not all, individuals in every one of the homes. The new records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and a checklist of

	required/typical documents was used to ensure consistency across individuals. The Coordinator of Consumer Records and the Unified Records Coordinator were both committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records and were interested in improving the records as implementation of this new system moved forward. SASSLC should ensure that record keeping is tied into the facility's quality enhancement program and that quality assurance activities occur related to record keeping. Moreover, it will be important for SASSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. Management of the individual notebooks may become a challenge, especially regarding whether the size of the notebooks competes with the goal of having information readily available to direct support professionals. A system for auditing a sample of records every month was in place beginning in July 2010. The reviews were conducted by the URC and appeared to be thorough. The auditing process should be coordinated with the QE department so that the checklists used are the same. A system for ensuring that problems identified by the URC's audit are corrected. The monitoring team looks forward to SASSLC's implementation of the new record keeping policy and practices.

#	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.	SASSLC made progress in this area and established a unified record according to DADS policy for some, but not all of the individuals. Therefore, the rating for this provision item is noncompliance. DADS developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. SASSLC adopted this policy in whole and incorporated it into their facility policy that was titled "Consumer Record, Policies and Procedures Manual." It was revised 5/13/10 and was quite lengthy. SASSLC should ensure that the contents are in line with the DADS policy and, further, approval from DADS central office should be obtained. The monitoring team looked to see if SASSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement	Noncompliance

#	Provision	Assessment of Status	Compliance
		Agreement. At the time of the onsite tour, the unified records coordinator reported that SASSLC had converted approximately 60% of the records. Rather than going home by home, SASSLC had converted some of the records at every home. This exposed all staff to the new records, but also left all homes with both record systems in place during this transition period. The unified records coordinator estimated that all records would be converted by the end of September 2010. The records that were converted to the new system consisted of • Active record • Individual notebook • Master record • Overflow files The facility's records activities were overseen by Janet Prince Page, Coordinator of Consumer Records (CCR), and Noemi Cardenas, Unified Records Coordinator (URC). The URC was in this position for less than a year, but had worked at SASSLC for more than 30 years, primarily as a records clerk on the homes. She was very familiar with record keeping practices. In addition, there were eight records clerks at the facility, one for each home. The records clerks had primary responsibility for managing and maintaining the records under the direction of the URC. The CCR and URC described their primary goal as meeting the new policy. The URC described a process of staff training and shared the documents that she used for this training. The training addressed the new policy, the main components of the unified record, the new tables of contents for the active record and individual notebook, and issues around falsification of records. She reported that 84% of the staff on campus had been through this training. In addition, the URC described an in-depth training provided to the records clerks. It was a full day of training that included the assembling of a new active record and new individual notebook. The monitoring team had the opportunity to speak with a number of the records clerks as well as with many staff and clinicians at all levels regarding their experiences with the new record keeping systems. Their comments are summarized below in this section of the report. The CSS and URC liked that the data entry components of the record were in one place and that documents were now ordered in order with the most recent document on top. They also liked the new appearance of the active record. They reported that they had received a good response from staff and managers at the facility.	

#	Provision	Assessment of Status	Compliance
		The monitoring team was pleased to hear that the URC maintained frequent contact with URCs at other facilities, in this case, with El Paso SSLC and San Angelo SSLC. <u>Active records</u> The new active records varied in size based upon the amount of information in the individual's record. Most records contained three three-inch binders. Some contained only two binders, and others contained four binders. The active records were divided across the binders in the same way for all individuals. The active records were constructed following the order of sections from the state's table of contents. The integrated progress notes and physicians orders were together in the records, and for individuals with four binders, these two sections comprised the third binder, making it relatively easy for clinicians to access this information and to make entries. In the opinion of the record keeping staff, the active records were neater, more organized, and information was easier to find. They reported that the new plastic tabs were sturdier than what they had been using. The monitoring team looked at more than a dozen of these new records across the facility. Two records were reviewed in some detail and appeared to be representative of the full set of records that had been converted to the new system (Individual #349, Individual #15). This review found some problems in these records, indicating that SASSLC still had a lot of work to do to meet the requirements of this provision beyond the transfer of records into the new formats. Below are comments regarding this review. • The rights assessment section was empty. It should have had the rights assessment in it. • The consents section had a number of consents in it, but there was no way to know if the consents in this section represented all of the consents that should be present. Some sort of checklist should be created so that the records clerk (and program auditors) can determine if all consents are present. • The habilitation section contained a lot of information. Similar to the comments immediately above regarding consents, the monitoring team was unable to determine if any habilitation consultations or notes might have been missing. • The BSP's HRC review had expired. The one in the record was approved in 12/08 and therefore had expired in 12/09. • The section on community was empty. It was unclear if this was appropriate or if documentation was missing.	

#	Provision	Assessment of Status	Compliance
		• The record, however, contained a lot of useful information. For example, the physician's orders, integrated progress notes, and daily approval of hand mitts appeared to be correct and up to date. • In the medical records: o documentation of the time of day using the 24-hour clock or am and pm was not consistently and completely implemented. o there was unclear documentation of transcription of all physician's orders, including 180 day orders. o IPNs often had multiple blank lines at the bottom of pages. o Number corrections were entered in the record without using established procedure to make the entries. Errors or mistakes are to have a single line drawn through them with initial, date, and time the error was made and the corrected information entered. Late entry procedure may be required. o Individual #227's 180 day physician's orders had an additional signed order for Prostat 30 ml via g-tube three times daily added on 8/7/10. It was unclear when and by whom the order had been transcribed. o Individual #92: Of 23 IPN entries from 7/9/10 through 8/9/10, thirteen were without the time of the entry documented. o Individual #306 had numerous IPN entries by nursing staff that did not include the time of the entry for example on 7/31/10, 8/3/10, 8/6/10, 8/9/10, 8/11/10 and 8/12/10. o Individual #288's June 6/10 weight measure was corrected from 80 pounds to 88 pounds by writing an eight over the zero. o Individual #197's record had a change of the day on a 7/1/10 integrated progress note from a one to a six, and a 6/9/10 IPN changed a two to a three for the number of days her Augmentin was to be received after hospital discharge. o Individual #343 had frequent IPN entries without the time of the entry documented, 6/10/10-6/22/10. <u>Individual notebooks</u> Individual notebooks were in place as per the state's policy. The individual records reviewed by the monitoring team appeared to contain everything required by the state's table of contents. This, however, led to the notebooks being very full (nearly exceeding the capacity of the one-inch binders) and thereby heavier and more cumbersome than the planners of this system likely anticipated. The purpose of the individual notebooks was to ensure that all relevant information was at hand for direct support professionals. SASSLC will need to ensure that this is the case, that is, that the notebooks serve their intended purpose. This may require obtaining	

#	Provision	Assessment of Status	Compliance
		regular feedback and suggestions from direct support professionals and management staff at the homes and day programs. The CSS noted that a staff questionnaire is implemented periodically and it contains an opportunity for the staff to provide suggestions. More effective, however, would be to directly seek out staff opinions regarding the new recordkeeping systems. For example, the monitoring team learned that many of the staff found the individual notebooks to be cumbersome and to be particularly unwieldy during community outings. The monitoring team was also concerned as to whether this might be counter-therapeutic for some individuals, whether this might distract staff from attending to the individuals, and whether it would create a negative stigmatizing effect, especially when multiple notebooks were transported by staff in a wheeled backpack on outings to places such as Fiesta and SeaWorld. <u>Master records</u> A master record was kept for each individual. Some of the items in the master record were used regularly by some of the departments at SASSLC, such as psychology. The record keeping staff made sure that documents were available as needed. SASSLC created and used a checklist that listed the documents that should be in each individual's master record. This helped the contents to be consistent across individuals. Examples of items on the checklist included birth certificate, social security cards, burial policies, and original documents regarding determination of disability. <u>Overflow files</u> Documents taken from each individual's records were stored and managed by the record keeping staff according to the record thinning schedule provided by the state. <u>Comments from staff</u>: Below are summarized comments from the many staff who spoke with the monitoring team. SASSLC management should consider these comments as they move forward with continued development of the new recordkeeping practices at the facility. • The new active records were an improvement from the previous version. • The new tabs were sturdier than what was used in the previous version of the records. The new tables made it easier to find sections and documents. • Placing newer documents on top of older documents made it easier to review and manage the documents. • The individual notebooks were good to have because they went with the individuals around campus and, therefore, staff were able to record behavior. • On outings, however, the staff were carrying too much information and the	

#	Provision	Assessment of Status	Compliance
		books were too cumbersome. Staff had to bring all of the individual notebooks along in a wheeled backpack. • Sometimes staff were documenting in the record when on outings instead of interacting with the individuals. • It would be better to keep the data sheets for skill acquisition teaching plans back to the date of the PSP rather than for only the previous three months. • There were concerns about the individual notebooks being lost or misplaced. • Individual notebooks created an extra challenge because the records clerk had to make sure that all updated documents got into the individual notebooks after being placed into active record	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy. DADS maintained a spreadsheet indicating the status of policies, protocols, and procedures for each provision in Part II of the Settlement Agreement (i.e., sections C through V).	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	A quality assurance and quality enhancement procedure to ensure a unified record was not in place. SASSLC's quality enhancement department needs to be involved in addressing this provision item. Even so, the URC conducted five audits of individual records in July 2010. This was her first time doing these audits. Her plan was to do a review/audit of the unified record for five individuals each month. The audits were based upon the monitoring team's checklist for this provision of the Settlement Agreement and the URC's own checklist. The monitoring team was pleased to see that these activities were occurring. The URC's own checklist was different than the record audit form used by the QE department. The URC and QE should coordinate their reviews so that they are using the same form for assessing the components and quality of the components of the unified records. A review of the five audits indicated that they included a lot of useful information for program managers. The URC appeared to have done these reviews thoroughly. A method needs to be put in place to ensure that feedback is received by the program and that the items noted in the audit have been corrected.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, SASSLC should get feedback and suggestions from staff who use the records. This information can be used to improve the record keeping system and components. Implementation of the new record keeping system had only occurred a few months prior to the onsite monitoring visit. Once staff have used the system, useful feedback can be obtained from clinicians, managers, and direct support professionals. This will be especially important for the ongoing usage of the individual notebooks.	
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.	The facility did not have a means to assess this provision item even though the URC's audits indicated that this was occurring. Her criterion was whether entries were included in the integrated progress notes. This was a useful, but not sufficient way to determine whether this provision item is being met. The addition of individual notebooks should improve the integrity of behavioral data collection by decreasing the time between the occurrence of a behavior and it being recorded (see K4). Nevertheless the monitoring team noted that the individual notebooks were either not with individuals (vocational workshop example K4), or were kept in locked rooms (K4) Within the medical records there were many areas that required attention if records are to be useful in making care, medical treatment, and training decisions: • The new flow sheet forms to track health issues to resolution did not provide adequate direction or space for both the data and the initials of the nurse making the entry. Several forms such as the enteral nutrition flow sheet did not have a designated space for the date and/or the individual's name. For example, Individual #306 had no name on her July enteral nutrition flow sheets. The flow sheet form had no area designated for the individual's name. • Although nursing recordkeeping practices were improved from the baseline review, forms for tracking health status information, such as neurological checks, intake/output, diabetic records, and seizures continued to be disorganized, incomplete, and inconsistently referenced as reviewed by clinical professionals. Also see nursing sections M1 and M4 for examples. • Individual notebooks were frequently found in records rooms or were located in the residence after the individual had left for other activities. During the observation of psychiatry clinic, the nursing case manager and the psychologist provided the psychiatrist with historical data verbally. There were some instances where the psychologist provided information regarding target symptoms via a grid with numbers of specified target symptoms occurring within a reporting period. There were also some rudimentary graphs reviewed, however, with no specific	Noncompliance

#	Provision	Assessment of Status	Compliance
		definitions of the target symptoms being monitored, and no inclusion of noteworthy events (i.e., medication changes, situational stressors), these graphs were not overly useful. There was another challenge, specifically the lack of computer data access. The two physicians, who had been providing services for an extended period of time, had their personal computers with them during clinic. While their personal data was not provided for review as part of this monitoring, they verbally reported having a plethora of historical data regarding the individuals on their caseload. In fact, during two clinic observations (with the same physician), the physician reviewed the personal computer files and was not noted to review the individuals record. Given the presence of this data, it may behoove the facility to determine the accessibility of this data, and how this information can be protected via facility servers and utilized by all psychiatrists in clinic. In doing so, the facility may also want to investigate allowing the psychiatrists read only access to psychology data to allow for better integration and collaboration.	

Recommendations:

1. Complete the conversion of all individual records to the new system.
2. Ensure facility policy is in line with state policy. Obtain approval from DADS central office.
3. Assess individual notebooks to ensure they are being used as intended, that their size is not too large for the notebooks to be useful, and the manner in which responsibility for carrying the notebooks is assigned.
4. Complete the development of policies as described in provision item V2.
5. Incorporate record keeping activities into the facility's quality enhancement program, including ensuring the data collected by the URC during her record audits are included in the QE program.
6. Regularly modify checklist audit tool based upon the findings of record audits, such as adding detail to the checklist regarding consents and habilitation section contents.
7. Develop a method to ensure that any needs or problems identified in the record audits are corrected.
8. Obtain feedback and suggestions from those staff who regularly use any components of the unified records.
9. Ensure records are used in making care, medical treatment, and training decisions.

10. Provide a master medical record in each nurses' station with not only instructions on where to file/find items but also on how to fill out forms and functionally use them.

11. Label all forms with version/date, and remove access to all old forms in nurses' stations.

12. Data should be presented graphically, over a period of time reflecting data collection prior to the start of or adjustment of medication as well as following a medication adjustment.

13. Review the personal data collection of the two long-term facility psychiatrists. Determine how that information can be transferred to the facility services for security and then shared with all facility psychiatry physicians.

14. Provide read only access to psychology documentation for psychiatrists in an effort to increase collaboration and integration of services.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABLLS-R	Assessment of Basic Language and Learning Skills - Revised
ACLS	Advance Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADA	American Diabetes Association
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AIMS	Abnormal Involuntary Movement Scale
AMS	Annual Medical Summaries
ANE	Abuse, Neglect, Exploitation
APS	Adult Protective Services
APC	Admissions and Placement Coordinator
ARD	Admissions, Review, and Dismissal
ASA	Acetylsalicylic Acid (Aspirin)
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a day
BLS	Basic Life Support
BMD	Bone Mineral Density
BMI	Body Mass Index
BSP	Behavior Support Plan
CAM	Controlled Ankle Motion
CAP	Corrective Action Plan
CBC	Complete Blood Count
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCR	Coordinator of Consumer Records
CDDN	Certified Developmental Disabilities Nurse
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPAP	Continuous Positive Airway Pressure
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act

CV	Curriculum Vitae
CZP	Clonazepam
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DASI	Dysphagia Management System
DCP	Direct Care Professional
DCS	Direct Care Staff
DEXA	Dual-energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM-ID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DVT	Deep Vein Thrombosis
e.g.	exempli gratia (For Example)
EKG	Electrocardiogram
ER	Emergency Room
ESRD	End Stage Renal Disease
FLACC	Face, Legs, Activity, Cry, Consolability
FTE	Full Time Equivalent
FY	Fiscal Year
G	Gram
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
HAB	Habilitation
HCG	Health Care Guidelines
HCS	Home and Community-based Services
HMP	Health Maintenance Plan
HPV	Human Papillomavirus
HRC	Human Rights Committee
HST	Health Status Team
IBWR	Ideal Body Weight Range
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IM	Intra Muscular
IMT	Incident Management Team

IOA	Inter Observer Agreement
ISP	Individual Support Plan
IPN	Integrated Progress Note
IV	Intravenous
LAR	Legally Authorized Representative
LBS	Pounds
LOD	Living Options Discussion
LODR	Living Options Discussion Record
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
LZP	Lorazepam
MAR	Medication Administration Record
MBS	Modified Barium Swallow
MD	Medical Doctor
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MMR	Measles, Mumps, and Rubella
MOSES	Monitoring of Side Effects Scale
MOT	Masters, Occupational Therapy
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphyloccus aureus
MS	Master of Science
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NPO	Nil Per Os (nothing by mouth)
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Polyethylene Glycol
PET	Performance Evaluation Team

PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTA	Physical Therapy Assistant
PUSH	Pressure Ulcer Scale for Healing
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SAISD	San Antonio Independent School District
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Structured Program Objective
SPOI	Supplemental Plan of Improvement
SSLC	State Supported Living Center
TCID	Texas Center for Infectious Diseases
UIR	Unusual Incident Report
URC	Unified Records Coordinator
USPSTF	U.S. Preventive Services Task Force
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulation
WBC	White Blood Cells