United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

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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 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 (SA), 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, and 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 State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Health Care 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 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, at-risk procedures, 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, restraint, 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, recordkeeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, at-risk individuals, and for a variety of other sections of the report.

The Monitor's role is to assess and report on the State and the Facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes might 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, 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 review. The Monitoring Team made additional requests for documents while onsite.

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 (CLDPs), 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 onsite, 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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 review. 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, was, as always, supportive of the monitoring team's activities throughout the week of the onsite review. He was readily available, ensured that all requested information was obtained, and directed all of the

staff to work cooperatively and openly with the monitoring team. For example, he was available to members of the monitoring team for individual and/or group meetings throughout the week.

The monitoring team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Moneke Tyner. She worked tirelessly during the week of the onsite review, as well as during the weeks immediately proceeding and following the onsite review, to ensure that the monitoring team members were able to obtain the information they needed to conduct this review. The monitoring team was particularly appreciative of the improvement in the organization and presentation of the many documents requested by the monitoring team throughout this process compared to the previous onsite review.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. 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.

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 review. 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, the Settlement Agreement required the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. The facility did so and, in the monitoring report below, the Monitor describes and comments upon the self-assessment steps the facility undertook to self-assess compliance and the results of this self-assessment. This is provided for each of the 20 provisions of the Settlement Agreement. At SASSLC, the self-assessment document was called the POI (Plan of Improvement). The format of the POI was revised since the last onsite review and was a major and noticeable improvement from the previous more lengthy version.

The POI, being a new document and requiring a new process, was completed only two weeks prior to this onsite review. The intent of the POI is that it is completed immediately following the onsite review and then is updated even further once the facility receives the written report from the Monitor. In this way, the POI can be fully informed by the monitoring team's activities (onsite and written) and line-up with the monitoring team's comments and recommendations. The Monitor fully understands that this was the facility's first attempt at this new POI and that

facility and DADS staff had been working on this new style POI for a number of months. Therefore, the comments regarding the facility's self-assessment in the below sections of this report refer only to the monitoring team's agreement or disagreement with the facility's recent self-ratings. The monitoring team looks forward to the next POI providing more detail, including indicating the specific activities the facility undertook towards achieving substantial compliance with each of the provisions of the Settlement Agreement.

Fourth, a number of management changes had occurred at the facility since the previous onsite review, additional management changes were occurring during the week of the onsite review, and others were likely to occur over the coming months. Changes in management and leadership are usually disruptive to the stability of operations at a facility, such as SASSLC, however, they also present the opportunity for renewed effort and innovation. At SASSLC, the monitoring team was impressed with the new members of the facility's senior management and senior clinical staff. Each of these new staff appeared competent, energetic, and committed to working towards successfully meeting the requirements of the Settlement Agreement, working in an integrated manner, and contributing to an improved level of service:

- Psychiatry Director
- Psychiatrist
- Dentist
- Clinical Pharmacist
- QMRP Coordinator
- Active Treatment Coordinator

Other leadership and clinical positions were needing to be filled. These included the Chief Nurse Executive, Nursing Operations Officer, full time physician, and human rights officer. In addition, the week of the onsite review was the last week for the Director of Quality Enhancement and Incident Management. Further, the Admissions and Placement Coordinator was likely to retire later this year after many years of service. The monitoring team hopes that the facility is as successful in filling all of these positions as it appears to have been in filling the six positions listed above.

Fifth, SASSLC was struggling with the many new service provision changes that were occurring across all of the DADS SSLCs. These changes included

- New PSP documents and new style PSP meetings
- New Community Living Discharge Plan activities and documents
- New assessment and management of individual at-risk procedures
- New Physical and Nutritional Management Team procedures

Sixth, as detailed in the full report below, SASSLC had made progress in some areas, but a lot of work was still required in order for the facility to achieve substantial compliance in the many provisions of the Settlement Agreement. In this report, the Monitor rated 16 items as being in substantial compliance and 144 items as being in noncompliance (i.e., 10%). As the reader will see below, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are some comments on a few general topics that affected all areas of operation at the facility.

- Direct service staffing. The three unit directors, the assistant director of operations, and the facility director focused on actions to reduce staff turnover by specifically focusing on staff retention activities (also see section E1). The group worked hard over the past six months and data indicated that turnover had reduced from around 60% to 33% at the time of this onsite review. The facility contacted other facilities (e.g., Richmond SSLC) to learn some of what facilities with low turnover rates had been doing. Most impressive about the SASSLC activities was its focus on (a) support for new staff during their first three months, and (b) retention and staff satisfaction. Some of the actions initiated included:
    - Scheduled communication opportunities with direct supervisors and unit directors.
    - Recognition, appreciation, and positive reinforcement .
    - A new employee council that met monthly: a representative from each of the 13 homes met with the ADOP as a group over lunch. Meeting minutes showed that many relevant topics were discussed.

  A stable direct care workforce sets the occasion for progress in the many provisions of the Settlement Agreement because, in large part, direct care staff are required to implement the many clinician- and organization-designed activities (e.g., PBSPs, dining plans, PNMPs, identification of health issues, community integration)
- At-risk and aspiration: SASSLC was just beginning to implement the statewide initiative on the new at-risk policy and procedures, with a specific focus on aspiration and pneumonia issues. Implementation was not yet adequate as evidenced by meeting contents and staff interview as noted in this report (see sections F, M, and O).
- Integration of services. There was a lot of discussion and comment around the facility regarding a desire to meet the provision of integrated clinical services (see section G) and integrated individual program plans (see section F). The new managers and clinicians, noted above, were already engaging in activities towards greater integration. Further work will be required to include all disciplines, and to set the occasion for disciplines to work closely together when needed (e.g., psychology and psychiatry, pharmacy and medical). A recent example was the collaborative and integrated work of psychiatry and dental in addressing pretreatment sedation and desensitization.

- Engagement and activities. The facility continued to make engagement in activities a priority. Some progress was noted (see section S), but an improvement in amount and variety of vocational opportunities, community employment, community activities, and community-based training were still needed.
- Monitoring tools. SASSLC had modified a number of the monitoring teams' checklist monitoring tools and was using some of the tools as modified by DADS central office. These modifications made the tools more user-friendly and appropriate for use by facility staff.

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

Restraints

- The number of restraints, particularly chemical restraints, had increased since the last monitoring visit. A list provided to the monitoring team showed a total of 51 restraints were utilized for crisis intervention involving 16 individuals from 8/1/10 through 12/31/10. Of the 51, there were three mechanical restraints, eight physical restraints, and 40 chemical restraints.
- The facility had not gathered and analyzed data on restraints monthly or produced a monthly or annual report that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred. It was not possible to determine the exact percentage change in number of restraint incidents at SASSLC since the last monitoring visit because data had not been collected in a consistent format.
- The facility indicated that it was looking at restraint reduction. There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, Daily Incident Management Review Team (IMRT) meetings, and Human Rights Committee (HRC) meetings. Three areas of focus were identified by the monitoring team that will be essential in reducing restraints incidents at the facility.
    1. The facility needs a system to gather clear, consistent data on the number of restraints that are occurring at the facility.
    2. Consistent alternative behavioral strategies for crisis intervention need to be clearly stated. Staff should be trained to implement alternative behavioral strategies for individuals who they support. The effectiveness of strategies needs to be monitored and strategies revised when not effective.
    3. The facility had made noteworthy improvements in engagement levels for individuals at the facility (also see section S1 below). The next focus should be upon expanding options in day programs to

include a wider variety of meaningful work and recreational activities at the facility and in the community.

- On a positive note, the dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures through evaluating past use of restraints and developing desensitization strategies for individuals who required the use of restraint during dental appointments.

Abuse, Neglect, and Incident Management

- Investigation of 114 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 6/1/10 through 11/31/10. These 114 cases included 191 allegations involving 102 individuals identified as potential victims, and 127 staff at SASSLC identified as possible perpetrators.
- Of these 191 allegations, 22 (12%) were confirmed by DFPS. Sixteen (8%) additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The other cases included 77 (40%) unconfirmed cases, 15 (8%) cases referred back to the facility, and the remaining outcomes were either pending or not yet included in monthly data reports.
- There were 610 injuries reported at the facility for FY11 1st quarter. This was a decrease of 7% from the 4th quarter in FY10 and a decrease of 6% from the 1st quarter of FY10. Of the 610 injuries reported during FY11 1st quarter, 10 were considered serious injuries (2%), 517 (85%) were non-serious injuries requiring first aid, and 83 (13%) required no treatment.
- Interagency meetings were being held quarterly with SASSLC, DFPS, and OIG administrative personnel. According to minutes from these meetings, concerns noted below in this report were being discussed between the agencies involved. Minutes indicated that DFPS was working on initiating face-to-face contact within 24 hours of the allegation. The numerous cases with lengthy extensions were also discussed at the interagency meetings. These meetings were a positive step towards resolving these issues.

Quality Assurance

- The current QE director's last week at SASSLC was during the week of the monitoring team's onsite review and a new QE director was being recruited. A new QE director will need proper and thorough support and direction in order to maintain the facility's progress. Specific suggestions are presented in the report below.
- The development of an initial QE plan was one area in which the facility had made progress. The QE plan listed the topic areas and tools used by QE staff to collect data or to monitor as well as the frequency of review and sample size. The review below specifies the ways in which the QE plan needs to be developed in order to be comprehensive and useful to the facility. A second area of improvement was the entering of QE-collected data into a database and the creation of graphs and tables. A third area was the creation of a QE report that contained some of these data and graphs. Comments are provided below regarding ways to make the QE report a more

comprehensive and useful document. A fourth area of improvement was the initiation of the QAQI Council. A number of meetings had been held since its inception in September 2010. To be successful it will require an operating policy and procedure, a regular agenda of required topics, discussion of relevant topics, review of data, generation of corrective actions, and meaningful participation by members.

- Some of the monitoring teams' checklist tools had been, or were being, modified by the facility to make them more user-friendly for facility staff and thereby more useful. This was good to see and the monitoring hopes this activity will continue for all areas of the Settlement Agreement.
- Staff satisfaction and retention were a focus of the facility over the past six months. Positive results were obtained. A family member/LAR survey was recently initiated and results were only beginning to be received by the facility.
- The self-advocacy group had been meeting each month. A new human rights officer was being recruited to, among other responsibilities, facilitate the self-advocacy group. Meeting minutes indicated relevant topics were discussed. The monitoring team continues to suggest that the forum be used to teach individuals decision-making and problem solving skills.

Integrated Protections, Services, Treatment, and Support

- Achieving substantial compliance will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary, and then a plan to monitor progress will need to be implemented.
- The DADS policy for this section had been revised and approved 7/30/10. QMRPs had attended training and had begun to implement the new style process during annual PSP meetings. The new QMRP coordinator was aware of the challenges facing teams and had begun to look at strategies to facilitate the team planning process and plan development. QMRPs were the team members designated to facilitate meetings and model the new process during the planning stages. It was evident in observing team meetings throughout the monitoring visit that some QMRPs were more comfortable with the new process than others. All meetings observed were lengthy and the teams struggled to cover all information required for PSP development in a reasonable amount of time. It will be important to provide additional training and mentoring to QMRPs to ensure that this process develops into one that is meaningful and productive for the teams.
- While there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaningful day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community.

- Quality enhancement activities with regards to PSPs were in the initial stages of development and revision. 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.

<u>Integrated Clinical Services and Minimum Common Elements of Clinical Care</u>

- Progress was seen in the attention paid to the Settlement Agreement by clinical services staff across the facility. They were more knowledgeable about their relevant provisions and were aware of the need for providing clinical services in an integrated manner.
- A number of specific examples were provided to, or observed by, the monitoring team that showed ways in which SASSLC was making service provision more integrated across clinical service departments. These examples are provided in the report below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided. These are also provided below.
- A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility in engaging in those actions that will lead to, and demonstrate, the provision of integrated clinical services. Moreover, without additional guidance, there will be little consistency across SSLCs and little sharing of best practices. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.
- It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of these provisions.
- 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.

<u>At-Risk Individuals</u>

- The state had taken a number of steps to support positive results in the area of risk management. This included:
  - The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at SASSLC.
  - The new policy included changes in evaluating and addressing risks identified for individuals, designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status.
  - Forms had been revised for identifying and a risk action plan to address risk had been developed.
  - Risk Guidelines had been developed to be used by PSTs in rating risk factors.

    - A new initiative was being implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration.
- Implementation of the revised process began in late January 2011. Training on the new process was provided, but not to all staff. 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.

Psychiatric Care and Services

- The facility has designated a lead psychiatrist who was working to develop policy and procedure that included documentation requirements geared toward meeting generally accepted professional standards of care in psychiatry. While new documentation had been piloted on one home, there were challenges to the implementation of new policy throughout the facility. Given staff interviews, it was apparent that these challenges were related to both increased time commitment related to psychiatric clinic (more frequent clinic with fewer individuals scheduled) as well as increased documentation requirements for other disciplines (e.g., nursing and psychology). In order for psychiatry to meet the requirements of the Settlement Agreement, the department will need the support of facility administration and the leadership of related disciplines.
- Observations of psychiatric clinic performed during this monitoring review revealed improvements in clinical case consultation, a thoughtful approach to psychopharmacology, and improved diagnostics. The current practitioners were making efforts to review and revise diagnoses and adjust medication regimens. In doing so, there were reports that some individuals were experiencing increased behavioral challenges. These were good opportunities for psychiatry and psychology to work together to develop non-pharmacological interventions for specific individuals.
- Challenges remained, however, in that the psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate, timely data in order for them to make data informed decisions regarding pharmacology in an objective manner. In order for psychiatric services to improve to the level of generally accepted professional standard of care, the facility will need to make a cultural shift, which will require leadership and integration among all the necessary disciplines.

Psychological Care and Services

- There was progress in several items related to psychological services. These included the addition of internal peer review, introduction of a new and simplified data system, the expansion of the current data system, the use of more sensitive data presentation, and an increase in the number of individuals with Psychological Assessments.
- For the next review the monitoring team will be looking for the following:
    - Documentation demonstrating that peer review is occurring at least weekly

- The implementation of the new simplified data system across all homes and day programming sites
- The beginning of IOA
- The routine use of the graphing of data in intervals necessary to make treatment decisions
- An increase in the percentage of functional assessments that include all the necessary assessment components and have a clear summary of the variables hypothesized to affect target behaviors
- An increase in the percentage of Positive Behavior Support Plans that are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions, and
- Simplified PBSPs that attempt to consolidate target behaviors that serve the same function, and are consistently written in a style that would likely be understood by DCPs.

Medical Care

- Progress was noted in the operation and service provision in the medical department. Overall, individuals received appropriate routine care. Preventive services were provided, although there were some deficits noted in areas, such as colorectal cancer screening and osteoporosis screening. There was no database available to easily track preventive services.
- Management of chronic medical problems was generally adequate. A seizure management policy was created, but there had been no onsite clinic at the facility for two months and individuals were not seen off campus. Seventeen individuals were identified as having intractable seizure disorder, yet none of them had been evaluated for more aggressive treatment. Monitoring for side effects related to AED drug use was inconsistent. There were also problems noted related to follow-up of medical conditions.
- The external reviews of medical care had not been completed at the time of the onsite visit. The medical director completed a limited number of quarterly audits in December 2010 and those audits indicated compliance with acceptable standards of care. Mortality reviews were being completed, but lacked a true evaluation of medical care completed by a physician. The five mortality reviews completed resulted in zero recommendations related to medical care. The medical director tracked some important medical quality indicators, but a comprehensive and defined quality improvement system had not been implemented.

Nursing Care

- Several of the upper level management positions, including the Chief Nurse Executive, Nursing Operations Officer, and one of three Nurse Managers were vacant.
- All individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN Case Managers and Nurse Managers and were completed in a timely manner. Nursing assessments were more complete and had begun to provide more informative assessment summaries. Notwithstanding these positive findings, problems were noted with the conduct of nursing assessments,

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 remained inconsistent and incomplete.

- All individuals reviewed had most 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 primarily generic and more appropriate to address acute episodes or use as a guide for training direct support staff on specific conditions than for individualized long term management of a health risk or problem. The health management plan development process, and the mostly generic plans in place at the time of this review were in dire need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. One issue with the HMPs and ACPs was due to identification of health problems that were not in need of a HMP. Another issue was due to the application of generic/standard care plans or protocols to health problems that instead required individualized approaches and interventions.
- Observations of medication administration were conducted. During all observations, nurses 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 remained greatly reduced from the previous review, however, there were several areas of practice that did not meet acceptable professional standards, such as appropriate follow-up for response to treatment with PRN medications, accurate and consistent administration of insulin and Accuchecks for finger stick glucose levels as prescribed, and consistent vital sign monitoring related to administration of antihypertensive and other medications with potentially negative effects on blood pressure. There were three infection control errors related to medication/treatment administration.
- There were a number of monitoring and training efforts underway. Nurses were starting to monitor hypertension, pain, and diabetes mellitus. There were yet to be implemented plans for summary and analysis of results and validation of monitoring results in these areas by the Quality Improvement Nurse.

Pharmacy Services and Safe Medication Practices

- Medication orders were filled at the San Antonio State Hospital Pharmacy. This was an independent institution with an entirely different staff and this resulted in problems with implementing the requirement to document all interactions between the pharmacists and the physicians.
- The supervisory hierarchy of SASSLC placed the pharmacy department under the supervision of nursing. This structure was unique among SSLCs and is not considered standard practice. This structure likely contributed to problems in processes and a lack of adequate supervision of the pharmacy staff related to fulfilling some provisions of the Settlement Agreement.

- Drug regimen reviews were completed in a timely manner, but there were issues related to the content and consistency of data elements reported. There was also no mechanism in place to track physician implementation in those cases where there was agreement with pharmacy recommendations. The MOSES and DISCUS tools were being completed, but there was little evidence that practitioners utilized them. The DUE system was implemented, but the selection of drugs for review was not congruent with the recommendations of the Health Care Guidelines.
- Medication error reporting increased due to a new reconciliation process. This process resulted in discovery of more than 100 robotic errors each month. Additional processes were implemented to address this new problem.

Physical and Nutritional Management

- The PNMT process was initiated, but there was no assigned nurse, and the therapy clinicians also had other significant responsibilities as staff therapists. There was only one dietitian for the entire facility and there was no likely way that she would be able to adequately fulfill her role as the clinical dietitian for 281 individuals and also contribute significantly to the PNMT process. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The current system appeared to continue to come from a discipline-specific approach rather than an integrated comprehensive assessment process. There also seemed to be more of a review of existing supports to address the individual's risk status rather than a new examination and the development of a new plan. This team will continue to struggle with this as they serve as both the PST members and adjunct PNMT members and will have a difficult time looking at each case in a new manner.
- There continued to be implementation errors during meals, related to position and alignment as well as assistance techniques, adaptive equipment and diet texture and liquid consistency. Staff were not confident about the plans and often safely answered "aspiration" when asked why they did something rather than displaying an apparent understanding of the rationale. Staff consistently, but rotely, read the Dining Plans and diet cards prior to serving the individual. Often, however, they would proceed to leave out a step or use the wrong utensil.

Physical and Occupational Therapy

- Changes in leadership and key staff on extended medical leave presented significant challenges for this department over the last six-month period. They should be commended for their hard work and dedication during that time. OT and PT caseload sizes were excessive to ensure appropriate attention to assessments and to provide adequate supports and services to address chronic concerns, acute issues, and to promote skill acquisition. Generally, health and safety issues were addressed, but little to no interventions to address potentials for skill acquisition had been developed.

- The assessment format had been revised in the last one or two months to incorporate health risk assessments and to address supports required to address these. The clinicians were developing measurable health risk goals in the assessments, but had not yet consistently focused on skill acquisition outcomes for those who would benefit.
- There were very limited intervention plans developed beyond the PNMPs, however, when an action was identified as necessary to address a more acute issue, the plans that were implemented were appropriate and generally well documented. The scope of service, however, was limited to a handful of individuals and the goals were not measurable as written. The plans were not integrated into the PSP via addendums and were not reviewed routinely by the PST.
- PNMPs included staff instructions or precautions in the areas of assistive equipment, mobility, transfers, movement techniques, and positioning for wheelchairs, positioning/handling in a wheelchair or bed and during bathing and mealtime. Pictures illustrating assistive equipment and how the individual should be aligned or supported in that equipment were not available for any of the PNMPs reviewed in the homes. The focus of the PNMP was listed, but did not clearly relate to the health risk system in place at the facility. There was a new system implemented as of 1/1/11 and this should drive the need to revise the plans to accurately reflect the identified risks for each individual.
- Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP or per generally accepted practice. There were very few pictures with the written PNMPs to serve as visual guides for staff to improve compliance with implementation guidelines. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. In general, however, it appeared that there were improvements in staff attention to the details of proper positioning and compliance with the PNMPs compared to what was observed during the previous onsite review. Transfers observed were completed appropriately.

<u>Dental Services</u>

- The dental clinic opened in September 2010 in a limited space with one operatory. Basic dental services were provided and all individuals had been to clinic to attempt an initial and/or annual exam. Failed appointments were problematic and this was truly significant given the large percentage of individuals with poor hygiene ratings.
- The dental director had carefully drafted and implemented desensitization strategies and those were ongoing. Many individuals who had failed strategies were in need of assessments for formal desensitization plans. No desensitization plans had been developed because no formal functional assessments had been completed.

- Special supports for those at high risk for aspiration were needed. At the time of the onsite visit, suction toothbrushes were being utilized only for those individuals with tracheostomies. There were others who would likely benefit from this support.

Communication

- Not all individuals who needed AAC and other communication supports and services received them. There were at least 160 individuals living at SASSLC who were identified as nonverbal or minimally verbal and would be considered to have significant communication limitations with likely potential to benefit from AAC supports and services.
- A comprehensive assessment had been provided to all of those individuals identified as Priority 1 (100%), as well as 39% of those identified as Priority 2, 52% of those identified as Priority 3, and 30% of those identified as Priority 4. There were a number of individuals who had not received a communication assessment in up to 21 years. Overall there were approximately 62 individuals that appeared to have no current communication assessment and another 57 who had not received a communication assessment in five or more years.
- There was a very limited focus on expansion of communication skills or new skill acquisition. There were only a few home-based SPOs recommended and SPOs for only four individuals who participated in direct speech services though these were not integrated into the PSP.
- The majority of the AAC systems were portable and intended to be functional in a variety of settings. A number of devices had to be mounted because many of the initial devices were previously lost. It will be critical that all staff take on responsibility for taking care of the AAC systems issued to individuals to ensure substantial compliance with this critical element of the Settlement Agreement. During observations there were only a few devices that were observed in use.
- Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. The time spent would have been better if the focus had been on activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the entire process of habilitation and

engagement was reviewed. 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.

- Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were several improvements since the last review. These included development of an engagement monitoring tool, introduction of a skill acquisition monitoring tool, modification of skill acquisition plans (training instructions), improvement in the documentation of the rationale for SPO selection, development of a data system to track and improve training of individuals in the community, and improved individual engagement scores.
- These improvements could result in a relatively fast and dramatic improvement in this provision if they are coupled with a reorganization and simplification of how skill acquisition programming is organized, implemented, and monitored at the facility.

Most Integrated Setting Practices

- The number of individuals placed in the community had decreased over the past year. The number of individuals in the referral process at SASSLC had increased, though, overall, the numbers remained low, given the size of this facility
- Opinions of the professionals on the PST were not adequately incorporated into discussion, documentation, and decision-making as required (as noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document.
- The monitoring team was concerned about the way in which SASSLC determined individuals' preferences regarding community referral and placement based upon a number of observations during the week of the onsite review, as well as based upon a review of PSP documents. For example, single questions during annual PSP meetings were not likely to get at an individual's preference for something as abstract and important as choosing a place to live. Preferences must be obtained in a valid way, that is, in a way that is similar to the aspects of obtaining informed consent, including that the individual must have the capacity to understand the options available and information being presented, be informed adequately and thoroughly, and be able to provide his or her preference freely. For many of the individuals at SASSLC, the validity of their preferences will have to be determined in multiple ways.
- SASSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. Family members and LARs were involved in the lives of most of the individuals who were on the active referral list. A number of family members and LARs appeared to be willing to learn more about community placement, to go on tours, and/or to have their family member go on tours of community providers.

- SASSLC was beginning to implement an important aspect of the new CLDP process. Specifically, the placement process was occurring in a more individualized manner, planning was beginning earlier in the process, and PST members were more involved.
- QMRPs will need more training and support to implement and lead the new style, more complicated annual PSP meetings. Discussions of most integrated setting will need to be thorough and skills chosen for formal teaching will need to be related to community living and to the specific obstacles to referral and placement that the PST has identified. These obstacles need to be identified and addressed on an individual basis.
- The list of essential and nonessential supports in the CLDP was inadequate to meet the requirements of this provision. This was noted in the previous review and continued to be a problem. First, the CLDP did not identify needed supports from a wide range of possible supports that would be appropriate for the individual (e.g., especially given the list of prioritized outcomes on page 26 of the one CLDP completed since the previous onsite review). Second, the supports, both essential and nonessential, were not described in adequate detail. The wording did not provide the facility, the receiving provider, or the post move monitor with adequate guidance regarding the development, implementation, and monitoring of supports for this individual. Supports need to be defined in measureable observable terms, ways of determining if the support is present need to be specified, and a criterion for the presence of each support must also be included. The definitive identification of supports and their criteria will be required if post move monitoring is to be conducted adequately.

<u>Consent</u>

- The facility did not maintain a prioritized list of individuals needing an LAR. Not all PSTs were adequately addressing the need for an LAR or advocate. The facility was not actively pursuing guardianship for individuals at SASSLC. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had an active Human Rights Committee in place to review restrictions requested by the PST.

<u>Recordkeeping and General Plan Implementation</u>

- All of the active records had been converted to the new format and were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be given to either reducing the size or subdividing so that it is more manageable for all staff. Also, it would be helpful for there to be information as to what consents are appropriate and required for each individual.
- Individual notebooks were also in place for each individual and those that were reviewed by the monitoring team appeared to contain most everything required by the facility's table of contents. Many managers and staff

at the facility reported that the notebooks were cumbersome, difficult to use, included duplicated materials, and required a lot of extra effort to carry and ensure that they did not get lost or misplaced.

- A master record existed for each individual, however, they were not consistent across individuals in terms of contents and set up. This should be corrected.
- The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of the active record and individual notebook were conducted by the unified records coordinator. The facility would benefit if the results of these reviews were summarized, included in the facility's QE program, and presented to senior management from time to time.
- SASSLC had taken an initial step towards determining whether and how the unified records were used in making treatment decisions as specified in provision V4.

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 SASSLC Use of Restraint Policy revised 10/11/10 o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o Restrictive Practices Tracking Sheet as of 10/18/10 o List of all restraints by individual 8/1/10 -12/31/01 o Psychiatric clinic review notes for chemical restraints in sample #C.1 o A sample of Campus Coordinator Logs documenting restraint incidents o On Call Psychology Log 7/24/10 – 1/1/11 o A list of medical and dental restraints from 7/1/10-12/31/10 o PMAB Training Curriculum o Training transcripts for 24 SASSLC employees o Human Rights Committee meeting minutes from the last six months o Incident Management Review Team Meeting Minutes 7/26/10 – 12/7/10 o Restraint Reduction Committee meeting minutes from the last six months o Physician's Orders for medical restraints for the following individuals: Individual #7, Individual #246, Individual #337, Individual #310, Individual #265, Individual #23, Individual #94, Individual #306, Individual #87, Individual #349, Individual #167, Individual #309 o Positive Behavior Support Plan for: • Individual #95, Individual #232, Individual #188, Individual #218, Individual #268 o Safety Plan for: • Individual #188, Individual #232, Individual #218 o Functional Assessment for: • Individual #218, Individual #95 o Personal Support Plan addendum (PSPA) for: • Individual #218, Individual #95 o A sample of restraint documentation including:

Individual	Date/Type	Restraint Checklist/Face to Face Debriefing	PSP	PSP Addendum(A)	PBSP	Safety Plan
#64	12/28/10 Physical	X	8/26/10		9/26/10	

#188	12/19/10 Physical	X	7/20/10		12/1/10	7/20/10
#333	11/17/10 Physical	X	6/2/10		12/2/10	
#342	12/29/10 Chemical	X	3/1/10		12/1/10	
#111	12/6/10 Chemical	X				
#148	12/2/10 Chemical	X				
#272	11/24/10 Chemical					
#98	10/17/10 Chemical 10/16/10 Chemical	X X	2/1/10	9/1/10 9/21/01 9/23/10 10/5/10 10/12/10 10/22/10 10/27/10	6/1/10	10/18/10
#95	12/30/10 Chemical 12/18/10 Chemical	X X	10/20/10	10/8/10 9/23/10 9/16/10 9/10/10	2/20/11	
#284	12/9/10 Dental Sedation	Restraint Checklist	6/8/10			
#77	12/15/10 Dental Sedation	Restraint Checklist		11/8/10	11/15/10	
#253	12/14/10 Dental Sedation	Restraint Checklist	1/15/10			

Interviews and Meetings Held:

- Interviews with various direct support staff in homes and day programs
- Daisy Ellison, Psychology Coordinator
- Larrie Collier, Incident Management Coordinator
- Patricia Delgado, At Risk Coordinator
- Lawrence Algueseva, QE Program Auditor

	Observations Conducted: o Observations at all residences and day programs o Daily Incident Management Review Team Meeting 2/8/11 o Restraint Reduction Committee Meeting 2/9/10 o Human Rights Committee Meeting 2/10/11 o Annual PSP meetings for Individual #201 and Individual #302
	Facility Self-Assessment: The facility's Plan of Improvement for section C indicated that the facility was not in compliance with most of the provision items in Section C. The only provision item of C that the facility indicated compliance with was C2. The monitoring team was in agreement that the facility was in compliance with provision C2, but not in compliance with the other provision items in this section.
	Summary of Monitor's Assessment: Information submitted to the monitoring team regarding restraint incidents indicated that the number of restraints, particularly chemical restraints, had increased since the last monitoring visit. A list provided to the monitoring team showed a total of 51 restraints were utilized for crisis intervention involving 16 individuals from 8/1/10 through 12/31/10. This included • three mechanical restraints, • eight physical restraints, and • 40 chemical restraints. The facility had not gathered and analyzed data on restraints monthly or produced a monthly or annual report that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred. It was not possible to determine the exact percentage change in number of restraint incidents at SASSLC since the last monitoring visit because data had not been collected in a consistent format. The facility attributed the increase in restraint usage to efforts made by the psychiatrist and medical staff in reduction and modification of psychotropic medication regimens for many individuals at SASSLC. While it was noted that there had been medication changes for a number of individuals involved in restraints at the facility, there was no clear data gathered to track this assertion. It is, however, expected that as psychiatric medications are modified and reduced, the facility may see an increase in aggression and self injurious behavior until effective behavioral support strategies are developed to address individual behaviors. The facility continued to focus on the reduction and avoidance of the use of restraints. The facility indicated that it was looking at restraint reduction. In particular, the psychology department relayed to the monitoring team that restraint reduction was an ongoing focus at the facility. Three areas of focus were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility.

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1. The facility needs to develop a system to gather clear, consistent data on the number of restraints that are occurring at the facility.
2. Consistent alternative behavioral strategies for crisis intervention need to be clearly stated. Staff should be trained to implement alternative behavioral strategies for individuals who they support. The effectiveness of strategies needs to be monitored and strategies revised when not effective.
3. The facility had made noteworthy improvements in engagement levels for individuals at the facility (also see section S1 below). The next focus should be one of expanding options in day programs to include a wider variety of meaningful work and recreational activities both at the facility and in the community.

On a positive note, the facility had a new dentist and routine dental work was now completed at the facility. The dental staff were focusing on strategies to reduce the need for restraint during routine dental procedures through evaluating past use of restraints and developing desensitization strategies for individuals at the facility who required the use of restraint during dental appointments.

There were many meetings frequently held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, Daily Incident Management Review Team (IMRT) meetings, and Human Rights Committee (HRC) meetings.

As discussed further in C1 below, inconsistent documentation of restraints made it difficult to track and learn from previous restraint incident.
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#	Provision	Assessment of Status	Compliance

C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written	Based on information provided by the facility in a list of all restraints used for crisis intervention, between 8/1/10, and 12/31/10:
		• 16 individuals were the subject of restraints,
		• 51 restraints occurred,
		• 3 (6%) of these were mechanical restraints
		    o These three mechanical/protective restraint incidents involved the use of a helmet and wrist ties for one individual with serious self-injurious behavior, implemented as outlined in his behavior support plan.
		• 8 (16%)of these were physical holds,
		• 40 (78%)of these were chemical restraints,
		• 48 (94%)of these were emergency restraints, and
		• 3 (6%) of these were programmatic restraints
		    o These three mechanical/protective restraint incidents were the same as described immediately above.
		
		The facility provided a list of medical and dental sedation and restraints between 7/1/10 and 12/31/10:
			Noncompliance

#	Provision	Assessment of Status	Compliance
	policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	• 50 incidents of sedation or restraint occurred, • 38 of these were for dental appointments, and • 12 of these were medical appointments. The list did not clearly define the purpose of the medical and dental restraint in all cases, so it was not known how many of these were sedation for surgical procedures or how many were routine appointments. The facility needs to clearly identify the purpose of sedation given for medical appointments in order to address the need for desensitization plans. The facility identified 24 individuals with written dental desensitization plans in place. Prone Restraint Based on facility policy review, prone restraint was prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklist prone restraint was not identified. A sample, referred to as Sample #C.1, was selected. This included nine individuals, representing 56% of individuals involved in crisis intervention restraint incidents over the previous two quarters. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individual #95, Individual #64, Individual #188, Individual #98, Individual #272, Individual #333, Individual #342, Individual #148, and Individual #111. Based on a review of 11 restraint records for individuals in Sample #C.1 involving nine individuals, 0 (0%) showed use of prone restraint. Other Restraint Requirements Based on document review, the facility policies did state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included 11 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 10 of the 11 records (91%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. Examples of where this was the case included:	

#	Provision	Assessment of Status	Compliance
		o The restraint checklist for Individual #111 on 12/6/10 indicated that he posed an immediate danger to himself. According to the restraint checklist, he was "displaying continuous aggression/agitation and became physically violent towards staff including punching with extreme force, scratching, kicking, spitting and attempting to bite staff." A chemical restraint was administered. o The restraint checklist for Individual #95 on 12/18/10 indicated that a restraint was used after "she started destroying the closet doors, turning furniture, biting her wrist, and hitting her head on the wall." A chemical restraint was administered. An example where this was <u>not</u> the case included: o A restraint checklist for Individual #272 on 11/24/10 did not include a description of the behaviors leading up to the chemical restraint. • Aggression towards staff and/or peers or self-injurious behavior was indicated as the reason for the restraint on all forms that described behavior leading to the event. • For the 11 restraint records in the sample, a review of <u>the description of events leading to behavior that resulted in restraint</u>. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but did not describe events leading up to or causing these behaviors. Only two (18%) of the checklists gave a brief description of events that occurred prior to the restraint. This information would be useful for direct care staff to know to avoid future restraint incidents. Examples of good documentation included: o The restraint checklist for Individual #333 dated 11/17/10 indicated that he became aggressive towards staff when staff came in to transport him home from the workshop. o The restraint checklist for Individual #64 dated 12/28/10 indicated that she was in the living room, flipping through magazines, then charged at staff. Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #95 on 12/30/10, staff stated "head banging, hitting staff, history of refusing medication and meals." There is no indication what led to the aggressive behavior. o On the restraint checklist for Individual #272 dated 11/24/10, staff did not complete the comment section on events leading to the behavior that resulted in restraint.	

#	Provision	Assessment of Status	Compliance
		o The restraint checklist for Individual #188 on 12/19/10 indicated that he was "kicking, punching, throwing furniture, spitting," but did not describe events occurring prior to this behavior. • In eight of the records (73%), there was evidence that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered in a clinically justifiable manner. Examples where this was the case included: o The restraint list for Individual #95 dated 12/18/10 indicated that staff attempted a series of interventions to avoid restraint, including "blocking pads, per BSP and redirection by using a calming voice." o The restraint checklist for Individual #64 dated 12/28/10 indicated that staff attempted several strategies including verbal prompt, redirection, and moving others away prior to holding her hand, then held her arm. Examples where this was not the case included: o The restraint checklist for Individual #188 dated 12/19/10 indicated that staff attempted verbal prompts, redirection, PMAB protective skills, removed dangerous objects, moved away, traded out staff, and moved furniture. There was no indication that a least restrictive hold was attempted prior to implementation of a horizontal hold. o The restraint checklist for individual #272 dated 11/24/10 did not indicate that any interventions were attempted prior to the administration of a chemical restraint. o The restraint checklist for Individual #95 dated 12/30/10 did not indicate that other interventions were attempted prior to avoid restraint. It was not clear that all restraints used were the least restrictive intervention necessary. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. Facility policies identified a list of approved restraints techniques. • Based on the review of 10 restraints, 10 (100%) were approved restraints techniques. The facility is not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the three individuals in Sample #C.1 where physical restraint was used were reviewed. Of these, one of the individuals had a Safety Plan that defined the use of restraint. A sample of restraint documentation was reviewed for the following individual to determine if the individual was released from restraint according to criteria set forth in the Safety Plan: • For Individual #188, his Safety Plan included strategies for timed release of restraint at five minutes regardless of behavior exhibited at the time of release. Of three restraint incidents reviewed, three (100%) indicated that the individual was released from restraint according to the criteria set forth in the Safety Plan. For individuals in the sample who did not have Safety Plans, one of two (50%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to himself or herself. The following information was documented: • Individual #333 was restrained in a physical leg and arm hold on 11/17/10 lasting five minutes. The action release code indicated that he was lightly pulling at the restraint after one minute. At five minutes, the form indicated that he was released when had "met safety plan definition of calm and was released." His PSP did not indicate that he had a Safety Plan in place. • Individual #64 was restrained in a hand and arm hold on 12/28/10, lasting 35 minutes in duration. The action release code section of the restraint form indicated that staff attempted to release her but were unsuccessful every five minutes until she was released after 35 minutes. The code at that time indicated that she was released immediately when no longer an immediate or serious risk of harm to self or others. The facility was in substantial compliance with this provision.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the 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	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. This sample included 24 current	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	employees at the facility
		
		A review of training transcripts, including their hire dates, and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that
		• Twenty-three of 24 (96%) had current training in RES0105 Restraint Prevention and Rules.
		    o Four of the 24 staff did not complete the refresher training within 12 months of the previous training.
		• Twenty-four of 24 (100%) had completed PMAB training within the past twelve months.
		    o Eleven of the 24 (46%) did not complete refresher training within 12 months of previous restraint training.
		
		The facility needs to ensure that employees complete training on the all elements of restraint use at least every 12 months. The facility is not in compliance with this provision item.	

C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 11 restraint records (Sample #C.1), nine (82%) indicated that restraint was used as a crisis intervention. The restraint checklist for Individual #98 dated 10/17/10 described restraint used for crisis intervention, but staff indicated that it was a medical restraint for the type of restraint. On the restraint checklist for Individual #333 dated 11/17/10, staff did not complete the section for type of restraint. Facility policy did not allow for the use of restraint for reasons other than crisis intervention. All staff were trained that restraint should only be used as a "last resort" measure. Restraints, however, can be ordered for medical reasons and for pretreatment sedation. PSPs were reviewed for six individuals in the sample. None of the individuals had "Do Not Restrain" orders in place regarding the restraint type documented. Individual #98's safety plan indicated that staff should not use a baskethold or a horizontal hold with her. Her restraint documentation indicated that chemical restraint was the only type of restraint used with her. In nine of nine records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders or recommendations from other team members. While the facility had begun to focus on the reduction of restraints necessary to complete dental treatment, there was no evidence that a similar focus was occurring in regards to restraint utilized to complete medical treatment. The facility did not maintain a	Noncompliance

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		comprehensive list of individuals for whom medical restraint was being used and plans reviewed during the monitoring visit did not address strategies to reduce the use of medical restraints. The facility did identify individuals for whom dental restraint had been historically used and the dental staff were evaluating the use of restraint for each individual at the facility. Attempts were being made to complete routine dental work without the use of restraint and desensitization programs were being implemented for those who continued to need work completed with restraint. The facility will need to develop a system to track the use of restraints used to complete both medical and dental treatment to ensure that teams have discussed restraint use and developed desensitization plans to try to reduce the use of restraint. The facility is not in compliance with this provision.	

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	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based.
		
		Based on a review of 10 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows:
		• In six out of 11 incidents of restraint (55%), there was assessment by a restraint monitor. The remaining five records included a partially completed restraint assessment form, but there was no indication of who had completed the form. Records that did not contain documentation of this included:
		  o Individual #148, 12/2/10
		  o Individual #95, 12/30/10
		  o Individual #342, 12/29/10
		  o Individual #111, 12/6/10
		  o Individual #333, 11/17/10
		• In five out of 11 instances (45%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included:
		  o Individual #148, 12/2/10 (did not indicate time of monitoring)
		  o Individual #95, 12/30/10 (did not indicate time of monitoring)
		  o Individual #342, 12/29/10 (did not indicate time of monitoring)
		  o Individual #111, 12/6/10 (did not indicate time of monitoring)
		  o Individual #333, 11/17/10(did not indicate time of monitoring)
		  o Individual #64, 12/28/10, (late)
		• In 10 instances (91%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included:
			Noncompliance

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	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.	◦ Individual #342, 12/29/10 • In 11 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. The physician's orders for a sample of 10 individuals was reviewed to determine whether or not the physician had specified the schedule and type of monitoring required when ordering sedation for medical or dental treatment. Nine (90%) of the orders included directions for monitoring as required by this provision. Individual #87 had an order for sedation prior to a vision exam on 1/10/11. The order did not specify the schedule and type of monitoring required by staff. The physician's orders for a sample of two individuals was reviewed to determine whether or not the physician had specified the schedule and type of monitoring required when ordering mechanical restraints for protective medical purposes. Neither order included instructions for monitoring the restraint. • Mittens and elbow splints had been ordered for Individual #349 on 6/24/10. There were not instructions for removing the restraints to check for circulation or skin breakdown. • Soft wrist ties had been ordered for Individual #167 on 9/30/10. There were no instructions for release or monitoring while in restraint. Based on a review of 11 behavioral restraint records for restraints that occurred at the facility there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in nine (82%) of the instance of restraint. Many of the restraint checklists indicated that a nursing assessment did not occur until more than 30 minutes after the restraint. Restraint records where this did not occur as required included: ◦ The restraint checklist for Individual #188 on 12/19/10 indicated that the assessment by the nurse did not occur until one hour and 12 minutes after the restraint was initiated. ◦ The restraint checklist for Individual #64 on 12/28/10 did not include documentation of monitoring by a nurse. • Monitored and documented vital signs in eight (73%). Records that did not contain documentation of this included: ◦ Documentation for Individual #333 on 11/17/10 indicated that the nurse made an attempt to monitor the individual's vital signs five minutes after he was released. The individual refused and another attempt was not made. ◦ The restraint checklist for Individual #64 on 12/28/10 did not include	

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		documentation of monitoring by a nurse. o The restraint checklist for Individual #98 on 11/17/10 indicated that the nurse attempted to take her vital signs twice following administration of a chemical restraint, but the individual refused. • Monitored and documented mental status in 10 (91%). Records that did not contain documentation of this included: o Individual #333 on 11/17/10 A sample of documentation for the last three dental restraints was reviewed. Based on a review of the last three pretreatment sedation dental restraint records there was documentation that the restraint was monitored by a licensed health care professional in three (100%) of the records. The facility needs to develop a plan to ensure that monitoring and post restraint reviews are conducted as required and documented consistently. Restraints were not being assessed or monitored consistently as required by this provision. The facility was rated as being in noncompliance with this provision item.	
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	A sample of 11 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • In five (45%), continuous one-to-one supervision was indicated as having been provided. Six (55%) did not indicate level of supervision provided on the restraint checklist. • In 11 (100%), the date and time restraint was begun were indicated. • In 11 (100%), the location of the restraint was indicated. • In six (55%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Four of the restraint checklists described the behavior that was occurring, but did not indicate what events were occurring that might have led to the behavior. One (Individual #272) did not describe the events or the behavior leading to restraint. • Examples of inadequate documentation included: o The restraint checklist for Individual #95 dated 12/30/10 stated, "head banging, hitting staff, history of refusing medication and meals" in the section describing events leading to the behavior, thus, offering no indication what might have precipitated this behavior. o The restraint checklist for Individual #342 dated 12/29/10 stated, "SIB, aggression toward staff" in the section describing events leading to the behavior.	Noncompliance

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	alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In 11 (100%), the specific reasons for the use of the restraint were indicated.
		• In 10 (91%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. On the restraint checklists for Individual #333 (dated 11/17/10), staff did not mark the type of restraint on the restraint checklist.
		• In 11 (100%), the names of staff who applied/administered the restraint was recorded.
		• Observations of the individual and actions taken by staff while the individual was in restraint for three physical restraints were recorded, including:
		  o In three (100%), the observations were documented every 15 minutes and at release.
		  o In three (100%), the specific behaviors of the individual that required continuing restraint were recorded.
		• In five (45%), the level of supervision provided during the restraint episode was indicated.
		• In three of three (100%) of physical restraint incidents, the date and time the individual was released from restraint were indicated.
		• In five (45%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded.
		
		In a sample of 11 records (Sample #C.1), restraint debriefing forms had been completed for 11 (100%).
		
		A sample of three individuals subject to medical restraint was reviewed and in three (100%), there was evidence that the monitoring had been completed as required by the physician's order.
		
		This sample of eight individuals who were the subject of a chemical restraint was reviewed. In eight (100%) of eight restraints, documentation indicated that prior to the administration of the chemical restraint, the psychologist was contacted to assess whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met.
		
		As noted in the review of documentation above, the facility was not in compliance with the requirements of this provision item.	

C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three	According to SASSLC documentation, during the six-month period prior to the onsite review, a total of five individuals (Individual #218, Individual #232, Individual #188, Individual #95, and Individual #268) were given chemical restraint more than three times in a rolling 30-day period. No instances were reported of the use of physical or	Noncompliance

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	times in any rolling thirty day period, the individual's treatment team shall:	mechanical restraint more than three times in any rolling 30-day period. All five of these individuals (100%) were reviewed to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) were requested from the facility for all five individuals. The following documents were received and reviewed: • PBSPs for all five (100%) individuals, • safety plans for three (60%) individuals (i.e., Individual #188, Individual #232, and Individual #218), • functional assessments for two (40%) individuals (i.e.,, Individual #218 and Individual #95), and • PSPAs for two (40%) individuals (i.e., Individual #218 and Individual #Individual #95). The results of this review are discussed below with regard to Sections C7a through C7g. This item was rated as being in noncompliance because none of the PSPAs reviewed reflected an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint. It is recommended that the facility ensure that a PSPA meeting occurs following more than three restraints in any rolling 30-day period. Additionally, these meetings should be organized so as to ensure that each of the issues below are discussed and documented. Finally, in order to achieve substantial compliance with this item, SASSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors has been developed, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Neither (0%) of the two PSPAs minutes reviewed reflected a discussion of the individuals' adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. Individual #98's PSPA minutes stated that she appeared to be depressed, but how this psychosocial factor, for example, affected her dangerous behaviors was not documented. Individual #98's psychological condition may be an important precursor of the behavior provoking restraint, however if it was hypothesized to be an important factor, the discussion in the PSPA would need to include how this factor potentially affects her dangerous behavior that provokes restraint, and a recommendation to address the condition.	Noncompliance
	(b) review possibly contributing	None (0%) of the PSPAs reviewed reflected a discussion of possible contributing	Noncompliance

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	environmental conditions;	environmental factors. Examples could include such things as noisy environments and suggestions for reducing noise to prevent the future probability of restraint.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For neither (0%) of the two PSPAs reviewed, were structural assessments of the behavior provoking restraints discussed. This item is concerned with a review of antecedents that may affect the behavior provoking restraints. Examples of issues discussed here could be the role of antecedent conditions, such as placing demands or the presence of novel or unfamiliar staff. This discussion should also discuss how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed).	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. None of the PSPA minutes reviewed (0%) reflected a discussion of the functions of the behavior provoking restraints.	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, 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	All five individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Five (100%) were based on the individual's strengths; • Four (80%) specified the objectively defined behavior to be treated that led to the use of the restraint (Individual #95's definition of disruption was not operational); • Five (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the five plans); and • Five (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Three of the five PBSPs (60%) to weaken or reduce the behaviors that provoke restraint, however were determined to be inadequate (i.e., Individual #218, Individual #95, and Individual #188) because they did not contain clear, precise interventions based on a functional assessment (see K9). The three Safety Plans of the individuals in the sample were reviewed:	Noncompliance

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	terminating the use of the restraint shall be set out in the individual's ISP;	▪ In all three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In all three (100%) of the safety plans reviewed, the maximum duration of restraint authorized was specified; • In all three (100%), the designated approved restraint situation was specified; • In all three (100%), the criteria for terminating the use of the restraint were specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K11 for more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was no evidence in the PSPA minutes reviewed, or PBSPs of these five individuals, indicating that any individual's PBSP was modified (when necessary) to decrease the future probability of an individual being restrained.	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.	Observation of the Daily Incident Management Team (DIMT) meeting confirmed that restraint incidents were reviewed by the team the following working day, but this review did not include an adequate assessment to determine the circumstances under which such restraints were used. Restraint incidents were reported to the DIMT and referred to the PST for follow-up. PSTs met following restraint incidents to review restraints, but as noted in section C7, supports and prevention strategies developed by teams were often not consistently implemented and revised when not effective. A sample of documentation including Restraint Checklist and Face-to-Face Debriefing, and Review Forms related to 11 incidents of non-medical restraint was reviewed by the monitoring team (Sample #C.1). This documentation showed that: • In 0 (0%), review by the PST and DIMT was documented in the restraint incident documentation. As noted throughout Section C, restraint documentation was often incomplete or inadequate for determining circumstances of the restraint. One (9%) of the Restraint Review forms in the sample indicated errors or incorrect procedures in documentation, application, or monitoring of the restraint. The restraint assessment for Individual #333 on 11/17/10 recommended refresher training for staff on PMAB, documentation, and	Noncompliance

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		SASSLC policy for restraints. The facility needs to develop a review process that includes identifying problems with restraint application and monitoring procedures and developing a plan to address any deficiencies identified. Strategies to avoid restraints should be developed and monitored for effectiveness by PSTs following restraint incidents. The facility is not in compliance with this provision.	

Recommendations:

1. Behavior support plans should identify which behaviors indicate a true risk for potential harm to the individual or others and train support staff to recognize those behaviors.

2. The facility needs to look at engagement levels for individuals frequently restrained for self-injurious or aggressive behaviors and develop plans to increase engagement levels when indicated.

3. Ensure that all staff are trained on accurately completing restraint documentation.

4. The facility needs to develop a plan to ensure that monitoring and post restraint reviews of vital signs are conducted as required and documented consistently.

5. Physician's orders for protective restraints should specify the type and frequency of monitoring required.

6. Include specific desensitization strategies in PSPs for individuals who require restraints for routine medical and dental appointments. Monitor and document progress on plans and modify plans as necessary.

7. Ensure that a restraint monitor is present within 15 minutes of the start of a restraint to assess the individual and monitor restraint application.

8. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

9. Behavior support plans should be reviewed and revised when strategies are not effective for reducing the number of restraints implemented.

10. Attend to the requirements of section C7.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy: Incident Management #002.2, dated 6/18/10 o SASSLC 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 SASSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation dated 6/18/10 o SASSLC Policy: Level of Supervision revised 9/16/10 o HHSC HR Manual for Background Checks o DFPS Criteria for Establishing a Pattern of Spurious Allegations o Incident Management Committee meeting minutes for 10/1/10-12/31/10 o Three most recent five-day status reports o Minutes from quarterly Interagency Meeting (DADS, OIG, and DFPS) o Training transcripts 24 employees o Training and background checks for the last three employees hired o Training transcripts for facility investigators (six) o Training transcripts for DFPS investigators (three) o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were not hired based on background checks o Results of background checks that led to employee termination o A sample of self reporting of criminal activity documentation for current employees o List of Injuries by individual since 1/1/10 o A sample of 59 Client Injury Reports, including: • Individual #304, all injuries since 9/1/10 • Individual #167, all injuries since 9/1/10 • Individual #256, all injuries since 9/1/10 • Individual #95, all injuries since 9/1/10 o Log of all A/N/E allegations since 1/1/10 including case disposition log of employees reassigned due to ANE allegations o Sample of notifications when an employee was reassigned due to allegations o PSPs for • Individual #254, Individual #250, Individual #40, Individual #234, Individual #86, Individual #72, Individual #349, Individual #298, Individual #279, Individual #327, and Individual #304. o PSPs and PSPAs since 9/1/10 for four individuals with the highest number of injuries including:

- Individual #304, Individual #167, Individual #256, and Individual #95
- Documentation from the following completed investigations:

Case #	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
Sample D.1					
37852000 1	Physical Abuse	Inconclusive	8/29/10 9:50 am	8/29/10 10:00 am	9/16/10 extension
37623660 2	Neglect (2) Physical Abuse (2)	Confirmed Inconclusive Confirmed (2)	8/25/10 1:50pm	8/27/10 9:09 am*	10/1/10 3 extensions
37607740 3	Physical Abuse (2)	Unconfirmed	8/24/10 8:14 pm	8/27/10 9:48 am*	9/10/10 extension
37799040 4	Neglect (3)	Unconfirmed	9/6/10 1:24 pm	9/7/10 1:20 pm	9/25/10 extension
38287869 5	Neglect (3)	Inconclusive (2) Unconfirmed (1)	10/13/10 8:46 pm	10/15/10 4:30 pm*	11/20/10 3 extensions
38102680 6	Physical Abuse (2) Neglect (1)	Unconfirmed (1) Other (1) Unconfirmed	9/24/10 6:01pm	9/27/10 4:00 am*	10/22/10 2 extensions
38330109 7	Physical Abuse	Confirm/Reportable Conduct	10/28/10 10:05 pm	10/29/10 5:00 pm	12/13/10 4 extensions
38301583 8	Emotional/Verbal Abuse (3) Neglect (1) Physical Abuse (1)	Confirmed (1) Unconfirmed (2) Unconfirmed Unconfirmed	10/19/10 12:51 pm	10/21/10 11:00 am*	12/16/10 extensions
38399596 9	Physical Abuse	Confirmed	11/14/10 6:47 pm	11/15/10 4:30 pm	11/24/10
38358764 10	Neglect	Inconclusive	11/6/10 7:23 am	11/9/10 5:35 pm*	12/6/10 2 extensions
38462676 11	Emotional Verbal Abuse	Confirmed	11/30/10 1:04 pm	12/2/10 2:07 pm*	12/10/10
38413200 12	Physical Abuse	Confirmed	11/19/10 8:31 am	11/22/10 12:50 pm*	12/20/10 2 extensions
38350042 13	Neglect (3)	Confirmed (3)	11/1/10 6:45 pm	11/4/10 5:15 pm*	12/15/10 3 extensions
38258621 14	Neglect Physical Abuse	Confirmed Confirmed	10/5/10 6:22 am	10/8/10 5:15 pm*	10/21/10 extension
37623560	Neglect (3)	Confirmed (3)	8/25/10	8/27/10	9/4/10

15	Physical Abuse (2)	Confirmed (2)	2:50 pm	4:50 pm*	
38410478 16	Neglect Physical Abuse	Inconclusive Inconclusive	11/17/10 5:14 pm	11/18/10 6:30 pm*	12/5/10 extension
38449296 17	Physical Abuse	Unconfirmed	11/24/10 7:49 pm	11/27/10 10:20 am*	12/13/10 extension
38460496 18	Emotional/verbal Abuse Physical	Unconfirmed Unconfirmed	11/28/10 5:06 pm	11/30/10 10:15 pm*	12/18/10 Extension
38423520 19	Sexual Abuse	Unconfirmed	11/22/10 11:30 am	11/22/10 3:25 pm	12/12/10 extension
37938763 20	Exploitation Physical Abuse	Inconclusive Unconfirmed	9/15/10 3:36 PM	9/17/10 11:10 pm*	10/4/10 extension
Sample D.2					
UIR 11-015 37970900	Neglect	Referred Back	9/17/10	9/21/10 11:00 am	9/23/10
UIR 10-078 37540100	Serious Injury Neglect	 Inconclusive	8/20/10 11:00 am	8/23/10 7:55 pm	8/24/10
UIR 11-008	Serious Injury Undetermined Cause	n/a	10/6/10 1:00 pm	Unknown	10/14/10
UIR 11-020	Serious Injury Determined Cause	n/a	11/28/10 7:06 pm	Unknown	12/2/10
UIR 11-021	Serious Injury Determined Cause	n/a	11/29/10 1:00 pm	Unknown	12/2/10
UIR 11-023	Serious Injury Determined Cause	n/a	12/15/10 9:30 am	Unknown	12/27/10*
UIR 11-025	Serious Injury Determined Cause	n/a	12/23/10 2:15 pm	Unknown	12/30/10
Sample D.3					
UIR 11-002	Sexual Incident	n/a	9/17/10 10:30 pm	Unknown	9/22/10
UIR 10-006	Serious Injury Determined Cause	n/a	9/26/10 6:07 am	Unknown	10/4/10
UIR 11-011	Death	n/a	10/16/10 11:30 am	Unknown	10/21/10
UIR 11-026	Death	n/a	12/23/10 5:20 pm	Unknown	12/28/10

* = late

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

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in

	homes and day programs o Ralph Henry, Facility Director o Larrie Collier, Incident Management Coordinator o Leticia Jalomo, ANE Coordinator o Daisy Ellison, Psychology Coordinator Observations Conducted: o Observations at all residences and day programs o Daily Incident Management Review Team Meeting 2/8/11 o Human Rights Committee Meeting 2/10/11
	Facility Self-Assessment: The facility POI indicated that SASSLC was in substantial compliance with all sections D of the Settlement Agreement except section D3e. The monitoring team found that while some areas of section D were in substantial compliance, there were a number of areas not in compliance particularly in regards to documentation.
	Summary of Monitor's Assessment: According to a summary of abuse, neglect, and exploitation trends for the previous two fiscal quarters provided to the monitoring team, investigation of 114 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 6/1/10 through 11/31/10. These 114 cases included 191 allegations involving 102 individuals identified as potential victims, and 127 staff at SASSLC identified as possible perpetrators. Of these 191 allegations, 22 (12%) were confirmed by DFPS. Sixteen (8%) additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The other cases included 77 (40%) unconfirmed cases, 15 (8%) cases referred back to the facility, and the remaining outcomes were either pending or not yet included in monthly data reports. There had been a 26% decrease in the total number of allegations reported from FY10 4th quarter to FY11 1st quarter. There were an additional 45 serious incidents at the facility that did not involve allegations of abuse or neglect during the same two quarters. This included one death and 33 serious injuries. There were a total of 610 injuries reported at the facility for FY11 1st quarter. This was a decrease of 7% from the 4th quarter in FY10 and a decrease of 6% from the 1st quarter of FY10. Of the 610 injuries reported during FY11 1st quarter, 10 were considered serious injuries (2%), 517 (85%) were non-serious injuries requiring first aid, and 83 (13%) required no treatment.

	As noted in section D3e below, investigations completed by DFPS did not always commence within 24 hours of the initial report as required by the Settlement Agreement, nor were they completed within reasonable time frames. Interagency meetings were being held quarterly with SASSLC, DFPS, and OIG administrative personnel. According to minutes from these meetings, these concerns were being discussed between the agencies involved. Minutes indicated that DFPS was working on initiating face-to-face contact within 24 hours of the allegation, but they will continue to follow their policy. The numerous cases with lengthy extensions were also discussed at the interagency meetings. These meetings were a positive step towards resolving these issues.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, and • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated the same commitment of zero tolerance. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: • There were posters regarding this mandate posted throughout the facility. • In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the monitoring team questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they would report the incident to DFPS and to the facility director. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months. DADS zero tolerance policy did not require dismissal from employment. The monitoring team will be reviewing this policy. Below are three observations made by the monitoring team regarding the facility's implementation of actions related to zero tolerance: • Employees at SASSLC were required to sign a form titled Acknowledgement of SASSLC Employee Responsibility for Reporting Abuse/Neglect Incident(s) form annually according to policy. These signed forms were not available for review	Noncompliance

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		by the monitoring team. • In DFPS case #37623660, two allegations of physical abuse were confirmed. Video surveillance confirmed that the allegations did occur. Both APs falsely testified that they did not drag the individual across the floor, yet this was contradicted by video surveillance. Documentation of disciplinary action showed that both APs were returned to direct support positions following a suspension. • In DFPS case #37623560, an allegation of physical abuse was confirmed. The employee was suspended for 10 days, and then returned to a direct support position.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		

	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy III.A.5, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS and the facility director. This was consistent with the requirements of the Settlement Agreement.
		
		With regard to serious incidents, the facility policy entitled Incident Management required that all serious incidents be reported to the facility director to be reported to DFPS within one hour if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. This policy was consistent with the requirements of the Settlement Agreement.
		
		According to data provided for the two quarters prior to the monitoring visit in the facility's quarterly trend reports for 6/1/10 – 11/30/10:
		• There were 114 DFPS investigations involving:
		  ○ Total abuse allegations – 138 (some cases included multiple allegations)
		  ○ Results of neglect allegations:
		    ▪ Confirmed - 22
		    ▪ Unconfirmed - 77
		    ▪ Inconclusive - 16
		    ▪ Administrative Referral – 15
			Noncompliance

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		▪ Pending – 8 (Note: Some investigations involved multiple allegations.) • Other serious incidents investigated by the facility included: o Unauthorized Departures – 3 o Sexual Incidents – 2 o Deaths – 1 o Serious Injuries Determined Cause – 28 o Serious Injuries Undetermined Cause – 4 Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for other serious incidents. Two samples of investigations were selected for review. These included: • Sample #D.1 which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 which included a sample of facility investigations. Some of these were investigations that had been referred to the facility by DFPS, while others were investigations the facility completed related to serious incidents. See the list of documents reviewed for investigations included in this sample. In addition to the investigation reports contained in Sample #D.1 and Sample #D.2, additional incident reports were selected for review. Sample #D.3 was the sample of those additional serious incidents investigated by the facility. Based on a review of the 20 investigation reports included in Sample #D.1: • Seventeen (85%) of reports in the sample indicated that DFPS was notified within one hour. o In DFPS investigation #37623660, staff witnessed the individual being dragged to her room on 8/1/10, but did not report the incident as abuse. It was later reported to DFPS on 8/25/10. o In DFPS case #38350042, it was discovered that the individual had a fracture to her femur requiring surgery. The facility was unable to determine how the fracture occurred. It was not reported to DFPS until 11/1/10.	

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		- In DFPS case #376235560, staff allegedly witnessed an individual being physically abused on 7/28/10. It was not reported to DFPS until 8/25/10. • Twenty (100%) indicated, the facility director or designee were notified within one hour. • Nineteen (95%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. Exception included: - DFPS #38399596 involving physical abuse was reported to DFPS at 6:47 pm on 11/14/10. Law enforcement was not notified until 10:10 am on 11/15/10. Criminal activity was confirmed by OIG. • Only one (7%) investigation report in the sample indicated when or if DADS regulatory or the state office was notified by the facility. A standardized UIR which should have contained information about notifications was not included in investigation files in nine out of 14 investigation files in Sample #D.1. Based on a review of 11 incident reports included in Sample #D.2 and #D.3: • Eight (73%) showed evidence that serious incidents were reported within the timeframes required by facility policy. Exceptions included: - For UIR #11-002, the incident was reported at 10:30 pm on 9/17/10. The correspondent was notified at 10:15 pm on 9/20/10. Policy required notification to the correspondent within 24 hours. The primary correspondent was not notified until 9/20/10 at 10:15 am. This did not meet the requirement to report within 24 hours. - For UIR #AN11-015, the individual received 1st and 2nd degree burns under her left armpit and chest on 9/6/10. The incident was not reported to DFPS until 9/17/10. - For UIR #10-078, the individual with one-to-one supervision sustained a serious injury identified at the hospital on 8/18/10 at 1:30 pm. The facility completed an initial investigation, but did not notify DFPS until 8/20/10 at 11:00 am. • None (0%) showed evidence that serious incidents were reported to all appropriate parties as required by facility policy. None of the UIRs indicated that the state office was notified the next working day by 9:00 am. DADS reported that the state office was notified in all cases and documentation was available, but was not maintained in the investigation file that was provided to the monitoring team. The facility had a standardized reporting format. The facility used the Unusual Incident	

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		Report Form designated by DADS for reporting all unusual incidents. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 11 incident reports included in Sample #D.2 and Sample #D.3: • Eleven (100%) utilized the standardized reporting format. • Eleven (100%) were completed fully. The facility was not in compliance with this item. The facility needs to ensure notification is made to all parties required within required timeframes and document this information on the UIR.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy the facility was mandated to assure the safety and protection of individuals by immediately removing alleged perpetrators. Procedures for removing the alleged perpetrator were described in the policy in section X, titled Temporary Work Duty Reassignment of Alleged Perpetrators. Based on a review of 16 investigation reports included in Sample #D.1, 13 (81%) of alleged perpetrators were removed from direct contact with individuals immediately following the facility being informed of the allegation when the AP was known. • One case involved unknown perpetrators. • DFPS #38350042 was reported to DFPS on 11/1/10, the alleged perpetrators were not reassigned until 11/19/10 and 11/20/10. • In DFPS #37938763, the investigator expressed concern that two staff had witnessed the AP talking with the victim following his reassignment to a position of no contact with the individual and prior to the completion of the case. Documentation was included in the facility file of a signed statement by the AP acknowledging his reassignment and included instructions prohibiting contact with individuals served by the facility. • In DFPS #38399596, an allegation of physical abuse was reported on 11/14/10. The facility UIR #AN11-041 stated that the AP was "removed from consumer direct care and reassigned to alternate duties" on 11/22/10 at 3:20 pm. DADS reported that the AP was reassigned on 11/14/10 at 8:30 pm. AP was placed on Emergency Leave on 11/22/10, after the facility was notified by OIG that criminal activity was found against the AP. Based on a review of 15 investigation files in which the AP was identified, 14 (93%) indicated that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation or the conclusion of the investigation	Noncompliance

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		allowed their return to direct contact duties, or the employee was not returned to the position due to the outcome of the case. The following cases are examples that showed documentation that the facility was in compliance with this provision: • In DFPS cases #38330109, #38399596 and #38350042, the investigation file included documentation of the APs dismissal following DFPS' determination of confirmed abuse or neglect allegations. • In DFPS case #37607740, #38287869, and #38358764, the investigation file included evidence that the AP was not allowed to return to a position requiring contact with individuals until the case was completed and allegations were unconfirmed. The following is an example that did not document compliance with this provision: • The investigation file for DFPS#38258621 did not include information regarding disciplinary action taken by the facility following the completed investigation. An allegation of neglect and one of physical abuse were confirmed and the case was completed on 10/21/10. DADS reported that the confirmed physical abuse allegation resulted in termination of the employee on 12/27/10 and the confirmed neglect allegation was under review and not completed until 2/9/11 resulting in disciplinary action taken on 2/23/11. The facility did have a system in place for assuring that alleged perpetrators were not returned to regular duty until notification was made by the facility investigator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of the case. Based on a review of the seven UIRs in sample D.2 and D.3, it was documented that adequate additional action was taken to protect individuals in 10 of 11 cases (91%) on the UIR completed by the facility. For U10-078, on 8/18/10, the individual sustained a serious injury while on one-to-one supervision. The alleged perpetrator was not immediately removed from contact with the individual and DFPS was not notified until 8/20/10. In all other cases in the sample, immediate action to protect the individual was documented in the investigation file. For example: • In UIR #11-008, documenting a serious injury from a fall, the individual received immediate medical care, his LOS was increased until the PST could meet, a fall risk assessment was completed, and staff were in-serviced on cleaning up spills and liquids from the floor immediately.	

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		• In UIR #11-020, documenting a serious injury from a fall, the individual received immediate medical care, nursing staff developed an acute care plan, and direct care staff was in-serviced on the plan, and his LOS was increased. • In UIR #11-021, the individual was sent to the emergency room after staff noticed bruising to her foot. X-rays revealed a fracture to her left foot. Nursing staff developed an acute care plan for the injury and direct support staff were in-serviced. An emotional/stress assessment was completed. The PST met to discuss his LOS. His PNMP was updated to reflect his change in mobility. • In UIR #11-023, the individual had a fracture. She was sent to the hospital for immediate care, an acute care pain plan was implemented by the nurse, her LOS was increased to one-to-one, and her PST met to discuss supports needed. Staff were in-serviced on the use of her wheelchair with elevated leg rest, gerichair, and recliner, including correct procedures for transfers. • In UIR #11-002, documentation of a sexual incident between two individuals indicated that the level of supervision was immediately increased to one-to-one and a nursing assessment and emotional assessment was completed for both individuals. The facility was not found to be in substantial compliance with this provision. The facility needs to ensure that all alleged perpetrators are immediately removed from contact with the victim.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-base training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. It further mandated that all supervisors must ensure that required training is appropriately documented by certification and date of completion as directed by the Health and Human Services Commission's Facility Support Services' Competency Training and Development Department. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. Not all training had been completed as required. A review of the training curricula related to abuse and neglect and incident management was reviewed for: (a) new employee orientation and (b) annual refresher training. The results of this review were as follows: Review of 24 staff records (Sample #C.2), showed that; • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months.	Noncompliance

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		• 11 (46%) of 24 employees with current training completed this training within 12 months of the date of previous training. • 18 (75%) of the 24 employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • Three (17%) of the 18 employees with current training completed this training within 12 months of the date of previous training. Based on interviews with eight staff: • Eight (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation. • Eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility needs to ensure that all employees receive annual training as required by the state policies on abuse and neglect and incident management. The facility was rated as being in noncompliance with this provision item.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item II.B, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation during pre-service and every 12 months thereafter. A sample was requested to determine if annual acknowledgements had been signed. The facility did not provide the monitoring team with signed acknowledgement to report abuse and neglect forms, so this verification was not possible. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was not in substantial compliance with this item. A sample of signed acknowledgement to report forms will need to be provided to the monitoring team at the next monitoring visit.	Noncompliance
	(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	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation section I.M, SASSLC would maintain and provide a resource guide on recognizing and reporting signs of abuse, neglect and exploitation of individuals to the individuals, their primary correspondents, and their LAR. The resource guide would be provided to all new individuals upon admissions, and annually to the individual, LAR, and primary correspondents.	Noncompliance

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	who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. In interviewing a sample of four individuals, all four (100%) were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. One investigation indicated that appropriate reporting procedures had not been given to an individual's family member. In a summary of a witness statement in DFPS case #38460496, staff stated that the individual's sister reported an alleged incident of verbal abuse to him following a home visit. The staff person told the investigator that he gave the sister the home manager's phone number and told her to call the next business day. Based on a review of 11 individuals' PSPs (Sample #D.4) completed in December 2010 and January 2011, only one (9%) PSP included documentation that the individual, or LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The nine PSPs where this information was not found were new style format PSPs, including the PSPs for Individual #254, Individual #250, Individual #40, Individual #234, Individual #86, Individual #72, Individual #349, Individual #298, Individual #279, and Individual #304. The one old style PSP in the sample (for Individual #327) contained documentation that this information had been shared with individuals and their LARs. The facility was not in compliance with this provision. Documentation that information on identifying and reporting unusual incidents was shared with the individual and/or their LAR will need to be maintained by the facility.	
	(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.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy section I.F, the facility would comply with this mandate by posting and supplying information on individual rights in a visibly, accessible area on each living unit and day program site. A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights,	Substantial Compliance

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		• information about how to exercise such rights, and • information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all but one of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The space utilized for the "Forever Young" program did not have a rights poster posted. An assistant ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer. Documentation of investigations indicated that the assistant ombudsman and rights officer reviewed completed investigations. The facility was attempting to develop a more active self-advocacy group on campus. Monitoring team members had the opportunity to attend a self-advocacy group meeting during the visit. Information was provided to members of the self-advocacy group regarding their rights and how to report rights violations. The facility was rated as being in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item IV.E, incidents were reportable to law enforcement. The policy mandated that the facility director or designee would immediately, within one hour, notify DFPS of any allegation that may involve criminal activity. DFPS was then responsible for notifying the appropriate law enforcement agency. Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications and the facility investigative file included information on the outcome of investigations by law enforcement. OIG provided the facility with an email notifying the facility of the conclusion to their investigation. Based on a review of 20 allegation investigations completed by DFPS (Sample #D.1), in 13 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 13 (100%). The facility investigator reported that the facility had a cooperative working relationship with both OIG and local law enforcement. The facility is in substantial compliance with this item.	Substantial Compliance

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	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IX, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. The policy included a list of phone numbers for the facility director, the Office of Attorney General, the Office of Inspector General, and DFPS to report any suspected retaliation. Based on interviews, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ SASSLC policy addressed this mandate. ▪ Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. Based on a review of investigation records (Sample #D.1), there was one concern noted related to potential retaliation. An anonymous allegation letter stated that the employee was "scared of staff members retaliating for reporting the allegations." Although investigation reports did not identify the reporter for allegations of neglect and abuse, it was evident in at least some of the investigative reports reviewed that staff at SASSLC had reported co-workers to DFPS and there was no indication that retaliation had occurred in these cases. The facility was in substantial compliance with this item.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The facility Incident Management Policy Item IX.A.2 required the Incident Management Coordinator to review and make use of audit reports that evaluated whether significant resident injuries were reported for investigation at least semi-annually. Sample #D.2 included investigations completed on a sample of injuries. As noted throughout section D, these investigations appeared to be routine. Additionally, a sample of injury reports and supporting documentation was reviewed for all injuries since 8/1/10 for Individual #95, Individual #304, Individual #167, and Individual #256. The sample included a total of 59 injuries, of those, 42 were witnessed and 17 were discovered injuries. For each of the 17 (100%), the facility had conducted an investigation to try to determine the cause of the injury. The Incident Management Coordinator developed a Significant Injury Audit Tool that reviewed injuries of non-typical nature, such as injuries to the head, breasts, buttocks, and genital areas. This tool had been completed for two quarters. He reported that corrective action steps would be taken when applicable.	Substantial compliance

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		Minutes from Incident Management Review Team meetings for 10/1/10-12/31/10 were reviewed and indicated that injuries of both known and unknown cause were reviewed the next working day following the injury or discovery of the injury. The facility was in substantial compliance with this provision.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The SASSLC Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • required that investigators be qualified as directed in state policy. The policy required all facility investigators to complete the following courses: Comprehensive Investigator Training (CIT0100) and People with MR (MEN0300); • required that investigators be outside of the direct line of supervision of the alleged perpetrator. The training records for three DFPS investigators were reviewed with the following results: • Two out of three DFPS investigators (67%) had completed the requirements for investigations training. It was noted that one investigator was recently transferred into the MH&MR investigations program and had not completed training. He would not have responsibility for performing investigations until required training was completed. • Two out of three DFPS investigators (67%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for seven investigators were reviewed with the following results: ▪ Two out of seven facility investigators (29%) had completed the requirements for investigations training.	Noncompliance

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		o Edna de la Cruz-Jones, Campus Administrator, had not completed training on conducting investigations. She had completed the preliminary investigation for UIR #11-023, UIR #11-011, and UIR#U11-022. o Michelle Rodriguez, Facility Investigator, had completed all investigations in Sample #D.2 and Sample #D.3 not involving abuse or neglect. Her training transcript did not indicate that she had received training in conducting investigations as required by the facility policy. o Jessica Rodriguez, Campus Administrator, had not completed training on conducting investigations. She had completed the preliminary investigation for UIR#11-025, UIR #11-021, and UIR #11-020. o Roy King, Campus Administrator, had not completed training on conducting investigations. He had completed the preliminary investigation for UIR #11-008. o Adriane Berry-Sumlin, Campus Administrator, had not completed required training on conducting investigations. She had not completed any of the facility investigations in the sample reviewed. ▪ Seven out of seven facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The facility was not in compliance with this provision. The facility needs to ensure that all staff responsible for completing investigations have completed training required by the state policy.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IV, staff were required to cooperate with DFPS during investigations. The policy did not contain similar language addressing investigations conducted by OIG or local law enforcement. Review of the investigation files in Sample #D.1 showed that in 20 out of 20 investigations (100%), facility staff cooperated with DFPS investigators. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. Larrie Collier, Incident Management Coordinator and Leticia Jalomo, ANE Coordinator both reported that the facility had a cooperative relationship with both DFPS and OIG. Interagency meetings with SASSLC, OIG, and DFPS are now being held quarterly. An interagency meeting was held on 11/9/10 and on 1/11/11 with staff from SASSLC, OIG, and DFPS to discuss the investigation process and responsibilities of each agency.	Noncompliance

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		The facility will need to update their policy to include mandated cooperation of employees with all investigative agencies to ensure compliance with this item.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the facility, the following was found: • Of the 20 the investigation records from DFPS (Sample #D.1), 14 had been referred to law enforcement agencies. For 14 out of these 14 (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. This was documented through correspondence between OIG, local law enforcement, DFPS, and SASSLC • Of the 11 investigation records from the facility (Sample #D.2), 0 had been referred to law enforcement agencies. None of the investigations involved allegations of criminal activity. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	According to SASSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were mandated to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Exhibit B of the policy provided guidelines for the securing of evidence. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • Evidence that needed to be safeguarded was in 19 out of 20 (95%) DFPS investigations, the one exception noted was DFPS #38399596. Blood at the scene of the incident was cleaned up prior to the Campus Administrator arriving to survey the scene and take pictures. • Evidence that needed to be safeguarded was in 9 out of 9 (100%) facility	Substantial Compliance

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		investigations. Video monitoring footage was provided to DFPS as requested. Photographs were taken of injuries and shared with investigators as necessary. The facility was in substantial compliance with this item.	

	(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 facility Incident Management policy mandated investigations of serious incidents:
		• were to commence within 24 hours or sooner, if necessary (Item V);
		• were to be completed within five calendar days of the incident (Item VI.A.6);
		• did require a written extension request from the facility director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances (Item VI.A.6); and
		• were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action (Item VI.B).
		
		To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		• Five out of 20 (25%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation.
		  o The following were the investigations for which adequate investigatory process did occur within the first 24 hours or sooner, if necessary: DFPS Cases #37852000, #37799040, #38330109, #38399596, and #38423520.
		  o <u>Please note</u>: DFPS and the monitoring teams have discussed this issue and DFPS indicated that it planned to make the commencement of the investigation more explicit in the investigation report. In this way, actions taken by DFPS to commence an investigation will be clearly indicated.
		• Two out of 20 (10%) were completed within 10 calendar days of the incident.
		  o For all investigations not completed within 10 days there was documentation of a written extension request that had been approved
			Noncompliance

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		by the Adult Protective Services Supervisor. The following are some examples that did not show that extraordinary circumstances existed that necessitated the extension. ▪ In DFPS case #37623660, allegations of physical abuse and neglect were reported to DFPS on 8/1/10. The first extension request on 9/3/10 indicated that the investigator needed to interview additional witnesses. It was not clear why these witnesses were not available at an earlier date. On 9/13/10, a second extension was filed indicating that another interview was to be scheduled and training files were needed from the facility. There was no indication why training files were being requested more than a month after the investigation began. On 9/23/10, a third extension was requested for an additional interview with a psychologist at the facility. The investigation was finally signed and dated as completed on the 60th day (10/1/10). The facility's internal review sheet indicated that the final report was not received until 11/2/10. ▪ In DFPS case #37607740, an allegation of physical abuse was reported to DFPS on 8/24/10. An extension on 9/3/10 was filed stating that witnesses have not been available for interview. Two witnesses were interviewed following the extension request on 9/8/10. Both were employees of the facility. It is unknown why they were not available for interviews prior to that date. When asked to recall the day of the incident, one witness stated that she could not remember the events of that specific date. ▪ In DFPS case #37799040, an allegation of neglect was made on 9/5/10. An extension was filed on 9/16/10 stating that witnesses had not been available and video surveillance needed to be reviewed. Video surveillance records were not requested by the investigator until 9/16/10 even though it was immediately evident that the incident occurred in an area that was being monitored. The first interview was conducted on 9/7/10 and no additional interviews were conducted by the investigator until 9/17/10. Five additional interviews were conducted after 9/17/10. ▪ In DFPS case #38287869, involving neglect reported on 10/13/10, three extensions were filed. The case was closed on 11/20/10. All three extensions were requested so that additional interviews could be completed. It was not known	

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		why the individuals to be interviewed were not available at an earlier date. ▪ In DFPS case #38102680, three extensions were filed. The second extension dated 10/11/10 indicated that a statement was needed from the psychologist. A statement was not obtained from the psychologist until 10/18/10. There was no documentation indicating why this statement was not obtained prior to this date. ▪ In DFPS case #38413200, reported on 11/19/10, two extensions were filed on 11/29/10 and 12/9/10 for additional interviews to be conducted. There was no indication that this constituted extraordinary circumstances. o Seven (39%) of the 18 investigations not completed within 10 days were completed in 30 or more days. o Eleven (61%) of the 18 were completed in 15 to 30 days. For the one that was not completed within 10 days, there was documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. • All 20 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In 15 (75%) of the 20 investigations reviewed, concerns or recommendations for corrective action were included. The following are examples of investigations that included appropriate recommendations: o For DFPS #38410478, the investigator noted that there was a concern that the individual engaged in self-abusive behaviors, but there was no behavioral plan in place to address this. She recommended that the team meet to discuss and resolve the issue. o For DFPS #3785200, the investigator expressed concern regarding the extensive prior case history with the individual as the victim. It was recommended that staff were retrained on the individual's BSP. o For DFPS #3779904, the investigator expressed concern that there were only two staff on duty at night and one was one-to-one supervision. o In DFPS case #38287869, the investigator listed several concerns regarding documentation at the facility and recommended that the facility meet and address issues with documentation. o In DFPS case #38358764, the investigator expressed concern that staff was unaware of a wedge recommended in the PNMT plan for positioning and the wedge was not available. She recommended that	

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		the facility meet to address this concern. o In DFPS case #38258621, the investigator noted several concerns regarding documentation reviewed and witness statements including a concern that the individuals BSP indicated that she was an adult with no guardian, when there were guardianship papers in her record showing that she has a guardian. She also noted inconsistencies in her medical record regarding her risk for injury. The Incident Management Coordinator indicated that the facility continued to work with DFPS to expedite their investigation process. The issue had been discussed in quarterly interagency meetings. DADS reported that in the future, DFPS will work with regional staff to ensure that clear justifications are given for why particular witnesses were unavailable prior to the deadline for case completion. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Zero out of nine (0%) of the UIRs reviewed indicated when the investigation commenced. The UIR indicated when the incident was reported and what action was taken by the investigator, but did not include a time and date for the action taken (e.g., the UIR did not note the time and date the victim or witness was interviewed). • Eight out of nine (89%) were completed within 10 calendar days of the incident: o UIR #11-023 was reported on 12/15/10. The facility concluded its investigation on 12/27/10. • Eight of the eight (100%) completed within 10 days indicated that the facility director had reviewed the report on the day that the report was concluded, however, the director's name was typed with no signature. • All eight (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In nine of the investigations reviewed, recommendations for corrective action were included in nine of the investigations (100%). The recommendations were adequate to address the findings of the investigation. The facility needs to ensure that documentation reflects the day that the investigation concluded and dates and times for any follow-up action taken. The facility investigator and director should sign the report upon review. The facility was not in compliance with this provision.	

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	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Based on a review of SASSLC Incident Management Policy Item VI.B, it did require that:
		• the contents of the investigation report be sufficient to provide a clear basis for its conclusion, and
		• the report utilize a standardized format that sets forth explicitly and separately:
		  o Each serious incident or allegations of wrongdoing;
		  o The name(s) of all witnesses;
		  o The name(s) of all alleged victims and perpetrators;
		  o The names of all persons interviewed during the investigation;
		  o 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;
		  o All documents reviewed during the investigation;
		  o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		  o The investigator's findings; and
		  o The investigator's reasons for his/her conclusions.
		
		The only information that was found to not be routinely documented in DFPS reports was whether or not past allegations involving the AP or incidents involving the victim were considered in the evidence reviewed.
		
		To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		• In 20 out of 20 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		• The report utilized a standardized format that set forth explicitly and separately, the following:
		  o In 20 (100%), each serious incident or allegations of wrongdoing;
		  o In 20 (100%), the name(s) of all witnesses;
		  o In 20 (100%), the name(s) of all alleged victims and perpetrators(when known);
		  o In 20 (100%), the names of all persons interviewed during the
			Noncompliance

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		investigation; ○ In 20 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ○ In 20 (100%), all documents reviewed during the investigation; ○ In 0 (0%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ▪ In DFPS case #3860496, dated 11/28/10, involving an allegation of emotional/verbal abuse, the investigation did not include the AP's involvement in previous investigations, though he was the AP named in two other cases of emotional/verbal abuse on 8/22/10 and 10/13/10. A trend of prior allegations for the same AP in a close timeframe, even when unconfirmed, should at least be reviewed by the investigator for similarities. ▪ In DFPS case #37623660, one of the APs was involved in three other cases with similar allegations prior to completion of the case. This information was not included in the documentation. ○ In 20 (100%), the investigator's findings; and ○ In 20 (100%), the investigator's reasons for his/her conclusions. According to DADS, DFPS was preparing to implement policy and procedure that will instruct investigators to document the results of the prior case history review in the investigative report whether it was used or not. Currently, this information was stored in the IMPACT case management system, but did not translate to the written report. Facility Investigations The following summarizes the results of the review of facility investigations: • In seven out of nine investigations reviewed (78%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ○ For a serious injury involving Individual #348 documented on UIR #020, the only witness interviewed was the staff person who stated he was alone with the individual at the time of the accident. The investigator did not interview any other staff in the home to confirm the staff person's account of the incident or the nurse who saw the individual following the injury. ○ For a serious injury involving Individual #142 discovered on 11/29/10, there were some discrepancies in dates. It appeared that the incident occurred on 11/28/10 and was discovered on 11/29/10. The investigation was summarized in UIR #021. The chronology of the	

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		incident indicated that "the person served was found to have a swollen, bruised foot on 11/28/10." Other statements in the report indicated that the injury was not discovered until 11/29/10. It also indicated that the QMRP "spoke with the individual on 11/28/10" regarding the cause of the injury. In fact, it was more likely that the QMRP spoke with the individual at some point after 10/29/10 following discovery of the injury. • The report utilized a standardized format that set forth explicitly and separately, the following: o In nine (100%), each serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators when known; o In nine (100%), the names of all persons interviewed during the investigation; o In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In nine (100%), all documents reviewed during the investigation; o In eight (89%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. UIR #U11-020 did not indicate that the only witness in the incidents had been named as an AP in a physical abuse allegation three months prior to the incident. Findings were unconfirmed in the previous incident. o In nine (100%), the investigator's findings; and o In nine (100%), the investigator's reasons for his/her conclusions. All sources of evidence considered should be included in investigation reports. The facility is not in compliance with this provision.	
	(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	Based on review of SASSLC Incident Management Policy at section VII.C, the policy required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: (1) the investigation is complete; and (2) the report is accurate, complete and coherent. The policy required that the facility investigator must complete the Final Facility Investigation Report using the UIR format for each incident. This report is to be reviewed and approved by the facility director within five working days of the date the SSLC first learned of the incident (an exception is made for DFPS reports that are received within 10 calendar days from the date of initiation).	Noncompliance

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	or areas of further inquiry in the investigation and/or report shall be addressed promptly.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2 and #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 20 DFPS investigations included in Sample #D.1: • In 0 out of 20 investigation files reviewed (0%), there was evidence that the DFPS investigator's supervisor had conducted a review of the investigation report. • Investigation files included a review form completed by the facility titled Abuse/Neglect/Exploitation Review Authority. This form included a place to note allegations, findings, recommendations/concerns, and review by the Incident Management Coordinator, Director of Facility, Unit Director/Department Head, Facility Investigator, Human Rights Officer, ANE Coordinator, and Assistant Ombudsman. o In DFPS case #38301583, #38413200, #37623560, and #38258621, the facility requested a review of findings by DFPS based on concerns regarding evidence gathered during the review. <u>Facility Investigations</u> In nine out of nine (100%) UIRs reviewed for investigations not involving abuse or neglect, the form indicated that the facility director had reviewed the investigative report on the day that the investigation was completed by a typewritten name and date. None of the reports included the facility director, Incident Management Coordinator, or lead investigator's signature. It was noted that the facility policy required review within five working days of the incident; this timeline was met in seven of the 11 incidents reviewed according to the typewritten signature on the UIR. Three were completed in 10 or fewer days and one was reviewed 12 days from the date of the incident. There was no indication that review resulted in identification of any deficiencies in any of the final reports. The facility needs to ensure all investigations are promptly 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 should be noted and addressed by the reviewer. The facility was not in compliance with this provision.	

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	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A UIR was completed for each unusual incident in the sample.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	According to SASSLC Incident Management Policy IX.B, when disciplinary or programmatic action is necessary to correct a situation and/or prevent recurrences, the IMRT shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2 was selected for review. This subsample, Sample #D.6, included the following investigations: UIR 10-006, DFPS case #3839956, DFPS case #37623660, DFPS case #37623560, DFPS case #38413200, DFPS case #38330109, UIR#11-020, DFPS case #38350042 Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review: • For three out of six of the investigations reviewed (50%), prompt and adequate disciplinary action had been taken and documented. For example, the following disciplinary actions had been taken: o DFPS case #3839956 involved a confirmed allegation of physical abuse. The employee was dismissed following receipt of the investigative findings. o DFPS case #38330109 involved a confirmed allegation of physical abuse. The AP case was completed on 12/9/10 and the employee was dismissed on 12/22/10. In DFPS case #38350042, an allegation was confirmed of neglect. The employee was dismissed on 1/24/11. • The following are examples of investigations for which it did not appear prompt and appropriate disciplinary action had been taken: o In DFPS case #37623660, two allegations of physical abuse were confirmed. Video surveillance confirmed that the allegations did occur. Both APs falsely testified that they did not drag the individual across the floor, yet this was contradicted by video surveillance. Documentation of disciplinary action shows that both APs were returned to direct support positions following a suspension. There was no documentation	Noncompliance

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		o indicating that falsifying statements to the investigator was addressed with the employees. o In DFPS case #37623560, an allegation of physical abuse was confirmed. The employee was suspended for 10 days. This did not support the facility's zero tolerance for abuse policy. o DFPS case #38413200 indicated that a facility employee had physically abused the individual. There was no indication that the employee had been disciplined in regards to the confirmed allegation. • For eight out of eight (100%) of the investigations reviewed, prompt and thorough programmatic action had been taken and documented. For example: o UIR#10-006 involved a serious injury of determined cause that occurred on 9/26/10. On the day of the incident, nursing staff developed an acute care plan for the injury and documentation indicated that direct support staff were trained on the plan. o DFPS Case #38413200 included several recommendations regarding programmatic issues. The facility documented corrective action taken for each concern noted in the investigation. For example, there was concern expressed that the staff member was not familiar with the individual's BSP. The psychologist trained the staff member the day following the closure of the case. Additionally, all staff involved were retrained on abuse and neglect. DADS later reported that the case was under methodological review until 3/11/11. o DFSP case #38330109, staff were in-serviced regarding the individual's BSP and PNMP as recommended in the investigative report. o UIR #U11-020 included recommendations for a change in LOS. The investigation indicated that the individual's LOS was increased and staff were in-serviced on the new LOS. It was also recommended that follow-up be scheduled with a neurologist. An appointment was scheduled. o DFPS case #38350042, the investigator noted concerns regarding staff's lack of knowledge regarding information in her PMNT. The facility follow-up included retraining all staff in the home on the individual's PMNT The facility needs to ensure that appropriate disciplinary action is taken and documented when appropriate. The facility was not in compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner	Based on review of SASSLC Incident Management policy Item V.D, records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff	Substantial Compliance

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	that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	member or individual. At the facility, investigation files were maintained in the investigator's office. Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The facility was in substantial compliance with this provision.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had a system in place to track data and trend information on unusual incidents and investigations. Data were compiled in a monthly and quarterly report with trends by: • Type of incident, • Staff alleged to have caused the incident, • Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The facility compiled quarterly reports that focused on all unusual incidents, all allegations of abuse and neglect, and all injuries. Reports allowed for the examination of any trends that may be significant for further review. A narrative summary of the data was included in the report. The facility's Incident Management Review Team reviewed these reports to address any significant trends indentified. The data were incorporated into the facility's overall quality assurance program. The facility was in substantial compliance with this provision	Substantial Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System	Substantial Compliance

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	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.	• Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility director had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 50 employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2010. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. The facility provided the monitoring team with a list indicating there were 11 applicants who were not hired based on background checks and two employees were terminated due to results of annual background checks. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample of self reporting forms for criminal activity was reviewed for five current employees. Documentation indicated that employees self reported criminal activity and the facility maintained information regarding the allegation and resolution of the case. In an interview with the facility director, he described action taken when applicants either reported or failed to report criminal offenses. The facility director made the final determination on continuation of employment, dependent on the outcome of a criminal investigation. His decisions were based on the facts and were mindful of his responsibility to safeguard the individuals and staff of the facility. The facility was in compliance with this provision of the Settlement Agreement.	

Recommendations:

1. Ensure that all follow-up action to investigations reflects the facility's policy of zero tolerance for abuse and neglect.

2. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.

3. The facility needs to ensure notification is made to all parties required within required timeframes in regards to investigations.

4. The facility needs to ensure that all staff responsible for completing investigations has completed training required by the state policy.

5. Include documentation in investigation files regarding steps that were taken to ensure alleged perpetrators were not reassigned to direct contact with individuals pending either the investigation's outcome or at least a well-supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.

6. Ensure investigation reports include a summary of the investigator's analysis of the history of the alleged victim and alleged perpetrator if relevant to the current investigation.

7. The facility needs to ensure all investigations are promptly 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 should be noted and addressed by the reviewer.

8. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs.

9. The facility needs to ensure that documentation reflects the day that the investigation concluded and dates and times for any follow-up action taken. The facility investigator and director should sign the report upon review.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o SASSLC QE policy, #200-1, identical to DADS policy #003 o SASSLC QE Data Collection policy, #200-1B, dated 1/1/11 o SASSLC QE Plan policy, #200-2, dated 12/10 o SASSLC QE Plan, 2010 o Organizational chart, July 2010 o SASSLC policy list, two pages, not dated o List of typical meetings that occurred at SASSLC o SASSLC POI, December 2010 o SASSLC QE Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/7/11 o Set of tools used by the QE staff (see list below in E1) o Set of 12 blank new nursing monitoring tools o Completed PSP monitoring tool for PSP meeting observed by monitoring team, 2/7/11 o SASSLC QE Report, December 2010 data o SASSLC QE Reports, Monthly for September 2010-November 2010 o Various data graphs and charts for some of the data collected by the QE staff (see list below in E1) o QAQI Council meeting minutes: 2/9/11, 2/3/11, 1/21/11, 1/12/11, 12/15/10, 11/22/10, 11/16/10, 11/3/10, 10/26/10, 10/6/10, 9/16/10 (11 meetings) o QAQI Council meeting agenda, 2/9/11, and numerous handouts from that meeting o SASSLC residential services recruitment, hiring, and retention plan, 8/31/10 o SASSLC residential services staff survey questionnaire, three pages o SASSLC employee staff council monthly meetings minute, four meetings 10/10 to 1/11 o DADS survey of staff engagement (satisfaction) for SASSLC staff, February 2010 o SASSLC newsletter for employees and friends of SASSLC, The Bridge, 3/10, 6/10, 9/10 o DADS SASSLC family satisfaction survey online summary, 15 respondents o SASSLC CMS ICFMR review report, 9/24/10 o Self-advocacy meeting minutes, monthly, 10/10 to 12/10 (three meetings) Interviews and Meetings Held: o Ralph Henry, Facility Director o Larrie Collier, Director of Quality Enhancement o Joshua Castro, Laurence Algueseva, Mary Sweeney, QE department staff o Mandy Pena, QE department nurse o Moneke Tyner, Settlement Agreement Coordinator o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors

- Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs.

Observations Conducted:
- Many residences, day program, and vocational program
- QAQI Council Meeting, 2/9/11

Facility Self-Assessment:

The facility completed its self-assessment for this provision, called the POI. The POI had been extensively revised since the last monitoring review as noted in the Monitor's executive summary above. The facility rated itself as being in noncompliance with all five items of this provision. The monitoring team concurred with the facility's self-ratings for all of these provision items.

The narrative portions of the POI provided very limited information, but the QE director added more details during discussions with the monitoring team during the onsite review. The comments from the POI are listed below and reflected the content of these discussions, however, these comments are more a reflection of the intentions of the QE department rather than the status of its operation at the time of the onsite review.

- The QA Department…expanded the QA Plan to develop monitoring and data collection of various service deliveries.
- Because of the expansion of the QA Plan, QA Reports will be more detailed and identify areas in which corrective action is necessary. These reports will be reviewed in the QA/QI Council meetings where responsibility of corrective action plans will be identified and assigned.
- QA Department reviews the status of corrective action plans during QA meetings and modifies outcomes and adjusts times to meet deadlines as needed.

There were a number of action plans and they referred back to many, but not all, of the recommendations made in the previous monitoring report. The comments seemed reasonable and pointed to the activities and actions the facility was planning to take towards meeting those outcomes of the POI.

In addition, the presentation book prepared by the facility for this section of the Settlement Agreement was reviewed. Although not a requirement of the Settlement Agreement or the monitoring team, the facility's intention was for the presentation books to be an easy way for the monitoring team to learn about progress and activities of the department in relation to this provision. The SASSLC presentation book contained the new QE plan and new QE report.

Given the expected continued develop of the QE program at SASSLC, and given the upcoming assignment of a new QE director, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components.

	Summary of Monitor's Assessment: SASSLC was not in compliance with any of the items of this provision, however, progress had been made since the previous review and the QE department's activities appeared to be pointed in the right direction towards eventual substantial compliance. The current QE director's last week at SASSLC was during the week of the monitoring team's onsite review and a new QE director was being recruited. A new QE director will need proper and thorough support and direction in order to maintain the facility's progress. Specific suggestions are given below. The development of an initial QE plan was one area in which the facility had made progress. The QE plan listed the topic areas and tools used by QE staff to collect data or to monitor as well as the frequency of review and sample size. The review below specifies the ways in which the QE plan needs to be developed in order to be comprehensive and useful to the facility. A second area of improvement was the entering of QE-collected data into a database and the creation of graphs and tables. A third area was the creation of a QE report that contained some of these data and graphs. Comments are provided below regarding ways to make the QE report a more comprehensive and useful document. A fourth area of improvement was the initiation of the QAQI Council. A number of meetings had been held since its inception in September 2010. To be successful it will require an operating policy and procedure, a regular agenda of required topics, discussion of relevant topics, review of data, generation of corrective actions, and meaningful participation by members. Some of the monitoring teams' checklist tools had been, or were being, modified by the facility to make them more user-friendly for facility staff and thereby more useful. This was good to see and the monitoring hopes this activity will continue for all areas of the Settlement Agreement. Staff satisfaction and retention were a focus of the facility over the past six months. Positive results were obtained. A family member/LAR survey was recently initiated and results were only beginning to be received by the facility. The self-advocacy group had been meeting each month. A new human rights officer was being recruited to, among other responsibilities, facilitate the self-advocacy group. Meeting minutes indicated relevant topics were discussed. The monitoring team continues to suggest that the forum be used to teach individuals decision-making and problem solving skills.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living	SASSLC's QE program had improved and advanced since the previous onsite monitoring review. Much of the activity had only recently been initiated and more work needed to be done. Thus, although this item was found to be in noncompliance, the monitoring team was encouraged by the direction the facility and its QE staff were headed.	Noncompliance

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	units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>Policies</u> The DADS statewide policy #003: Quality Enhancement, dated 11/13/09, was adopted by the facility and renamed SASSLC QE policy, #200-1. This state policy, however, was being revised and was likely to be disseminated some time in the next few months. The facility will likely benefit from receiving additional direction via this new policy. In addition to the state policy, SASSLC had developed and implemented two facility-specific policies: SASSLC QE Data Collection policy, #200-1B, dated 1/1/11, and SASSLC QE Plan policy, #200-2, dated 12/10. The first policy briefly described QE's role in data collection and noted that data will be used for decision-making, and that monthly and quarterly reports were to be completed and submitted to the QAQI Council. The second policy stated that the QE plan was to include data, data were to be analyzed, resources would be devoted to this task, and corrective actions will be taken. Both of these policies, however, did not provide much detail and served more as an initial attempt at creating facility-specific policy. This was good to see, however, these policies should be revisited so that they provide more specifics as to the purpose of each policy. In addition, the facility should assess whether additional facility-specific QE policies are needed. For example, the monitoring team recommends that the facility develop an operating policy and procedure for the QAQI Council. <u>QE Department</u> The QE department was led by the QE director. He was in this position for about a year and a half. He also had responsibility for incident management at SASSLC. Unfortunately, the week of the onsite review was also his last week as QE director. The facility was, therefore, in the early stages of conducting a search to hire a new QE director. Interim plans were also being determined. The monitoring team hopes that the new QE director will continue to move the QE program towards substantial compliance with this provision of the Settlement Agreement. As the facility prepared to hire a new QE director, the monitoring team offers the following suggestions to assist in orienting the new director: • Mentor with an experienced QE director at another facility • Communicate regularly with the DADS central office discipline head for QE • Read, in detail, the previous monitoring reports for section E for SASSLC as well as for the other SSLCs reviewed by this monitoring team • Bring the SSLC QE directors together periodically to share common concerns • Share best practices across facilities • Set a minimum standard of outcomes and activities for every QE department. Each facility's QE department could then build upon these minimum	

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		expectations as per the unique needs of each facility. It might be helpful to facilities if these minimum standard outcomes and activities were included in the new DADS QE policy. The other members of the QE department had not changed since the previous onsite review. All four remained committed to having a quality QE program. They were dedicated and appeared to be organized and thoughtful about the way they conducted their activities. The facility was fortunate to have these staff members and the monitoring team appreciated their time during the onsite review. The facility should consider ways of supporting the continued professional development of the QE staff regarding generally accepted professional standards in quality enhancement and quality assurance in the field of developmental disabilities (e.g., readings, texts, workshops, invited presentations). The monitoring team met with the QE director, the QE staff (two program auditors, QE and QE data analyst), and the QE nurse. Across these three meetings, topics included quality assurance (in general), the QE plan, data collection, handling and management of data, graphing, inter-rater reliability, QE reporting, and provision of feedback to staff and managers. The monitoring team hopes that the QE department found these discussions to be useful. Moneke Tyner, the Settlement Agreement Coordinator, played a role in the collection and organization of data at the SASSLC. Both the QE director and the SAC were professional and responsive to the many requests of the monitoring team during the weeks before, during, and following the onsite review. The new QE director should be sure to collaborate with the SAC. As the QE program develops, more interaction and coordination will need to occur with the facility's service and operations departments. Three examples indicated that the QE staff were successfully working with other departments: • QE was no longer doing audits of individual unified records because these audits were being done by the unified records coordinator (see section V below). The plan was for the URC's data to eventually be submitted to the QE department for tracking and trending. This type of activity (i.e., the collection of data by a service department and then submission of those data to the QE department) is likely to occur more and more at SASSLC, also see discussion immediately below regarding the QE plan). • The QE nurse reported that she had an outstanding working relationship with the nursing department. • The QE-collected measure of activities at the PSP meeting was an outdated form	

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		that did not correspond with the new style of the PSP meetings, including format (i.e., free flowing) and content (e.g., at-risk determinations, optimal living discussion). The QE department will need to update this monitoring tool. Even so, the QE department might also benefit from taking some specific steps to more fully integrate into the overall operation of the facility. The monitoring team suggests that the QE director and SAC contact the QE director at the Lufkin SSLC regarding some of that facility's activities. These are also summarized in the October 2010 compliance monitoring report for Lufkin SSLC. Quality Enhancement Plan The development of an initial QE plan was one of the QE department's accomplishments since the last onsite review. Although the QE plan was not complete, the plan presented to the monitoring represented a reasonable beginning upon which to build a full QE plan. SASSLC's QE plan listed, in spreadsheet format, the measurements that were collected by the QE staff. That is, each row represented one of the QE staff's tools (these are listed in the next subsection of this report). Columns showed, for each of these tools, the person responsible for collecting the data, the frequency of the data collection, the specific tool that was to be used, and the sample size (other columns provided additional, but relatively useless, information). • The first 10 rows were QE-collected data and there were QE-created tools for each of these. • The next nine rows were health-related information, all taken from one of the 12 nursing monitoring tools (Annual/Quarterly Assessments). This information could be condensed into a single row and, moreover, an additional 11 rows could be added thereby creating a total of 12 lines in the QE plan, one row for each of the 12 nursing monitoring tools. • The next four rows were for each of the four components of the state's required trend analysis reporting (restraints, ANE allegations, unusual incidents, and injuries). It was good to see these metrics included in the QE plan. • The final nine rows were for a variety of other facility data and Settlement Agreement provisions, however, there weren't any specific tools for these items and it appeared to the monitoring team that these were perhaps placeholders for future development. SASSLC should consider the following next steps in its development of a comprehensive QE plan: • First, create a listing of all of the data that are collected at the facility. This would include all the types of data that are collected by all of the facility's many service	

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		and operational departments and staff. The San Angelo SSLC had begun to embark on these actions and the SASSLC QE director might benefit from contacting the San Angelo SSLC QE director. o Most of these data will be service provision or operational data. o Some of these data will also be from the service department or operational department's own self-monitoring. o Examples of data already likely collected at the facility that might be included in this comprehensive listing: ▪ Set of nursing data collected by the nursing department, especially regarding the incidence of certain disorders and illnesses. ▪ Set of data collected and managed by the medical department, including, for example, hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals. ▪ Direct care staffing levels. ▪ DADS All Hazards Preparedness and Response Plan. ▪ Data from the Admissions and Placement Coordinator and the Post Move Monitor (e.g., referrals, placements, obstacles to placement). ▪ Assigned risk levels. In addition, the QE department might consider doing reliability assessments of the risk levels assigned to individuals. ▪ The four provision items that specifically refer to the need for quality assurance (F2g, L3, T1f, and V3). ▪ Health Care Guidelines. ▪ Dental Guidelines. ▪ Staff satisfaction. ▪ Family/LAR satisfaction. • Then, the QE department, along with the QAQI Council, would determine which of these data were to be submitted to the QE department. o Some of the data submitted to the QE department would be included in the QE plan and thereby tracked and trended. o Some, but not necessarily all, of the data would be included in the QE department's QE report. • Incorporate into the QE plan the many areas that should be under the purview of the both the QE department and the QAQIC (i.e., senior management), such as items from each of the areas described in a correspondence from the DADS Assistant Commissioner for the SSLCs and sent to the QE departments at all of the SSLCs:	

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		◦ Settlement Agreement compliance reviews ◦ DADS ICFMR reviews ◦ the facility's own mock ICFMR reviews ◦ Life Safety Code reviews ◦ the FSPI ◦ All relevant quality assurance data from functional service areas of the facility (this is a repeat of the first two bullets above). • Continue to include in the QE plan all of the QE-collected data that are listed in each of the first 23 rows of the current QE-plan (though consider the suggestion regarding the health care rows given above). The DADS policy required the development and implementation of a quality enhancement plan. Moreover, even if not required by state policy, a QE plan will increase the likelihood of the facility meeting the requirements of this provision. QE Activities and Indicators The activities of the QE staff were primarily • the collection of data via direct observation, review of records, and staff interview • provision of feedback to staff and managers • participation on various committees and attendance at various meetings The QE staff determined which individuals and locations to monitor, and which PSP meetings to attend. They followed the QE plan when determining the frequency of review and sample size. Most of the tools described in the last monitoring review report continued to be implemented at SASSLC. The facility was incorporating the use of the monitoring tools used by the monitoring teams, but more importantly, had revised some of those tools to be more appropriate and user-friendly for facility staff (e.g., the 12 nursing self-monitoring tools). The monitoring team believes that this was a statewide activity and that the intention was to eventually adapt or develop self-monitoring tools for all Settlement Agreement provisions that were based upon, but not identical to, the tools used by monitoring team members. The monitoring team recommends that the state continue this activity. Below are listed the areas/topics monitored by the QE staff. Most of these appeared on the QE plan and some, but not all, appeared in the QE report: • Support observation and staff interview • Engagement, dignity and respect, and group management	

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		• Level of supervision • PSP meetings • Home management team meeting • Mealtime • Rights and restrictive practices • Appearance of individuals • PSP meeting documentation completed following the annual meeting • FSPI • 12 nursing tools adapted statewide from the monitoring teams' checklist tools • Trend analysis (statewide reporting on four areas: restraints, abuse neglect allegations, unusual incidents, and injuries) Recently, beginning in September 2010, the data collected by QE staff were entered into a database. Tables and graphs were created from the data by the QE department's data analysts. This was another example of the progress made by the QE department since the previous onsite review. Interobserver agreement had not yet been obtained for these measures, except for three of the nursing health care measures. That is, of the 12 tools used by the nursing department to self-monitor, the QE department was conducting interobserver reliability checks on three of the 12 (diabetes, pain, hypertension). The QE department's plan was to eventually conduct reliability checks on all 12. The results of the reliability checks were not yet calculated or summarized, however, the monitoring team and the QE nurse discussed the calculation of reliability as well as ways to present the results within the QE report. As the monitoring tools are revised to be used by the service departments, obtain interobserver agreement between service department staff and QE staff on the monitoring tools that are implemented by service department staff. In addition, the QE department should obtain interobserver agreement across QE staff for those tools that are only used by QE staff. In the baseline report and in the last monitoring review report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QE system at SASSLC. Some progress had occurred and some activities were just beginning. First, a staff satisfaction survey was initiated for residential staff by the residential unit director. It was a three-page survey and contained relevant questions. The blank form was shared with the monitoring team, but results were not because, in part, the survey was new and results were not yet tabulated. The plan, according to a note in "The	

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		Bridge" newsletter, was for to occur every six months. In addition, the unit directors, assistant director of programs, and facility director developed and implemented a new recruitment, hiring, and retention plan. To that end, SASSLC unit directors contacted other facilities (e.g., Richmond SSLC) to learn some of what facilities with low turnover rates had been doing. SASSLC's turnover rate was more than 60% and was reported to have dropped to 33% at the time of this onsite review. DADS should consider ways of sharing of these types of successes across SSLCs. Most impressive about the SASSLC activities was its focus on (a) support for new staff during their first three months, and (b) retention and staff satisfaction. Some of the actions initiated included: • Scheduled communication opportunities with direct supervisors and unit directors. • Recognition, appreciation, and positive reinforcement . • A new employee council that met monthly: a representative from each of the 13 homes met with the ADOP as a group over lunch. Meeting minutes showed that many relevant topics were discussed. The DADS survey from February 2010 was also reviewed by the monitoring team. Although the data were now more than a year old, management at SASSLC should also review the report to determine if there was anything of value to help inform and guide future activities by management. Second, DADS had recently initiated a survey of satisfaction of family members and LARs. The monitoring team was pleased to see this new activity. One-twelfth of the families and LARs were to be surveyed each month. Responses could occur via a paper format or via an online format. As of the week of the onsite review, 15 families/LARs had completed the survey. Overall, the comments were positive about SASSLC services. The specific comments provided on question #68 and question #69 should be reviewed and follow-up conducted, if warranted. Third, a measure to survey the satisfaction of related community agencies, providers, and vendors was not yet in place. The monitoring team continues to recommend doing so. Fourth, as also noted in the previous monitoring review report, self-advocacy meetings present another way of obtaining information that may be useful to the QE department and facility management. It also can provide a context in which individuals can be taught group problem solving and decision-making skills. Self-advocacy minutes for three monthly meetings, 10/10 to 12/10 were reviewed. Topics appeared to be relevant for	

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		the attendees and included: The five rights, restarting a self-advocacy newsletter, what does self-advocacy mean to you, what are your dreams, communication and SLPs, and "Speak Up" (bring up your concerns). An additional suggestion is to include in this meeting the teaching (and learning) of a structured group problem solving process, such as: • Define the problem in objective terms. • Generate two to four possible solutions. • Discuss the pros and cons of each solution. • Vote to choose a solution to implement. • Develop a plan to implement the solution. • Develop a plan to report on the results of implementation of the solution. The human rights officer was the facilitator of the SASSLC self-advocacy group. He had resigned from his position a few weeks prior to the onsite review. A new human rights officer had not yet been assigned. Support for the self-advocacy group, including the above recommendation, should be a priority for the new human rights officer. <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 at SASSLC, according to the QE director. The policy required a program improvement council; this was in place at SASSLC and is described in section E2 below. It was changed to a new title in September 2010, the QAQI Council. <u>QE Reports</u> The development of a QE report had occurred since the previous onsite review and was another accomplishment of the QE department. It is discussed in more detail below in E2.	
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	This provision item required the facility to analyze the data collected by the QE processes that were 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, however, progress had been made since the last onsite review. <u>QE Report</u>	Noncompliance

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	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.	As noted above, a QE report had been developed and, due to its recent introduction, had been, and was going to continue to be, reviewed and expanded. Nevertheless, even though inadequate, it represented a good start from which a more comprehensive and useful report could be created. Three monthly reports were submitted to the monitoring team (9/10 through 11/10). A fourth report, for 12/10, was completed right before the onsite review and was also presented at the QAQI Council (see below). The first three reports had a short section for each of the QE-collected data areas (listed above in E1). Each short section had a summary of the data and a few bulleted points of interest. The fourth report was far more lengthy and included graphic presentations of some of the data. The fourth report appeared to be well received by the QAQI Council and set the occasion for discussion among senior management attendees. Below, are some recommendations for the continued development and improvement of the facility's QE report (in addition to the points made above in E1 regarding the topics and data to include in the QE plan and QE report). • Try to minimize the number of pages by using an appropriate font size and including graphs on the same page with the narrative bullet points, when possible. • Use bullets to display the important points about each data set. • Only present information that is useful to the reader, therefore, consider the content of each bullet point. • Be thoughtful about when to use a line graph and when to use a bar graph. This was one of the topics of the discussions between the QE staff and the monitoring team. Briefly, line graphs are appropriate for data that are collected over time. The line graph is then helpful in determining trends over time. Bar graphs are more useful when comparing data across homes, individuals, types of incidents, and so forth. • Make graphs a consistent size. • Ensure the ordinate on each graph goes no higher than 100%. • Only include the trend analysis and its four components summarized and graphed in the same manner as all of data are presented, that is, don't include the 30 or so pages that are submitted to central office. • Specify when and why a corrective action plan is needed. <u>QAQI Council</u> The QAQI Council had met regularly, approximately two times per month, since its inception in mid-September 2010. Minutes from 11 meetings were reviewed (including minutes for the meeting attended by the monitoring team) and indicated a range of	

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		topics, primarily related to administrative, regulatory, and Settlement Agreement areas. It appeared, however, that the meetings were used to make announcements and provide information to the attendees rather than for discussion regarding quality enhancement and facility improvements. The meeting observed by the monitoring team, however, included more extended discussion about SASSLC services. The presentation of the QE report seemed to set the occasion for this discussion. For example, one of the components of the QE report presented by the QE director included data on the completion of the PSP document. Some of the scores were low. The facility director asked if more training was needed. The ensuing discussion included participation from the QMRP coordinator, QE program auditor, assistant director of programs, QE director, assistant director of administration, and director of active treatment. A second example was in regards to the trend analysis data. The facility director asked questions about differences in frequencies depending upon day of the week. It turned out that the day of week was not an important variable (and therefore, in the opinion of the monitoring team, should have been excluded from the QE report because it did not provide any valuable information to the QAQI Council). The meeting minutes from the QAQI Council should reflect these extended discussions (the current minutes did not). Moreover, the QAQI Council would benefit from having an operating policy and procedure to help delineate its purpose and guide its activities (e.g., agenda topics, expectations of participants). The information presented throughout this section of the report (section E) as well as the direction provided by the DADS Assistant Commissioner for the SSLCs should be used by the facility in the development of this policy and procedure. <u>CAPs, PITs, and PETs</u> The QE department had begun to try to track corrective action plans. The department used the state policy's CAP tracking spreadsheet. The QE department intended to have a CAP for all items that scored 70% or less on QE-collected monitoring. Unit directors and other administrative staff were expected to be involved in developing and responding to CAPs. The tracking sheet had only been recently initiated and did not yet contain all of the items that scored below 70%. Further, the contents regarding actions to be taken did not provide any other information other than one of these two phrases, "An action plan is needed…." Or "Team develops plan…." It seemed odd that one would have a corrective action plan that called for an action plan rather than including the actions within the corrective action plan. Therefore, this was one more area in which the facility had made progress, but still had more work to do. The QE director noted that they were not yet	

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		where they needed to be in this area, but were working towards it.
		
		The monitoring team has a number of considerations for the facility as it moves forward with meeting this requirements of this provision item. These considerations could be included in SASSLC's facility-specific policies regarding QE and the QAQI Council.
		• Determining whether or not corrective action is required (e.g., based on scoring of a monitoring tool, based on a level of data submitted, based on discussion at QAQI Council.
		• If there is a determination that corrective action is required, describe what that action will be. A formal Corrective Action Plan (CAP) is one possibility, but there are other types of corrective actions that might be more appropriate (e.g., development of a new policy, decision by facility director).
		• Create a method for tracking all corrective actions, not only corrective actions that require a CAP.
		• A corrective action, whether it be a CAP or not, may involve the formation of a Performance Improvement Team (PIT). A PIT, once formed, might also delegate certain activities to a Performance Evaluation Team (PET).
		• Specify how the requirements for corrective actions will meet the requirements of the items of this provision, that is:
		  o E2: 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.
		  o E3: disseminate corrective action plans
		  o E4: monitor and document implementation and outcomes of the corrective action
		  o E5: modify corrective actions as needed.
		
		SASSLC did not have any Performance Improvement Teams of Performance Evaluation Teams (PET).
		
		The monitoring team expects that an organized system of managing corrective actions will be created and maintained in the future and be available for review for the next monitoring review.	

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	SASSLC was not in compliance with this provision item.	Noncompliance

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	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.	See comments above in section E2.	
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 new DADS policy once it is disseminated.
2. Revise the two facility-specific policies to be more detailed and useful.
3. Develop a policy and procedure for operation of the QAQI Council.
4. Consider whether other facility-specific policies could be developed to assist the facility.
5. Orient the new QE director. Consider the suggestions made in E1 above, including mentor with an experienced QE director, communicate regularly with the DADS central office discipline head for QE, read previous monitoring reports for SASSLC and the other SSLC reviewed by this monitoring team, and collaborate with the SAC.
6. Develop the QE plan into a more comprehensive plan. Details are provided in E1 above. They include, create a listing of all data collected at the facility, determine which of these data should be submitted to the QE department, incorporate a variety of other types of data into the QE plan.
7. Update the tool used to monitor the PSP annual meeting.
8. Continue to revise the monitoring teams' checklist tools into versions that are useable by the facility and the QE department.
9. Obtain interobserver agreement between service department staff and QE staff on the monitoring tools that are implemented by service department staff. Obtain interobserver agreement between QE staff for those tools that are only used by QE staff.
10. Use data from staff satisfaction surveys. Summarize the data, track it across successive six-month surveys, and have a plan to respond to the results.
11. Use data from family satisfaction surveys. Summarize the data, track it across successive six-month periods, and have a plan to respond to the results.

12. Measure satisfaction of community affiliated agencies, providers, employers, health care providers, and so forth.

13. Hire and orient new human rights officer to his or her responsibilities regarding the self-advocacy group.

14. Develop the QE report into a more comprehensive and useable document. Consider the recommendations made in E2 above.

15. Create graphs of QE data that are consistent in format and understandable to the reader. Use line graphs or bar graphs correctly.

16. Ensure QAQI Council addresses all of the required topics as per direction from the DADS Assistant Commissioner for the SSLCs, and as detailed above in E2.

17. Ensure that QAQI Council engages in meaningful discussion about relevant topics.

18. Develop a comprehensive system to generate, implement, manage, and track corrective actions, as per E2 through E5, and as described above.

The following are offered as additional suggestions to the facility:

19. Engage the QE staff in professional development activities related to quality enhancement.

20. Consider other activities to integrate QE more fully into the facility. The monitoring team suggests that the QE director contact the QE director at the Lufkin SSLC.

21. Share successes and best practices regarding staff retention across SSLCs.

22. Include instruction in decision-making and problem solving during the self-advocacy group (and in other settings if possible).

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 Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum o SASSLC List of PSP development dates o SASSLC Admissions and Separations List 8/1/10 – 12/31/10 o The following documents for a sample of individuals: • Individual #150 – PSP dated 12/14/10, Assessments, SPOs • Individual #244 – PSP dated 12/14/10, Assessments, SPOs • Individual #72 – PSP dated 12/7/10, Assessments, SPOs • Individual #43 – PSP dated 12/16/10, Assessments, SPOs • Individual #140 – PSP dated 1/4/11, Assessments • Individual #289 – PSP dated11/18/10, Assessments, SPOs • Individual #276 – PSP dated 12/15/10, Assessments, SPOs • Individual #423 – PSP dated 12/16/10, Assessments, SPOs • Individual #87 – Draft PSP dated 1/7/11, Assessments, SPOs • Individual #83 – PSP dated 11/17/10, Assessments, SPOs • Individual #229 – PSP dated 1/6/11, Assessments • Individual #304 – PSP dated 12/9/10 • Individual #250 – PSP dated 12/9/10 • Individual #254 – PSP dated 1/5/11 • Individual #40 – PSP dated 12/2/10 • Individual #298 – PSP dated 1/4/11 • Individual #327 – PSP dated 1/5/11 • Individual #86 – PSP dated 12/2/10 • Individual #194 – Draft PSP dated 12/7/10 • Individual #327 – Draft PSP dated 1/5/11 • Individual #216 – Draft PSP dated 12/16/10 • Individual #292 – Draft PSP dated 12/14/10 o Review of documentation regarding psychiatry attendance at PSP meetings <u>Interviews Held:</u> o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Ralph Henry, Facility Director

	- Audrey Wilson, QMRP Coordinator - Pat Delgado, At Risk Coordinator - Lawrence Algueseva, QE Program Auditor <u>Observations Conducted</u>: - Observations at all residences and day programs - Annual PSP meetings for Individual #201, Individual #302, and Individual #306 - Observation of VAT training class for Individual #308
	Facility Self-Assessment: The facility's POI indicated that the facility was in compliance with about half of the provision items in section F. The POI indicated that the new PSP process had been implemented and procedures were in place to address many provisions in Section F. The monitoring team, however, could not support a compliance rating with Section F. As noted below, although there was progress noted towards substantial compliance, procedures were not yet consistently implemented to ensure that all individuals had a comprehensive plan in place to address needed services and supports.
	Summary of Monitor's Assessment: Compliance with section F of the Settlement Agreement will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings. PST meetings observed the week of the monitoring visit were in the new style format. For all QMRPs facilitating the meetings, this was a fairly new process for them, as well as for other team members participating in the meetings. As expected, the meeting format was not yet completely comfortable for the QMRPs and the other team members. Discussion with QMRPs throughout the visit indicated that they were becoming more fluent with the process, and other team members were learning how to contribute

	information at the meetings that would facilitate development of a plan that included supports necessary for individuals to achieve specific outcomes relevant to their preferences and identified needs. At the PSP meetings observed, team members discussed supports needed in relation to the individual's preferences and interests. While this led to a more integrated plan, there was still not much progress made on identifying outcomes that would support movement towards living and working in a less restrictive environment. The new QMRP coordinator was aware of the challenges facing teams and had begun to look at strategies to facilitate the team planning process and plan development. QMRPs were the team members designated to facilitate meetings and model the new process during the planning stages. It was evident in observing team meetings throughout the monitoring visit that some QMRPs were more comfortable with the new process than others. All meetings observed were lengthy and the teams struggled to cover all information required for PSP development in a reasonable amount of time. It will be important to provide additional training and mentoring to QMRPs to ensure that this process develops into one that is meaningful and productive for the teams. Quality enhancement activities with regards to PSPs were in the initial stages of development. 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. The new format of the plans indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding supports that the individuals needed throughout the day was more clearly stated in the newer PSPs. As noted throughout section F, while there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaningful day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. Throughout section F, the monitoring team has focused on trying to provide the facility with examples of where, when applicable, changes have been effective in producing desired outcomes and examples of areas where problems have been identified and will need to be addressed as new procedures are developed. The monitoring team looks forward to seeing how systemic changes will impact specific outcomes for individuals once the facility has had a chance to implement these changes.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two		

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	years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs at the facility were responsible for facilitating PST meetings, and for developing, monitoring, and revising treatments, services, and supports. All PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings as required. A sample of PST attendance sheets were reviewed for presence of the QMRP at the annual PST meeting. This sample included the PSPs for Individual #234, Individual #194, Individual #254, Individual #304, Individual #40, Individual #229, Individual #83, Individual #72, Individual #276, and Individual #43. At 10 out of 10 (100%) annual meetings, there was a QMRP present. Observation of team meetings during the monitoring visit revealed that QMRPs were struggling to facilitate efficient meetings in line with the new person centered plan development process. Two meetings observed by the monitoring team lasted close to three hours each. In one of these, the individual began hitting herself in the head by the end of the meeting (Individual #201). She had clearly stated her preferences and vision, but rather than brainstorming ways that the team could support her, a large part of her meeting consisted of input by the team on why her behaviors prohibited her from achieving her vision. A lengthy discussion of risk factors that could have taken minutes instead lasted over an hour. It was a frustrating process for both the individual and team members attending the meeting. The QMRPs role should be one of encouraging the individual and the team to develop necessary supports and strategies necessary for achieving desired outcomes. In these two annual PST meetings attended by the monitoring team, the QMRP Coordinator attended the meeting and modeled facilitation skills when necessary. It will be important that this kind of mentoring continues to occur as QMRPs are becoming comfortable with the new PSP process. The QMRP Coordinator had begun facilitating monthly QMRP meetings to share information and discuss problems. This was good to see and will likely lead to more efficient use of the time spent in the annual PSP meeting. See comments throughout this report regarding plan implementation, monitoring of plans, and revision of treatments, services, and supports. It was found that the planning process did not always result in a plan that was developed and accessible to staff responsible for implementing the plan. The facility was not in compliance with this provision.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals	A sample of attendance sheets was reviewed for compliance with this provision with the following results in terms of appropriate team representation at annual PST meetings. • Eight (80%) of 10 indicated that the individual attended the meeting;	Noncompliance

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	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.	• Four (40%) of 10 individuals had an LAR; four of these four (100%) were present at the annual PST. Staff present by discipline where relevant at the annual PST meeting included: • In 10 (100%) of 10, the QMRP attended the meeting, • In 10 (100%) of 10, residential staff attended, • In 10 (100%) of 10, day habilitation staff attended, • In five (100%) out of five, vocational staff attended, • In 10 (100%) of 10, nursing staff attended, • In nine (100%) out nine, psychology staff attended, • In zero (0%) out of five, the psychiatrist attended, and • In four (44%) of nine, appropriate PNM staff attended. • In one (25%)of four, appropriate nutritional staff attended. The following are comments regarding participation in PST meetings for these 10 individuals: • For Individual #304, there was a wide range of relevant disciplines in attendance and as a result, there was good discussion around supports that she needed. The attendance sheet did not indicate that the psychiatrist attended her meeting. She was receiving psychiatric support and was at risk for polypharmacy. • For Individual #254, his signature sheet did not indicate that he had participated in his annual meeting. It also did not indicate that his physical therapist had attended the meeting, though he utilized adaptive equipment for mobility and was considered at high risk for falls and injury. • For Individual #250, there was no indication that communication/SLP staff attended, though his PSP indicated that he communicated nonverbally. Consequently, there was little discussion around his communication skills or how the team might support expanding his ability to communicate with others. The psychiatrist was not in attendance at his team meeting either. His PST indicated that he was at high risk for polypharmacy and medication reductions were being considered. Input from the team at the team meeting would have been helpful in consideration of planned medication reductions. He was taking olanzapine, mirtazapine, oxcarbazepine, quetiapine, clozapine, and clonazepam. • For Individual #194, there was no indication that OT, PT, or the dietician attended her meeting. The PST indicated that she needed a wide range of supports in these areas throughout her day. It was noted that both nursing and psychology staff attended her meeting to address medical and behavioral supports that she might need. • For Individual #234, the signature sheet from her PST meeting did not indicate that a physical therapist attended, though she had a wide range of adaptive and	

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		assistive equipment and specific plans in place for positioning, transfers, movement, and mobility. Additionally, there was not a communication therapist in attendance. Her PST noted that, "improving her communication skills would enable others to better serve her." The dietician did not attend her meeting though she was on a complex, restrictive diet • The PST signature sheet for individual #276 indicated that an appropriate interdisciplinary team met to develop her PST. The one exception was the psychiatrist. Given her complex psychiatric needs, the input from the psychiatrist could have been beneficial in developing appropriate supports for this individual. • For Individual #83, all team members were in attendance at her annual PST meeting except for the psychiatrist. According to her PSP, she was receiving psychiatric supports services and had a history of psychiatric hospitalizations. The psychiatrist was attempting to adjust her psychiatric medications and she had refused to attend scheduled appointments with the psychiatrist. • The psychiatrist did not attend the annual PST for Individual #150, though he received psychiatric supports. • The PST signature sheet for Individual #229 did not indicate that the SLP attended her meeting though she needed communication supports throughout her day. It also did not indicate that her physical therapist had attended the meeting, though she utilized adaptive equipment for mobility and was considered at high risk for falls and injury. • There was no indication that Individual #43 attended his PST meeting or was involved in planning. The dietician was not in attendance at his meeting, though weight gain is a concern and was being addressed through a restrictive diet. When key members of the PST are unable to attend meetings, it is suggested that the team documents any attempts to get input before the meeting and include recommendations from each team member who could not attend the individual's PSP meeting. Given the lack of resources in psychiatry, psychiatrists have attended a limited number of PSP meetings. Psychiatry piloted the use of a treatment plan document for psychotropic medication in one home, this treatment planning document, while a good source of information was not tied to the individuals overall plan. The facility was rated as being out of compliance with this provision item.	
F1c	Conduct comprehensive assessments, routinely and in	The Personal Focus Worksheet (PFW) was the individualized assessment screening tool used to find out what was important to the individual, such as goals, interests,	Noncompliance

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	response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	likes/dislikes, achievements, and lifestyle preferences. For the majority of plans reviewed, this list was individualized and offered a good starting point for plan development. For some individuals, however, this list offered generic information that did little to offer direction to the team in terms of plan development. For example, Individual #289's list of what was most important to him included items related to Mickey Mouse, good health, leisure activities, good personal hygiene, and the opportunity to work. The list for Individual #423 was more individualized and included spiritual music, going to church with his mother, personal attention from staff, collecting cans and going to the recycling center, and making money. Information gathered from the PFW was used as a basis for PSP development in the PST meetings observed. Each QMRP reviewed the individual's list of preferences and members of the team contributed information on how this might be supported. This generally led to discussion and brainstorming by the team on ways to include each individual's preference into their day. Preferences were generally a list of activities available at the facility and teams did little to expand outcomes to encourage exposure to new activities in a variety of settings. Assessments for work and community living did not adequately address the lack of exposure to work and living opportunities. It is essential that assessments provide opportunities for individuals to participate in a variety of experiences relative to areas assessed. For example, vocational assessments tended to focus on how the individual performed on specific tasks available at the facility's sheltered workshop without regard as to whether or not the task was of interest to the particular individual. When performance was poor in that setting, it was determined that the individual did not have necessary skills to participate in supported employment. Vocational assessments should include situational assessment based on the individual's known skills and interests to determine if the individual is truly interested in possible work in an alternative setting. Some examples where adequate assessments were not completed for the individual included: • Individual #72 had not had a communication assessment, though it was noted in her Personal Profile that she has limited expressive language skills and communicates her wants primarily through vocalizations and gestures. • For Individual #276, a vocational assessment was completed prior to her PSP meeting. Her work assessment did not address skills that may be needed outside of the facility's sheltered workshop, or what her preferences might be for competitive employment. • It was noted that Individual #289 communicated through gestural and facial expressions. There was no indication that a comprehensive communication	

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		assessment had been completed. The PALS assessment had been completed to determine his functional living skills. The assessment did not address supports needed to complete task and offered little information that could be used in planning. Sections of the PALS assessment, including grooming, dental hygiene, money management, and social skills were marked as not applicable. The quality of assessments is thoroughly discussed throughout this report. See sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, and section R regarding communication assessments. 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. Compliance will need to be demonstrated in these other areas regarding the development, monitoring, and revising of assessments in order to achieve compliance with section F1c.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	A wide variety of assessments were performed prior to PSP development. The older PSP format included a summary of those assessments, while the newer PSPs showed an attempt to integrate the information into the plan where relevant. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. A sample of the newer style PSPs indicated that the team was doing a better job at integrating information into a meaningful plan that identified needed supports in relation to the individual's preferences. For example: • Individual #72 had a new style PSP that was a good example of a plan that integrated some assessment information into her plan and offered guidelines for supporting her and monitoring for risk. Her PSP had a comprehensive discussion around mobility supports and included very specific information on how staff would need to support the individual in a number of environments. Her vocational discussion included her preferences and supports that she needed while at work. Supports included in her PNMP were integrated into discussion regarding her preference for eating out in the community. • Individual #83's PSP indicated that the PST had discussed her preferences and	Noncompliance

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		the necessary supports needed throughout her day. Her risk information was integrated into her plan. For example, she was rated as high risk for weight concerns due to obesity. The team discussed specific exercise that she enjoys, such as walking, and integrated it into her plan. • Individual #250's PSP integrated supports needed for communication and mobility throughout his plan. The plan offered a clear description for how staff should provide needed supports, however, as noted below, assessments related to his preferences were not used for planning. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, it appeared that this information was not used to develop and implement protections, services, and supports for the individual. ▪ Individual #140 had a vocational assessment prior to the development of his PSP. Even though, the PSP noted that work was a priority for this individual, there was no discussion of work or any type of day programming in his PSP other than a statement that he would be referred for supported employment. ▪ The team had developed a fairly comprehensive list of activities that Individual #250 enjoyed. His plan did not include strategies to ensure that he would be supported to participate in the activities listed as preferences. Many of the activities could have been used as a basis to provide greater exposure to the community, which the team agreed was a priority. His objectives did not address that need. While the facility was making progress in addressing this provision, only a small number of individual's had gone through the new PSP process, so most individuals at the facility did not have plans in place that met this requirement. The facility was not in compliance with this provision.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The new DADS policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. The facility reported that staff were being provided educational opportunities on the CLOIP process. A training session was held on 12/10/10 to educate team members on community living options. Seventeen of 18 (94%) of the PSPs in the sample indicated that individuals and their LARs were offered information regarding community placement as required. Individual #327's PSP did not include a summary of the Living Options Discussion. PSPs indicated that community placement was discussed at all PST meetings except one	Noncompliance

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		(Individual #327). In most instances, the teams concluded that current placement was optimal for each person. As discussed throughout this section, plans still did not always address priorities for work and community living. In 16 (94%) of the 17 PSPs that discussed living options, the teams concluded that SASSLC was the optimal living placement for the individual. The PST annual meeting was observed for Individual #302. The team engaged in discussion around living options and determined that he had limited knowledge of community living. The team agreed that he might do well living in a smaller environment in the community. Plans were made to tour group homes in the community. There was very little discussion about other ways that he might gain greater exposure to the community. The team, however, did change his money management outcome from identifying money to a more functional goal of exchanging money for a purchase in the community. Although the team discussed a fairly comprehensive list of his preferences, discussion centered around ways that he could participate in activities that he preferred at the facility rather than brainstorm new activities in the community that would support his preferences. For example, he was interested in music. The team thought of many ways that his love of music could be supported at the facility, such as participating in music therapy, going to religious services where the chaplain played the guitar, and listening to music in the activity room and vocational setting. There was no discussion of activities in the community related to music. The team could have used this opportunity to brainstorm ways that he could gain greater exposure to the community and participate in activities that he enjoyed while in the community. The PST annual meeting for Individual #201 was also observed during the monitoring visit. She clearly stated that she would like to live and work in the community. The only barrier to living in the community noted by the team was her refusal to get up to go to work on time at the facility. Rather than address reasons why she did not want to wake up early or discuss how her preference to sleep late might be supported in the community, the team focused on why this was not acceptable behavior. A preference for sleeping late might not really be a true barrier to community placement, and in fact, it might be a reason to consider community placement if the facility cannot accommodate her preference for sleeping late. The team did not address her job preferences or suggest a vocational assessment to determine if she may be more interested in other types of work. She evidently had some valuable work skills, but was expected to attend work daily to work on a monotonous job making an average of 17 cents per hour. Her incentive for waking up to attend work was not clear, nor was it discussed. It was also noted that she was no longer refusing her medication as often, but she was refusing to wake up more frequently. The team did not raise the question of whether or not these two factors could have been related. The QMRP coordinator did a nice job of trying to	

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		steer the team into developing timelines for moving towards community placement, but the QMRP was clearly hesitant to develop a specific action plan to address community placement other than implementing an objective to teach her to use an alarm clock (also see section T below). Plans did not include strategies for integrating individuals into the community other than to provide opportunities to shop, eat out, and attend specific events. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Services were offered based on what was available at the facility. Some examples of priority needs and preferences for individuals that could have been addressed in the community included: • The team concluded community placement would be appropriate for Individual #229. There were no outcomes developed to provide exposure to the community or to move her closer to this goal. • The team determined that Individual #250 should be provided with greater opportunities for exposure to the community. He had a wide range of interest that could be supported in the community including, involvement in senior activities, attending church, going to the park, going to carnivals and fairs, and an interest in music. His outcomes included two outcomes to be supported in the community. One was a money management outcome involving shopping and the other was to have the opportunity to be involved in an on/off campus activity at least once per month. The team could have developed community participation outcomes around his preferences such as attending church or a seniors program in the community, as well as, offer the opportunity to visit a variety of specific places in the community to increase his awareness of community options and find new interests. • Individual #254's PSP indicated that he had limited exposure to the community. He had a wide range of interests that could have been supported in the community, but the only outcome to be implemented in the community involved going to the movies. • Individual #298 had one outcome to be implemented in the community related to shopping. There was no indication that this outcome was related to a preference or priority of his. His plan did list other preferences that could have been supported in the community. There was no indication that employment outside of the facility had been actively pursued for individuals in the sample. Only one individual in the sample was working in the community. A vocational training program was observed for individual #308. It was determined that he would benefit from supported employment in the community. A trainer was working with him on acceptable job skills and performance by watching a	

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		video and discussing work skills modeled. He had been referred to DARS for assistance with placement, but did not have all of the documents in place to begin receiving services from DARS. Although the facility had some success with placing three individuals in individually designed community employment (Individual #1 Individual #160, and Individual #192), it might benefit vocational staff at SASSLC to attend updated job coach/job development training to learn new skills for supporting individuals interested in obtaining supported employment. In this way, community employment opportunities might be made available to a larger number of individuals. While several individuals in the sample expressed a desire to work in the community, there was no indication that steps were actually being taken to secure integrated employment for any of these individuals or that community day habilitation had been considered. This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. The facility needs to provide additional training to teams in this area. The facility was not in compliance with this provision.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an	The PSPs reviewed included a list of "What's most important to the person?" For most individuals in the sample, this list was used as the basis for outcome development. As noted below, there were some exceptions to this, particularly around preferences for community participation and living options. It was not evident that this list was always the central focus in planning for the individual. Teams should use the "What's most	Noncompliance

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	explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	important to the person?" section of the PSP to then develop outcomes, include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to occurrence. For example: • Individual #150 expressed an interest in supported employment. His PSP did not include outcomes specific to supported employment. The plan was vague in terms of how the team would support this individual to move him closer to his goal. The plan referenced a vocational assessment, but did not address what barriers the assessment may have identified in terms of supported employment. • Individual #72's PSP noted that she had limited communication skills. Her plan did not identify communication supports that she needed. • Individual #304 was working in the community, but her plan did not include strategies to provide her other opportunities to engage in community activities based on preferences identified in her PSP. She enjoyed music, swimming, bowling, going out to eat, and going to the movies. There was no indication that she would have the opportunity to participate in any of these activities in the community. She also enjoyed crafts and had a plan for losing weight. These activities could have been supported by involvement in community craft programs, weight loss, and/or exercise programs. • See section F1e for additional examples. As also noted in section F1e, the PSPs did not address community integration and vocational programming. The facility had few options to address vocational services and discussion of real employment opportunities was not addressed in any of the PSPs reviewed. Individuals at the workshop should have been learning work skills that would transfer into employment skills for the community with the opportunity to make real wages in an integrated setting. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community. The facility was not in compliance with this provision item.	
	2. Specifies individualized, observable and/or measurable goals/objectives,	Outcomes were not always related to the individual's preferences and long-term vision, and plans were not consistent in addressing supports needed to achieve outcomes. Additionally, teams were not consistently identifying measurable strategies to overcome	Noncompliance

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	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;	obstacles to individuals being supported in the most integrated setting appropriate to their needs. Strategies included limited supports needed for implementation, but adequate supports were not always identified in assessment or, if they were identified, they were not included in planning. Some examples of outcomes and goals that were not measurable and/or did not include supports needed to accomplish the goal included: • Individual #150 had an outcome to participate in money management by learning banking/saving skills with verbal prompts. Strategies were not specific enough for staff to know what information should be documented or what would determine success. The action steps did not relate to purchasing an item, but the teaching technique included the statement, "staff should increase prompt level until he is able to purchase his item(s) himself." Rather than offering a hands-on learning opportunity to actually go to the bank and complete a transaction, the outcome was designed to learn about banking by talking about it in a classroom setting. A more functional, effective teaching method would be to go to the bank and complete a transaction with necessary supports. • Individual #150 had an outcome to "learn the different medications he is taking." The teaching techniques stated "this training will help him to learn his medications and the reasons behind them." There was no indication what information would need to be demonstrated to successfully complete the outcome. • Individual #150 had an outcome to "interact appropriately with others." A step listed to complete this outcome stated, "he will have no more than 6 episodes of psychosis per week." There was no direction for what staff would record as "an episode" or what staff supports would be necessary to prevent "an episode." Similarly, another step stated, "he will have 4 or less episodes or refusals per week." Again, there was no measure for staff to use to determine when an "episode" would be recorded. • Individual #72 had an outcome to pay for an item in a store/restaurant. Teaching strategies for this outcome were related to putting up a puzzle. • Individual #140 had a work outcome that stated "he will enjoy his job." The action step to achieve this outcome was "to stay in his assigned work area for a minimum of one hour." It was not clear how this would help him to meet this outcome or how progress would be measured. Some examples of outcomes and goals that were measurable and/or did include supports needed to accomplish the goals included:	

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		• Individual #244 had an outcome to remain working at her station. The plan described how staff should support this outcome and what would be measured and recorded as a successful trial. Strategies were consistent with recommendations from her vocational assessment. • Individual #87 had a work outcome to complete 25 units of a task. Communication and behavioral strategies were included in her teaching techniques. As noted in F1e, PSPs indicated that community placement was discussed at most PST meetings and in most instances the teams concluded that current placement was optimal for each person. Plans contained few strategies and supports to be provided in a more integrated setting. Other than shopping, eating out, and attending specific community events, plans did not designate that services would be provided outside of the facility, even though a lack of exposure to the community was noted as being a barrier in a majority of the plans reviewed. This provision will be further reviewed as applicable to the new person centered process during the next monitoring visit. The facility was not in compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. PSPs developed using the new person centered training, however, showed progress in this area. The newer plans were much more comprehensive in identifying and addressing risk for individuals and including supports that were needed by each individual. See section I of this report for specific examples of how risks were being identified and addressed in plans. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Then the facility must ensure that plans are developed and implemented in a timely manner. As noted throughout section F, the planning process did not always result in a plan being developed and distributed to staff responsible for implementing plans. This process will be further reviewed when the facility has had an opportunity to fully implement the new person centered planning process. The facility was not in compliance with this provision item.	Noncompliance

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	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	A sample of 34 implementation plans for five individuals (Individual #244, Individual #72, Individual #150, Individual #423, and Individual #276) was reviewed. The following is a summary of what was found: • 32 (94%) out of 34 included methods for implementation. Not all method descriptions, however, were specific enough to ensure consistent implementation of the outcome. The following are some examples where SPOs included methods that would allow for consistent implementation: o Individual #276's SPO for putting her socks on o Individual #423's SPO for crossing the street o Individual #72's SPO for bathing The following are examples where SPOs did not include methods that would allow for consistent implementation: o Individual #72's SPO for purchasing an item o Individual #150's SPO for learning about his medications o Individual #150's SPO for money management See sections K and S for additional comments on implementation strategies. • 34 (72%) out of 44 included time frames for completion, however, for 32 of these 34 (94%), the time frame was the annual PSP date rather than a date that corresponded with the individual's rate of learning. The team should assign completion dates that correspond with each individual's projected rate of learning. • 34 (100%) of 34 named the staff responsible for implementation. 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, outcomes in the PSPs reviewed did not always 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. See specific examples in F2a2. The facility was not in compliance with this provision item.	Noncompliance
	6. Identifies the data to be	Current implementation plans were reviewed for a sample of the following individuals:	Noncompliance

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	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.	Individual #244, Individual #72, Individual #150, Individual #423, and Individual #276. The following is a summary of this review. • 34 (100%) out of 34 identified the frequency of data collection • Two (8%) out of 34 indentified the person responsible for data collection • One (3%) out of 34 identified the person responsible for data review All SPOs reviewed had a list of data codes that were to be used to indicate progress or lack of progress on implementation, but it was not clear what behavior the individual needed to demonstrate to receive a mark indicating successful achievement for the outcome. Each SPO included a description of when outcomes should be implemented. Most SPOs named who would be responsible for implementation of each outcome, but did not indicate who would collect data and monitor implementation. Please also see section S of this report for further discussion of SPO data collection. The facility was not in compliance with this provision of the settlement agreement.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision of the Settlement Agreement will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, R, and T. Please refer to these sections of the report regarding the coordination of services. The facility is encouraged to implement a monitoring process that reviews which services and supports are needed by an individual and assess whether or not those services are addressed in the PSP. As noted in F2g, the facility did not have a quality assurance system in place to effectively monitor the quality of PSPs. While the monitoring team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines: • Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. • As evidenced in the newer style PSPs, teams were engaged in more integrated discussions during team meetings. • A new focus at the facility was the integration of psychiatry and dental services into the team process. The monitoring team looks forward to seeing progress made in this area at the next monitoring visit.	Noncompliance

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		The facility did not 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. The facility was not in compliance with this provision.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of 29 individual records was reviewed in various homes at the facility. Current PSPs were not available in 11 (38%) of the 29 records, indicating that support staff did not have information necessary to fully implement PSPs. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. As noted throughout this report, PSPs did not offer staff clear guidance on providing a range of supports to each individual to ensure training was consistently implemented and the person would remain safe and healthy.	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. It was not evident that the facility had a system in place to monitor implementation monthly and revise the PSP when outcomes were completed or there was a lack of progress. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate. As noted in F2a6, plans did not identify staff responsible for monitoring implementation of each SPO. It was not apparent that outcomes were monitored and revised as needed or that those who were responsible for monitoring plans were retraining staff on implementation if outcomes were not being implemented as written. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QMRPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP. The facility was not in compliance with this provision item.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing meeting facilitation and the development of a comprehensive PSP	Noncompliance

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	for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	document. A review of training transcripts for 24 employees indicated that 24 (100%) of the 24 had completed the new training on PSP process entitled Supporting Visions. As noted in F2f, QMRPs were not ensuring that current plans were developed and distributed to staff responsible for providing supports indicating that support staff had not been trained on plan implementation when plans were updated or revised. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. The facility was not in compliance with this provision.	

F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Of PSPs in the sample reviewed, 22 of 22 (100%) had been developed within the past 365 days.
		• 20 of 22 (91%) were revised within 365 of the previous PSP
		    o Individual #292's PSP date was documented as 12/14/10. Her previous PSP was dated 12/11/09
		    o Individual #216's PSP date was 12/16/10. His previous PSP date was 12/14/09
		• Five of 22 (23%) were still in draft format and had not been completed within 30 days of development
		
		As noted in F2c, a sample of plans were reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 38% of the plans in the sample were not current. Some plans were over a year old indicating that in some cases, PSPs were never distributed if developed.
		
		When asked about the missing plans in one home, the QMRP stated that she had not had time to develop the plan following the annual PST meeting. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have
			Noncompliance

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		information regarding services, risks, and supports for individuals in the home. Without a plan in place, staff do not have the tools that they need to safely and consistently support individuals. It also indicated that plans and implementation were not being revised, updated, and monitored as required and staff were not being trained to implement plans. One individual (Individual #83) in the sample had been admitted within the past year, and her PSP was developed within 30 days of admission as required by the facility policy. The facility will need to develop a system to ensure that all plans are revised at least annually and put into effect within 30 days of preparation. The facility was rated as being out of compliance with this provision item.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had developed a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E above). 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. The PSPs for Individual #150 and Individual #140 were almost identical. Both offered little individualized information for supporting the individuals and contained multiple errors and misinformation about the individual indicating that the plans had not been reviewed for accuracy. As noted in F2f, plans were not being revised annually and put into place within 30 days of development. The facility needs to implement a plan to monitor the development and implementation of PSPs. QMRPs should be held responsible for not completing plans in a timely manner and support staff should be trained to notify supervisors when they do not have the tools necessary to safely and consistently provide supports. An effective quality assurance system for monitoring PSPs was not in place at the facility. The facility is not in compliance with this provision.	Noncompliance

Recommendations:

1. Develop a system to ensure that PSPs are in individual records and updated as necessary.

2. When key members of the PST are unable to attend meetings, document any attempts to get input prior to the meeting and include

recommendations from each team member not present.

3. Provide additional training to PST members on developing and implementing plans that focus on community integration.

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

5. Provide training and support on facilitation to QMRPs as necessary.

6. Determine the need for additional psychiatric resources, to allow full integration of psychiatry into the treatment planning process.

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

8. 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.

9. 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.

10. Ensure that outcomes are consistently implemented and progress is documented and reviewed.

11. 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.

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

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, July 2010 o SASSLC policy list, two pages, not dated o List of typical meetings that occurred at SASSLC o SASSLC POI, December 2010 o SASSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 2/7/11 o Three documents related to dental and medical desensitization (Dental desensitization SASSLC, SASSLC health services dental/medical sedation and restraint, 8.0 Dental desensitization and restraints) o Two consultation reports regarding pretreatment sedation with comments from PCP, psychiatrist, and clinical pharmacist (Individual #74, Individual #233) o Two consultation reports with notation from facility physician that information was sent to PST and copy of corresponding IPN entry by physician (Individual #250, Individual #113) o List of clinical positions, staff and consultants o QAQI Council meeting minutes: 2/9/11, 2/3/11, 1/21/11, 1/12/11, 12/15/10, 11/22/10, 11/16/10, 11/3/10, 10/26/10, 10/6/10, 9/16/10 (11 meetings) o QAQI Council meeting agenda, 2/9/11, and numerous handouts from that meeting o Individual records of 18 individuals, as noted in section J o Documentation regarding psychiatry attendance at PSP meetings Interviews and Meetings Held: o Ralph Henry, Facility Director o Carmen Mascarenhas, MD, Medical Director o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Moneke Tyner, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program o QAQI Council Meeting, 2/9/11 o PNMT meeting 2/10/11

	- Three psychiatry clinics - Two morning meetings, led by medical director
	Facility Self-Assessment: The SASSLC POI rated G1 as in being in noncompliance, and G2 as being in substantial compliance. The monitoring team agreed with the G1 rating, but did not agree with the G2 rating, however, it is likely that SASSLC will achieve substantial compliance with G2 in the near future as noted below.
	Summary of Monitor's Assessment: SASSLC had made some progress in this provision area, but more work was needed. Progress was seen in the attention paid to the Settlement Agreement by clinical services staff across the facility. They were more knowledgeable about their relevant provisions and were aware of the need for providing clinical services in an integrated manner. A number of specific examples were provided to, or observed by the monitoring team that showed ways in which SASSLC was making service provision more integrated across clinical service departments. These examples are provided below. On the other hand, there were a number of areas in which integrated services could be, but were not being, provided. A draft of a state policy was reviewed. The policy was not yet complete. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility in engaging in those actions that will lead to, and demonstrate, the provision of integrated clinical services. Moreover, without additional guidance, there will be little consistency across SSLCs and little sharing of best practices. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational	Although this provision was not yet in substantial compliance at SASSLC, the monitoring team learned about, and observed, a number of efforts the facility had taken, and was planning to take, towards increasing the likelihood that integrated clinical services would be provided to individuals. Of particular note was the clinical staff's knowledge of their relevant Settlement Agreement provisions. This was an improvement from the previous onsite review, that is, clinical department directors and their staffs had become more informed and more directed in their actions towards the Settlement Agreement. The monitoring team had	Noncompliance

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	therapy) to ensure that individuals receive the clinical services they need.	the opportunity to talk with the medical director, Dr. Mascarenhas, numerous times during the week of the onsite review, including a discussion specifically regarding provisions G and H of the Settlement Agreement. An overall facility plan was not in place to address this item, although a number of activities were occurring (see below). A facility policy did not exist, however, a draft DADS statewide policy was available. This state policy was not yet complete. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. More work needed to be done, as acknowledged by the facility by its medical director, and as described below. Consequently, this provision item is rated as being in noncompliance. Examples of integration of clinical services that were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • A meeting occurred at 9 a.m. every weekday called the Morning Clinical Meeting. The purpose was for all clinical departments to meet and review any events that had occurred since the previous meeting and for each department to give an update on any important topics or cases. The meeting was attended by the monitoring team almost every day of the onsite review. The meeting was led by the medical director. It lasted less than an hour; participants were efficient in their presentations and comments. Attendance was consistent from all clinical departments except psychology. • Clinical staff were making notes in the IPNs. • The medical director reported that the PCPs and the dentist were collaborating on reducing risk factors for recurrent aspiration pneumonia by improving oral hygiene. • A two page description of the dental department's planned approach to desensitization indicated that "interdepartmental interaction" was required that included dental staff, PCP, psychiatry, pharmacist, QMRP, psychology, nursing, direct care staff, and the individual. Addressing desensitization was another area of improvement at the facility since the previous review. The document included 11 professional literature references. This was also good to see. • Two examples were presented of a consultation note that showed comments	

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		from the PCP, psychiatrist, and clinical pharmacist regarding the use of pretreatment sedation medication for that specific individual. Comments seemed to be individualized and appropriate (Individual #74, Individual #233) • Two examples of consultation reports were presented that showed notation from the facility physician that information was sent to PST and, in addition, a copy of the corresponding IPN entry by physician was also presented (Individual #250, Individual #113). This activity is also noted in G2 below. • The medical director led an interdisciplinary workgroup that developed several clinical guidelines/protocols. • The two new psychiatrists attended part of some of the PST meetings observed during week of the onsite review. • Observations of psychiatry clinic revealed good consultation and collaborative efforts with pharmacy. Pharmacy provided excellent information and together the two disciplines made thoughtful determinations regarding the individual's psychotropic medication regimen. • Following discussion with the monitoring team after observation of a medication administration, the pharmacist and physician were consulted by the CNE and medication pass times were adjusted to allow for future timely administration as ordered (see M6). • The unit directors, assistant director of programs, and the facility director worked on increasing direct care staff retention over the past six months. Turnover in these positions were reported to have been reduced from more than 60% to around 33%. Although not specifically a clinical service, the reduction in turnover will increase the likelihood of successful implementation of the many aspects of clinical care in which direct care staff are involved (e.g., PBSPs, PNMPs, dining plans, language and communication activities throughout the day, identification and reporting of health concerns). Other examples indicated that more work needed to be done: • There was no participation of primary care medical staff at PST meetings. • The pharmacy department was under the supervision of the nursing department. It is more typical for pharmacy to be directly under the medical director at a facility such as SASSLC. Moreover, it would set the occasion for more integrated clinical services because information would be more readily available to the medical director (also see comments in section N below). • Nursing did not appear to be included in the development of the clinical protocols and pathways. • Integration of clinical services was not evident in the written annual PSP document. The narrative should document the team's discussion and illustrate (a) how integration had occurred over the previous year and (b) plans to ensure	

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		integration of clinical care was to occur during the upcoming year. In addition, there will continue to be separate plans (e.g., PNMPs, BSPs, nursing care plans), however, the PSPs should identify (in action plans) the objectives of these separate plans, identify who is responsible for implementation, identify who will review data, any modifications of plans, and integration of these plans with other disciplines as appropriate. • The collaboration of nurses with other clinicians in interdisciplinary arenas requires nursing staff to be prepared to share complete and comprehensive health status data. Current nursing assessment, diagnosis/problem identification and health management planning were not complete and comprehensive (see M1, M2, and M3) impeding this process. • Nurses, usually Nurse Case Managers, were no longer participating in monthly psychiatric clinic nor were they completing and briefly summarizing data requested by the psychiatrists to be available at the reviews. • There was a paucity of neurological consultation and collaboration occurring since November 2010. The facility medical staff was exploring options for a new contract provider for this area. • There was limited collaboration of the development of communication plans between psychology, speech therapists and home staff, with some examples noted in section R below. • OT, PT, and SLP worked in a collaborative manner, however, they did not conduct co-assessment via observation in the day programs to identify potentials for skill acquisition plans and methods to enhance existing programs developed by day program staff. • SPOs were developed by QMRPs and implemented by DCPs and there was little interaction between these two groups, resulting in poor implementation integrity of the SPOs (see S3). • The dentist was writing general desensitization plans that were very successful, but psychology was not involved (see S1). 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. The recently formed QAQI Council may contribute to setting the occasion for this integration to occur.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall	The facility appeared to be responsive to recommendations from non-facility clinicians. SASSLC, however, should include in its operating procedures the requirement for an explicit statement, in the integrated progress notes, of the PCP's agreement or disagreement with each of these recommendations, and the requirement to refer	Noncompliance

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	review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	relevant information to the PST. The medical director reported that the physician notes if the information from the consultation should go to the PST and if it was sent to the PST. She reported that this was noted on the consultation report itself as well as in the individual's IPN. Two examples were provided that showed both of these notations (Individual #250, Individual #113). The medical director also reported that any disagreements with consultation recommendations would be noted on both the consultation report itself and in the individual's IPN, however, this rarely occurred. Finally, she reported that when the PCP agreed with the consultation recommendations the PCP had not, but now will, explicitly note their agreement with each recommendation. This will be monitored at the next onsite review.	

Recommendations:

1. Develop and implement policy.
2. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring
3. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.
4. Review and consider addressing the many items above in G1 under "Other examples indicated that more work needed to be done."
5. Ensure explicit statement of agreement with each recommendation from non-facility clinicians is included in the integrated progress notes.
6. Include a statement regarding the integration of clinical services in each individual's PSP document.
7. Consider the transfer of supervision of the pharmacy department from nursing to medical.
8. The facility should assess whether the medical director will need additional resources and support if she is to be responsible for the management of provisions G and H item along with her other administrative and client care responsibilities

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, July 2010 o SASSLC policy list, two pages, not dated o List of typical meetings that occurred at SASSLC o SASSLC POI, December 2010 o SASSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 2/7/11 o Sample one page new style quarterly medical review (Individual #299) o List of clinical positions, staff and consultants o QAQI Council meeting minutes: 2/9/11, 2/3/11, 1/21/11, 1/12/11, 12/15/10, 11/22/10, 11/16/10, 11/3/10, 10/26/10, 10/6/10, 9/16/10 (11 meetings) o QAQI Council meeting agenda, 2/9/11, and numerous handouts from that meeting o Individual records of 18 individuals, as noted in section J Interviews and Meetings Held: o Ralph Henry, Facility Director o Carmen Mascarenhas, MD, Medical Director o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Moneke Tyner, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program o QAQI Council Meeting, 2/9/11 o PNMT meeting 2/10/11 o Three psychiatry clinics o Two morning meetings, led by medical director
	Facility Self-Assessment: The SASSLC POI indicated that all seven provision items were not in compliance, and noted some comments regarding activities that were occurring towards meeting each provision item. The monitoring

	team concurred with these ratings as indicated below.
	Summary of Monitor's Assessment: Some progress was observed in regards to this provision item. First, a draft state policy was reviewed. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H (but not for provision G as noted above). Observations of psychiatric clinic performed during this monitoring review revealed improvements in clinical case consultation, a thoughtful approach to psychopharmacology, and improved diagnostics. The current practitioners were making efforts to review and revise diagnoses and adjust medication regimens. In doing so, there were reports that some individuals were experiencing increased behavioral challenges. These were good opportunities for psychiatry and psychology to work together to develop non-pharmacological interventions for specific individuals. Challenges remained, however, as for example, psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate, timely data in order for them to make data informed decisions regarding pharmacology in an objective manner. It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision. 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. It is recommended that the facility's QE department play a role in addressing this provision.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, 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. Although medical assessments, evaluations, and care were occurring as reported by the medical director and as commented on in section L of this report below, a method to ensure this provision item was being addressed across all clinical service areas was not yet in place (e.g., also see sections J, K, M, O, P, Q, and R). A draft DADS state policy was available and this was an improvement since the last onsite review. It addressed provisions G and H together. The policy was not yet	Noncompliance

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		completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. For this provision item, H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). Annual medical assessments were completed and included a plan of care for medical problems. Quarterly medical assessments were completed and provided brief updates to prior assessment in a standardized format. The plans did not truly address how the medical care plans would change, however, this requirement was in the Medical Services Policy. According to the medical director, physicians conducted sick call daily. The nursing department maintained a log of individuals with problems who needed to be evaluated. Annual and quarterly nursing 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 problems/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 (see sections M1, M2, and M3). The facility psychiatrists had performed 14 comprehensive assessments. They had, reportedly, reviewed the diagnoses of 110 individuals. Documentation regarding this review was generally good, however, as stated in J2, there was room for improvement. The facility's functional assessments (K5), PBSPs (K9), and psychological assessments (K5, K6, K7) were not consistent with generally accepted professional standards of care.	

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		Assessments were, for the most part, conducted on an annual basis by OT and PT, and issue-specific consults were completed upon referral or change in status. There were a number of individuals who had not had an appropriate comprehensive communication assessment in many years.	
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. SASSLC was not tracking or monitoring this requirement. The medical quarterly monitoring tool did not capture this requirement. The SASSLC Medical Services Policy and Procedures (11/11/10) required that diagnosis be consistent with ICD-9-CM codes. The medical director also reported that diagnoses were to fit assessments and that ICD diagnostic terminology was being used. While this was evident in annual assessments, quarterly reviews, and progress notes, there were frequent deviations in the application of this requirement to medication indications. Code numbers were not yet being used consistently; this was now also required in the new state draft policy.	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 or procedure in place to ensure or monitor that treatments and interventions were implemented timely and were clinically appropriate. The facility did not, at the time of this onsite review, have a way to manage this requirement across all clinical service areas. The medical director, however, reported that treatments were implemented timely, such as via follow-up on doctor's rounds, and telephone orders and that this information was included in the IPNs. Medical policy required that physicians "visit every home to see sick or injured individuals as well as to scan for potential medical problem." An SASSLC physician was on continuous telephone call for medical consultation regarding acute illness and injuries after normal business hours. The draft state policy listed eight areas of treatment that were to follow various national and/or state guidelines. A ninth area referred to the federal government's guidelines website. The medical director shared a copy of a new style quarterly medical review completed for one individual (Individual #299). It was one page long and included active medical problems, lab tests and results from the past quarter, and a list of current medications.	Noncompliance

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		Health management plans did not consistently address all of the health care needs of the individuals, but ACPs were developed in response to their emergent health care problems and risks. The interventions in the HMPs and ACPs were the same across most of the individuals, even 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 current psychiatrists had inherited a number of individual cases from prior treatment providers. They were attempting to review the diagnostics and the medication regimen. Given the issues with polypharmacy and some of the complicated medication regimens, 59 individuals were currently in the process of medication tapers. This was also an area where increased collaboration with psychology and nursing would be appropriate, specifically with increased attention to non-pharmacological interventions.	
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.	Some activity had occurred at SASSLC regarding the determination of clinical indicators and appropriate clinical protocols. Most notable was the development of a number of protocols at the facility. Some of these were for facility-specific use, others were developed at SASSLC as part of the statewide program to develop a set of clinical protocols for different medical conditions. The facility had developed a seizure management program and bowel management program. One immediate benefit of the development of the seizure management program was the creation of a database that allowed the medical director to identify 17 individuals with intractable seizure disorder. Those individuals were going to be referred to an epileptologist at the University Health Center. The application of these clinical indicators were not yet being applied to service and treatment for individuals. Further, there was no database. The draft state policy included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start to assist the facility in meeting this provision item as well as the other items of provision H. The psychiatrists had begun to indicate the time period for expected pharmacological benefit, however, this provision requires the collaborative development of target	Noncompliance

#	Provision	Assessment of Status	Compliance
		symptoms for monitoring and the close review of behavioral data. There were very few intervention plans developed by OT, PT ,and speech. In the case of speech, there were measurable goals, but documentation was limited and these were not outlined in the PSP as training objectives. In the case of PT, many of the goals were not measurable in the sense that they did not include performance criteria. Documentation was very consistent, but did not clearly relate to the stated goal. As a result, discharge from therapy was not well justified. 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.	
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. Development of state policy may help guide the facility in the determination of a system to effectively monitor the overall health status of individuals, not just their levels of risk. This might include a combination of a variety of information already collected by medical, nursing, pharmacy, and other departments at SASSLC, such as the annual and quarterly medical assessments, nursing assessments, and pharmacy reviews. The addition of a standardized quarterly assessment would assist in the monitoring of health status. The template for that review would require some expansion to capture critical health indicators. As health status has been folded into the PST process, and psychiatry was not a regular attendee, there was cause for concern that the health status with regard to specific psychiatric indicators was not appropriately monitored. The activities noted in the draft state policy commented on above in section H4 also apply to this provision item. As noted in section I of this report, the facility (and state) system for assessing and managing risk was in the process of changing to a PST-based review of risk and health status.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions	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
	shall be modified in response to 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. State policy was in draft and incomplete format. Comments are provided above in H1 through H5 and are not repeated here.	Noncompliance

Recommendations:

1. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H.

2. Ensure that all clinical services are addressed by the facility, not only medical activities.

3. 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.

4. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision.

5. Assess whether the medical director requires additional support and resources to be able to adequately oversee the facility's implementation of the provision H given her other administrative and direct client care responsibilities. Consider whether the nursing department might play a role in the oversight and implementation of provision H.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Risk Assessment Tools, dated 8/31/09 o DADS Integrated Risk Rating Form o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o List of individuals seen in the ER or hospitalized since 1/1/10 through 12/1/10 o List of individuals with fractures 1/1/010 – 12/31/10 o List of individuals with pneumonia incidents in the past 12 months o List of 10 individuals with the most injuries o List of all individuals residing at SASSLC and their risk rating levels o List of individual diagnosed with dysphagia o List of individuals with challenging behaviors o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals at high risk for GI concerns o List of individuals at high risk for aspiration o List of individuals that have contractures o List of individuals at risk for falls o List of individuals at high risk for skin integrity issues o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals at high risk for osteoporosis o List of individuals diagnosed with seizure disorders o List of individuals at high risk for seizures o List of individuals with poor oral hygiene o List of individuals requiring meal time assistance o List of individuals at risk for weight loss or weight gain o List of individuals receiving enteral feeding; enteral review list and enteral reviews 7/10-1/11 o List of individuals with BMI > 30, BMI < 20, and unplanned weight loss at six months of $\geq$ 10% o List of individuals with MRSA, Hepatitis A, B, and C, HIV, Positive PPD, H1N1, C diff, and STDs o Nutritional Management Committee meeting minutes from 8/25/10-12/22/10 o List of 10 individuals with the most injuries 1/01/10 – 12/31/10 o List of 10 individuals causing the most injuries to peers 1/1/10 – 12/31/10

	o List of falls 1/30/10 o List of top ten highest injuries 1/1/10-12/31/10 o List of top ten individuals causing peer injuries 7/10-12/10 o PSPs and assessments for: • Individual #83, Individual #72, Individual #229, Individual #423, Individual #150, Individual #239, Individual #43, Individual #140, and Individual #244, Individual #7 o Records of the 20 individuals listed in section M, including their Health Risk Assessments and HST Coordinator correspondence, data and completed reviews from 7/1/10-1/31/11 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Audrey Wilson, QMRP Coordinator o Patricia Delgado, At Risk Coordinator o Lawrence Algueseva, QE Program Auditor o Nurse Case Managers: 673, 670, and 671 o QMRP and residential staff: 665, 668, 670, 671, 672, 673, 766 o Informal meeting of Nutritional Management Team (NMT) and the monitoring team, 08/19/10 Observations Conducted: o Observations at all residences and day programs o Annual PSP meetings for Individual #201, Individual #302, and Individual #306 o PNMT meeting 2/10/11
	Facility Self-Assessment: The facility POI indicated that the facility was not yet in compliance with the provisions of section I. Notations in the POI indicated that the state office had provided At Risk Webinar training for various disciplines at the facility on 01/18/11. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I.
	Summary of Monitor's Assessment: The state had taken a number of steps to support positive results in the area of risk management. This included: • The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began prior to the monitoring visit at SASSLC. The new policy included changes in evaluating and addressing risks identified for individuals. • Forms had been revised for identifying and a risk action plan to address risk had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative was being implemented to address aspiration pneumonia. A tool had been

	developed to identify individuals at risk for aspiration. Risk categories included Seizures, Challenging Behaviors, Fluid Imbalance, Osteopenia/Osteoporosis, Skin Integrity, Weight, Respiratory compromise, Constipation/Bowel obstruction, Falls, Fractures, Aspiration, UTIs, Polypharmacy/Side effects, GI Concerns, Cardiac Disease, Circulatory, Diabetes, Choking, Hypothermia, Infections, and Dental. The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance. Implementation of the revised process began in late January 2011. Training on the new process was provided, but not to all staff. 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 facility reported that there was a written post-test following training and an onsite visit was conducted by the DADS central office nursing services coordinator to provide training for teams doing an actual meeting. The hope is that this process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The new state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The facility was mandated to have its risk assessments/risk ratings using the new At Risk Process completed at each of the regularly scheduled next quarterly PST meeting held between 1/1/11 and 3/31/11. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee. A list of indicators for each of 21 risk areas had been identified by the new state policy and each was to be rated according to how many risk indicators applied to the individual's case. The new policy had expanded the number of risk areas being addressed by this process to include choking, aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, diabetes, gastrointestinal problems, osteoporosis, seizures, skin integrity, infections, polypharmacy, challenging behaviors, falls, fractures, fluid imbalance, hypothermia,	Noncompliance

#	Provision	Assessment of Status	Compliance
		urinary tract infections, and dental status. A risk level of high, moderate, or low was to be assigned for each category. Observation of five annual PSP meetings scheduled the week of the review showed that PSTs had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. An At Risk Coordinator had been identified at the facility and she was responsible for attending meetings and facilitating the risk discussion. The conversation around risk was somewhat awkward and lengthy at the meetings observed. Even so, the monitoring team observed some meaningful multidisciplinary discussion occurring during each of the PSP meetings observed. Teams were attempting to identify risk and weave that information into the discussion regarding supports needed for the person to achieve their desired outcomes. Individual #306's PSP meeting on 2/9/11 incorporated health risk identification and ratings utilizing the new policy. It was one of the PSP meetings observed by the monitoring team. The Integrated Risk Rating Form was utilized, but the health status data summaries and clinical indicators (rationale) initially provided by team members were not objective and did not include any data to support the rating (e.g., no rationale for medium hypothermia rating, a goal to maintain adequate oxygenation without increase in oxygen provided as the rationale for a medium rating for respiratory compromise). The HST Coordinator provided assistance and support during the meeting, recording additional information provided by the team related to the various risk areas on the Integrated Risk Rating Form. She also facilitated participation by the PST nurse in presenting and discussing Individual #306's aspiration triggers and risk factors. The nurse team member, however, did not provide detailed objective data related to each of the other health risks, including those already rated as medium or high. Even so, the PST discussed other factors related to her risks that went beyond the scope of the items listed in the Risk Guidelines, including her over-riding issue, potential for deterioration related to her vascular dementia. A sample of 10 new style PSPS developed using the new person centered planning process was reviewed to determine if risk were being properly identified by PSTs. Seven of these 10 occurred prior to 1/1/11 and, therefore, the new risk assessment procedures were not yet required. The three PSPs that occurred after 1/1/11 also did not yet incorporate the new risk assessment procedures. Training was not completed at the facility on the new risk process until 1/18/11. Even so, the following comments may be useful to the facility as it begins initiation of the new risk assessment procedures. • Individual #229's PSP provided a good example of where the team attempted to identify supports needed throughout her day to minimize her risk status in some	

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		areas. The plan described her need for supervision and support regarding her risk for injuries and falls in terms that provided clear direction for any staff supporting her. The plan identified her risk for weight, medical concerns, polypharmacy, and injury, but indicated that she was at low risk for aspiration. She was on a pureed diet, so it was assumed that at some point the team had determined that she was at risk for choking or aspiration. This should be discussed by the team and if it is determined through assessments that she is not at risk for choking or aspiration, the team should consider removing the modified texture restriction from her diet. Her nursing assessment indicated that she had a diagnosis of GERD, but it was not addressed in her PSP. It was not noted in her PSP that she was at risk for high cholesterol, though her annual physical indicated that she was on medication and a modified diet to address high cholesterol. Additionally, she was not identified as being at risk for poor oral hygiene though her last dental assessment noted that her oral hygiene was poor with heavy plaque. The team, however, did implement an outcome to address her dental hygiene. • Individual #7's PSP indicated that she was at risk for polypharmacy, fractures, choking, and pica. The PSP did not identify risk factors that should be monitored in regard to polypharmacy or describe supports needed to address her risk for choking. She was not identified as being at risk for seizures though she was on medication for seizure control and had a seizure in the past year. • Individual #83 was identified as being at risk for weight, dental, and UTIs. Supports were addressed in her PSP for all three risk areas. Her nursing assessment indicated that she had been diagnosed with osteoporosis, but this was not addressed as a risk factor in her PSP. • Individual #423 was identified as being at risk for weight, skin integrity, and challenging behaviors. His PSP stated that his risk for weight and skin integrity would be monitored by the nurse. The plan did not indicate strategies necessary for direct support staff to address his risks other than a sentence that stated, "he is encouraged to drink low calorie sodas and his current diet best meets his medical needs." Other risk identified in his PSP included a risk for falls and choking. His plan did not adequately address supports needed to address these risks either. • Individual #43's PSP indicated that he was a risk for polypharmacy, challenging behaviors, and falls. The plan did not address what the support staff should monitor for in terms of polypharmacy. The only support listed to address falls was "ensure he has his own shoes on." The plan noted that this would be monitored by the psychiatrist. His plan also noted that he is on a modified textured diet, but did not indicate that he was at risk for choking. His physical included constipation on this list of active problems, but it was not identified as a	

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		risk. • Individual #150's PSP indicated that he was at low risk in all areas. His OT assessment indicated that he was on a modified textured diet due to his risk for choking. The PSP did not address his diet or adaptive equipment. His medical assessment indicated that he had a diagnosis of hypertension. This was also not addressed in his PSP. • Individual #244's PSP stated that she was low risk in all categories. Her medical assessment indicated that she had a long history of SIB leading to lacerations, ulcerations, and cellulitis. Her dental assessment noted poor oral hygiene with heavy plaque and calculus. • Individual #72's PSP indicated that she was at medium risk for weight, medical concerns, and polypharmacy. The plan did not describe supports necessary to address these risks. The plan also noted that she was at risk for falls and described supports necessary to prevent injuries from falls. • The PSP for Individual #239 indicated that he was at high risk for pneumonia and aspiration. The team determined that he was at moderate risk for skin integrity, constipation, respiratory, and polypharmacy. This was consistent with information from his assessments. Although he had plans in place addressing supports needed to minimize risks, he was hospitalized 8/7/10 and 12/12/10 for pneumonia. His PSP did not indicate that he was at risk for poor oral hygiene, though his most recent dental assessment indicated that he had periodontal disease and poor oral hygiene. He did have an outcome to address dental health. • The PSP for Individual #140 indicated that he was not at risk in any area. His assessments supported this determination. The facility was not yet in compliance with this provision of the Settlement Agreement, but it was noted that they were attempting to address this provision and put safeguards in place for individuals at the facility. It is expected that all individuals at SASSLC will have gone through the new risk identification process by the time of the next monitoring visit.	
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	The new At Risk policy required that when an individual was identified at risk, the PNMT or BSC begin an assessment within five working days if the individual was referred by the PST, or if any other facility- or state-determined criteria were met. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. In addition, health	Noncompliance

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	individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Even so, there were examples of cases where once it was identified that an individual suffered a significant change in one of more of his or her at-risk conditions, mini-staffing meetings (PSPAs) were convened in a timely manner and nurse case managers consistently attended and participated in these meetings. Further, the new procedures of referral to PNMT or BSC had just been implemented at the time of the monitoring visit. 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. One of the most important aspects of a health risk assessment process is that it effectively prevent the preventable and reduce the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	
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. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. 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 of this report for examples. The new policy requires that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the PST in response to risk categories identified by the team. Throughout the 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 risks or identify supports needed to monitor those risks. Locating "aspiration triggers/aspiration trigger sheets" and specific directions to direct support staff in the individual's notebooks regarding health risks were not consistently demonstrated. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk.	Noncompliance

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		Although PSPs included a number of plans to address risk identified by the PST, during observations of homes by the monitoring team, it was noted that PSPs were often missing from individual records, so direct support staff did not have current information regarding risks available to them. As noted in section F of this report, a sample of 29 individual records was reviewed in various homes at the facility. Current PSPs were not available in 11 (38%) of the 29 records. If there is not a current PSP in the home, staff do not have the information that they need to provide safe supports and services to individuals in the home. Staff cannot be held responsible for implementing a plan that they do not have. The facility needs to implement a monitoring system to ensure that staff have information readily available at all times to provide necessary supports to each individual in the home. The facility was not in compliance with this provision item.	

Recommendations:

1. Implement the state new policies and procedures on at risk individuals.
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.
4. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.
5. Implement a monitoring system to ensure that direct support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o 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 schedule of such meetings scheduled to occur during the week of the visit, including a key to any acronyms used on the schedule. o Policies, procedures addressing the use of pretreatment sedation medication. These included Dental/Medical Sedation and Restraint, Guideline for Dental Conscious Sedation and General Anesthesia, Dental Desensitization, and Restraint Policy. o For the past six months, a list of individuals who have received pretreatment sedation medication for medical or dental procedures that included: date the pretreatment sedation was administered, and the name, dosage, and route of the medication, and an indication of whether a plan was in place to minimize the need for the use of pretreatment sedation medication. Also included was the Dental Desensitization Memorandum, and minutes of the Restraint Reduction Committee meeting dated 10/15/10. o Consultation reports regarding pretreatment sedation for dental clinic regarding the following individuals: Individual #284, Individual #42, Individual #75, Individual #108, Individual #248, Individual #104, Individual #277, Individual #249, Individual #63, Individual #105. o A spreadsheet of individuals prescribed psychotropic/psychiatric medication, that included: • Name of individual; • Residence/home; • Diagnoses; and • Medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). 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, including intra-class polypharmacy. o A list of individuals being monitored for tardive dyskinesia. o A list of individuals with tardive dyskinesia. o A separate list of individuals being prescribed each of the following:

	• Anti-epileptic medication being used as a psychotropic medication • Lithium • Tricyclic antidepressants • Trazadone • Beta blockers being used as a psychotropic medication • Clozaril/clozapine • Mellaril o List of new admissions since 1/1/10, and whether a Reiss scale was used. o For five individuals most recently admitted, and for seven other individuals: • Their most recent psychiatric assessment; • Last three psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members; and • For the past year, ▪ Dates of all Psychiatric Treatment Reviews, ▪ Health Services Team notes, ▪ MOSES and DISCUS exams, ▪ Neurology consults (if any); and ▪ The most recent Medical, Pharmacy, and Nursing summaries. Across these individuals, at least one individual from each psychiatrist's caseload. o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations. o Description of availability of genetic screening for individuals. o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects. o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o Job description of psychiatrists. o A list of all psychiatrists, including board status, if employee or contracted, and number of hours working per week. o CVs of all psychiatrists, including any special training, such as forensics, disabilities, etc. o Overview of psychiatrists' weekly schedule. o Description of administrative support offered to the psychiatrists. o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility. o Over the past 12 month, a list of continuing medical education activities attended by medical and psychiatry staff. o Over the past 12 months, a list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff. o For the past six months, minutes from the committee that addresses polypharmacy.

	o For the last 10 newly prescribed psychotropic medications: • Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication, • signed consent form, • PBSP, and • HRC documentation. • For the last year, 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). <u>Documents requested onsite:</u> o For all Reiss Screens completed in the last six months that indicated the need for a psychiatric evaluation: • Name of Individual • Date of Reiss Screen • Date of Psychiatric evaluation o All data presented, physician consents, progress notes and orders from Dr. Vale's clinic dated 2/9/11 regarding the following individuals: • Individual #101, Individual #244, and Individual #9. o Five examples of consent for psychotropic medication performed by psychiatry. o Names of every individual who has had a psychiatric assessment per Appendix B with date of assessment. o Ten examples of comprehensive psychiatric evaluations per Appendix B. o Documentation of psychiatry attendance at PSP, PSPA, or PST meetings. o Ten examples of psychiatric consultation regarding pretreatment sedation for dental or medical clinic. o List of all individuals with medical/dental desensitization plans. o Five examples of desensitization plans. o For the last ten individuals requiring chemical restraint: • Doctor's order • Nurses Notes • Documentation from the psychiatry clinic immediately following the incident (e.g. within one week). o All data presented, doctor's progress notes, and doctor's orders from Dr. Vale's clinic 2/7/11 regarding the following individuals: • Individual #163, Individual #7, Individual #34, Individual #246 o All data presented, doctor's progress notes and doctor's orders from Dr Howland's clinic 2/8/11 regarding the following individuals: • Individual #232 and Individual #252. o Documentation from PSP dated 2/8/11 regarding Individual #259. o These documents:

	- Individual Information Sheet - Consent Section - Personal Support Plan and addendums - Behavioral Support Plan - Human Rights Committee review of Behavioral Support Plan - Restraint Checklists for the previous six months. - Annual Medical Summary - Quarterly Medical Review - Hospital section for the previous six months. - X-ray, laboratory examinations and electrocardiogram for the previous six months. - Comprehensive psychiatric evaluation. - Psychiatry clinic notes for the previous six months - MOSES/DISCUS examinations for the previous six months. - Pharmacy Quarterly Drug Regimen Review for the previous six months - Consult section - Physician's orders for the previous six months. - Integrated progress notes for the previous six months. - Comprehensive Nursing Assessment - Dental Section o For the following individuals: - Individual #111, Individual #122, Individual #304, Individual #218, Individual #95, Individual #216, Individual #1, Individual #169, Individual #268, Individual #347, Individual #259, Individual #252, Individual #130, Individual #188, Individual #107, Individual #276, Individual #208, Individual #272 <u>Individual Interviews and Meetings Held</u>: o Sandra Vale, M.D., facility lead psychiatrist o George Howland, 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, Ida Perez, R.N., acting Chief Nursing Executive and Nursing Operations Officer, Mary White, R.N., QE nurse from Abilene SSLC o Sharon Tramonte, Pharm.D., clinical pharmacist o Carlos Rodriguez, psychiatry assistant o J.P. Fancher, D.D.S., Ph.D., facility dentist o Ashley Smith, Pharm.D., clinical pharmacist <u>Observations Conducted</u>: o Observation of PSP meeting for Individual #259 o Observation of psychiatric clinic for the following individuals: - Individual #101, Individual #244, and Individual #9.

	○ Observation of psychiatric clinic for the following individuals: • Individual #163, Individual #7, Individual #34, Individual #246 ○ Observation of morning clinical services meeting on two consecutive days ○ Observation of psychiatric clinic for the following individuals: • Individual #232 and Individual #252. ○ Observation of facility pharmacy and therapeutics committee meeting
	Facility Self-Assessment: The facility self-assessment regarding this section of the Settlement Agreement was reviewed for this monitoring report. The facility self-assigned two areas, J1 and J2, in substantial compliance. The monitoring team affirmed these ratings. The self-assessment assigned a noncompliance rating for the remainder of the provisions. The facility did report efforts toward achieving substantial compliance and noted plans to address each area. A review of the facility POI revealed that while the facility had outlined specific plans/goals to achieve compliance in each area, with the current lack of resources in psychiatry, as well as the need for interdisciplinary cooperation, goal attainment will likely be difficult.
	Summary of Monitor's Assessment: SASSLC was found to be in substantial compliance with two of the items in this section of the Settlement Agreement. The facility has designated a lead psychiatrist who was working to develop policy and procedure that included documentation requirements geared toward meeting generally accepted professional standards of care in psychiatry. While new documentation had been piloted on one home, there were challenges to the implementation of new policy throughout the facility. Given staff interviews, it was apparent that these challenges were related to both increased time commitment related to psychiatric clinic (more frequent clinic with fewer individuals scheduled) as well as increased documentation requirements for other disciplines (e.g., nursing and psychology). In order for psychiatry to meet the requirements of the Settlement Agreement, the department will need the support of facility administration and the leadership of related disciplines. Observations of psychiatric clinic performed during this monitoring review revealed improvements in clinical case consultation, a thoughtful approach to psychopharmacology, and improved diagnostics. The current practitioners were making efforts to review and revise diagnoses and adjust medication regimens. In doing so, there were reports that some individuals were experiencing increased behavioral challenges. These were good opportunities for psychiatry and psychology to work together to develop non-pharmacological interventions for specific individuals. Challenges remained, however, in that the psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate, timely data in order

	for them to make data informed decisions regarding pharmacology in an objective manner. 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.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	SASSLC did have a lead psychiatrist designated, and had recently retained a second permanent full time psychiatric physician. With the new additional physician, there were a total of two full time equivalent psychiatrists providing care at the facility. The lead psychiatrist has been providing services at the facility for approximately seven months. This physician was board certified in adult psychiatry by the American Board of Psychiatry and Neurology, and was board eligible in Geriatric Psychiatry. The newly recruited psychiatrist began work at the facility 12/1/10. This physician was board eligible in adult psychiatry, and had one additional year of child/adolescent psychiatry training. While neither of these psychiatrists had previous experience in the area of developmental disabilities, both were hard working, energetic, and had a desire to learn more about the field. To this end, one or both physicians had participated in continuing medical education topics including psychopharmacology, epilepsy, posttraumatic stress disorder, and autism within the previous eight months. Although the two psychiatrists practicing at the facility at the time of this monitoring review were making strides with regard to the provision of psychiatric services, there have been road blocks to the full implementation of policy and procedure that included new documentation requirements that will be necessary for psychiatry services to meet generally accepted professional standards of care. As stated in the previous monitoring report, and in this report, psychiatry will need administrative and interdisciplinary support in order to move forward.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable	Per interviews with the two 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 as observed during the monitoring review, were based on verbal report of staff members present in the psychiatry clinic (e.g., the nurse case manager, psychologist, QMRP, direct care staff, clinical psychologists), record review, and some data review. Some individuals were seen more frequently according to need.	Substantial Compliance

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	manner, by a board-certified or board-eligible psychiatrist.	The psychiatrists admitted that, due to time constraints, they were slowly completing comprehensive psychiatric evaluations as time allowed. A list of all individuals who had been evaluated per Appendix B was requested. Per this list, a total of 14 individuals had undergone evaluations using this format. Of these 14, eight were complete and followed the Appendix B format. The others were performed by prior treatment providers and were not of the same quality. The facility lead psychiatrist described plans to review the six evaluations and update them to comply with the requirements of this provision. For further discussion regarding this, please see section J5 below. A review of 18 records of individuals at SASSLC revealed improvements in the quality of the documentation in the monthly and quarterly medication reviews. There were marked improvements in the justification for psychotropic medications, diagnostic formulations, and in the descriptions of the justification for the use of specific psychopharmacological agents. This was especially notable in new medication prescriptions documented via the "New Psychotropic Medication Initiation Form." A review of documentation revealed that the current psychiatric providers were making attempts to review the diagnosis and regimens of individuals recently assigned to their caseload due to the recent resignation of two previous providers. Per documentation provided, between the dates of 8/23/10 and 12/30/10, the diagnoses of 110 individuals had been reviewed. For example: • Individual #119 – Medications prescribed for this individual included Remeron and Lithobid. The previous indication for these medications was "aggression, disruptive behavior, and inappropriate sexual behavior." Previous diagnoses included "Intermittent Explosive Disorder, and Mental Retardation, Severe." Documentation dated 11/18/10 by the new treatment provider revealed, "the regimen was started by a previous psychiatrist…it looks like the lowest effective dosing is being utilized for Lithium. Remeron is dosed in the higher ranges, but she appeared to respond well when titrated to target depressive symptoms… appears to meet criteria for Bipolar I disorder, most recent episode depressed, without psychotic features according to chart review. According to…notes of previous psychiatrist…appeared to have a depressive episode in 2/10….Remeron was increased to…current dose of 45 mg at bedtime and seemed to ameliorate these symptoms. History shows manic symptoms have consisted of hypersexual behavior, smearing feces, overall increased agitation, decreased sleep. Her depressive episodes are characterized by significant crying spells, refusals, and irritability. I am still trying to clarify intermittent explosive disorder. Past aggressions appeared more episodic	

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		in nature, like what may occur with bipolar rather than sporadic, spontaneous – will continue to clarify." Following this documentation, the indication for Remeron was adjusted to depression associated with Bipolar Mood Disorder, and Lithobid indication was adjusted to Bipolar Mood Disorder. This example noted a review of the individual's historical data, a cogent review of symptoms associated with a particular diagnosis, as well as a rationale for treatment with a particular medication. • Individual #67 – The new treating psychiatrist wrote: "Diagnosis needs to be clarified as unclear if has Bipolar or if it is Schizoaffective, Bipolar Type – staff do report psychosis and echolalia…continues with occasional outbursts. Pharm.D. reports Carbamazepine is metabolizing Thioridazine...regimen started by previous psychiatrist…don't aggress with this regimen…does not appear to be clear justification for use of Thioridazine especially given his right bundle branch block…will add diagnosis of Obsessive Compulsive Disorder – has repetitive behaviors centered around excessive cleanliness (compulsions), unclear if has obsessions…taper Thioridazine…then discontinue as cant justify it's use; benefits do not appear to outweigh risks…may still need antipsychotic for psychosis, but could utilize a safer antipsychotic – will review if has Tardive Dyskinesia- staff report this, but MOSES and DISCUS do not reflect." This documentation outlined the physician's thought processes with regard to a rationale for medication adjustment. It also noted a review of associated medical data (EKG, MOSES, DISCUS) and how that information will be utilized in making medication recommendations. • Individual #43 – A previous diagnosis of Autistic Disorder and Mental Retardation, profound had been documented. The new provider added a diagnosis of Bipolar I disorder, most recent episode manic without psychotic features and Pica. "Providing intermittent care….new to me. No significant change with titrated Lithium, and I have concerns for neurotoxicity – immediate plan would be to discontinue verapamil and next step will be to taper Zyprexa to justified dosage range…regimen started by previous psychiatrist – I absolutely do not agree with this regimen, there is no substantial evidence that adding Carbamazepine to Lithium is advantageous, further there are reports of increased neurotoxicity when Verapamil is added to Lithium or Carbamazepine – he is on both…discontinue Verapamil as may cause neurotoxicity, no evidence of efficacy with Bipolar…discussed diagnosis with the team, appears to meet criteria for Bipolar I disorder without	

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		psychotic feathers, most recent episode manic; has obsessive compulsive features related to Autism, but not enough to warrant separate OCD diagnosis…will obtain neurology consultation to see if neurologist is ok with tapering Carbamazepine due to…no recent seizure history…will monitor vital signs…will add Pica diagnosis, meets criteria for this." The above examples are illustrative of the marked improvement in documentation. What was missing, however, was a review of the specific target symptoms for monitoring. All team members signed these diagnostic reviews. This would have been a good opportunity to review/document objective rating scales, and specific target symptoms for monitoring. Regardless, given the marked improvements, this section will be assigned a rating of substantial compliance. There were also examples included that were not as complete as those above. These were attributable to a newly recruited physician, unfamiliar with practice in state supported living centers. There were, however, improvements noted in the more recent documentation from this physician. The practice of psychiatry within the SSLC environment is challenging, and much different than physicians are accustomed to. Mentoring for new physicians should be a priority. DADS could also consider the development of a "practice pearls of wisdom" manual to assist new physicians with the transition into practice in this environment. The facility could also 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 item, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In all records reviewed, individuals prescribed medication did have a PBSP on file. As indicated in section K of this report, however, overall, the PBSPs did not meet the generally accepted professional standard of care. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a treatment program. There was, however, no indication that psychotropic medications were being used as punishment or for the convenience of staff. While all individuals prescribed medication had diagnoses noted in the record, staff interviews and document review revealed concerns regarding the accuracy of the reported diagnoses and treatment. The current psychiatric treatment providers were making attempts to clarify diagnoses and determine the indication for specific psychotropic medication regimens in the wake of the resignation of two prior psychiatric	Noncompliance

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		providers in October 2010. For further discussion regarding this issue, please see the discussion below in sections J8 and J13. There were concerns regarding the lack of treatment integration between psychiatry and psychology and the need for improved treatment team functioning. The psychiatrists had begun writing justification for psychotropic medications as well as treatment plans for medication, which contained some behavioral-pharmacological hypotheses regarding the individual's treatment. The facility had taken some steps toward fulfilling this requirement via the completion of comprehensive psychiatric evaluations and planned to complete additional comprehensive assessments. 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. A review of documentation regarding the last 10 individuals who required chemical restraint revealed that these 10 occurrences were between the dates 12/6/10 and 1/19/11. In all instances, a psychiatrist's clinic note regarding the incident was included. This was an improvement from the prior monitoring review, where psychiatry was not always consulted prior to the administration of emergency psychotropic medication. A review of the documentation provided revealed good documentation from psychiatry regarding the justification for the utilization of additional medication. As psychiatry was now involved in the process, the need for increased collaboration between psychiatry and psychology in the behavioral management of crisis behavior was apparent.	
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 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	Per staff interviews, the facility had recruited a new dentist, who began work at the facility 9/1/10. He was providing limited care at the time of the review, however, had been ordering and receiving dental equipment with plans to open a full clinic in October 2011. At the present time, the dentist and his staff were performing dental assessments and encouraging routine oral care. Initially, the dentist had suspended the use of pretreatment sedation for dental pending increased contact with the individual patients. This new facility dentist had experience in treating "dental fear" patients, and was using a multi-pronged approach in his efforts to enhance oral care. For instance, the dentist had been providing presentations to staff regarding oral care and engaging in skill building for individuals. He reported spending time on individual homes at dental hygiene time, and using a dental desensitization plan for some individuals that he developed following a literature review that was based on	Noncompliance

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	including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	fear patients. Per staff interview, it was apparent that there were challenges in the collaborative development of individualized desensitization plans with psychology. Examples of a template desensitization plan were provided for Individual #1, Individual #169, Individual #277, Individual #130, and Individual #267. The plans were identical with the exception of the name of the individual. The desensitization attempts per these template plans were at a frequency of one per month, which was grossly insufficient to promote familiarity with dental staff or processes. Furthermore, rewards for participation were not individualized. Dental staff interviewed had excellent ideas regarding reward for participation (e.g. polishing nails, providing head, hand, or foot massage), but these would need to be included in an overall plan for desensitization. A review of the facility self-assessment revealed plans to begin an individualized desensitization process via psychology (also see section S below). More recently, following the development of a consultation system and policy and procedure, the use of dental pretreatment sedation had resumed at the facility. The facility has instituted a consultation report document that required input from dental, primary care, psychiatry, and clinic pharmacology prior to the use of pre treatment sedation. This was process was formalized in policy and procedure entitled Dental/Medical Sedation and Restraint dated 9/15/10. The following are two examples of interdisciplinary consultation regarding pretreatment sedation chosen at random from available documentation regarding Individual #284, Individual #42, Individual #75, Individual #108, Individual #248, Individual #104, Individual #277, Individual #249, Individual #63, Individual #105. The review of these documents in total revealed examples of good clinical consultation and coordination between disciplines. • Individual #284 – "…seen…without sedation or restraints…could not cooperate to allow a routine exam and cleaning…has been treated in the dental clinic in the past with oral Thorazine 200 mg... Primary care…[history of] depression, epilepsy…responded to Thorazine intermittently…psychiatry…currently on Fluoxetine…Thorazine appears to be an appropriate choice for her at this time…given the long half life of Fluoxetine, the dose can be held for that day and resumed the next day…clinical pharmacology…combination of chlorpromazine and Fluoxetine could result in a prolongation of the QT interval…must be considered in the risk/benefit analysis…already receiving Clonazepan 1 mg…twice daily…can affect the level of sedation and recovery." • Individual #105 – "requires pretreatment sedation for dental procedures to control anxiety and behavior... Lorazepam 1 mg 90 minutes before his	

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		appointment has not worked well and 2 – 3 mg Lorazepam is planned for current treatment. Please advise…primary care…ok with increased dose of Ativan…psychiatry…patient not currently seen by psychiatry…if patient is currently not on a routine dose of benzodiazepine, I think an increased dose is ok…clinical pharmacology…no significant drug interactions anticipated." Further interviews with the dental staff revealed inventive use of the individual's existing pharmacological regimen. For example, if an individual was already prescribed a benzodiazepine, the dental clinic staff attempted to schedule the appointment for 90 minutes after the regularly scheduled dosage was administered to potentially avoid the need for additional medication.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	There was turnover in psychiatric providers at the facility that resulted in a more stable and active set of psychiatric providers than were previously available to the facility. As of 12/1/10, there were two full time psychiatrists providing services at the facility. One full time psychiatrist began work at the facility 12/1/10. This psychiatrist was board eligible in adult psychiatry and had one additional year of child psychiatry training. A second physician, a board certified adult psychiatrist who was also board eligible in geriatric psychiatry (boards scheduled for 2012), joined the facility psychiatry department approximately seven months prior to this monitoring review. 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. Per interviews with facility staff, this psychiatrist had been given the designation of lead psychiatrist. This lead psychiatrist was energetic, organized and ambitious with regard to meeting the requirements of the agreement. She had the support of the newly recruited psychiatrist, who saw her as a capable leader, who had "great organization skills…I am happy to work with her." As in the prior review, the facility medical director was very supportive of the psychiatric staff and invested in their success. As stated in J6, there had been some barriers to the implementation of new processes with regard to psychiatry, specifically as they required increased efforts of other disciplines (e.g., meetings to discuss collaboration and integration, additional documents that required completion). It was apparent that the facility was invested in addressing these barriers, based on discussion with senior management during the onsite review. Regardless, in order to meet the requirements of this agreement, there must be integration of psychiatry into the facility treatment program. It was questionable whether the current allotment of psychiatric clinical services will be	Noncompliance

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		sufficient to provide clinical services at the facility. At the time of this review, there were a total of 80 available clinical hours, with eight of these officially assigned to administrative duties. Per observations during the monitoring review, it was apparent that administrative responsibilities of the lead psychiatrist were more encompassing than the eight hours allotted. Per observation, interview, and review of the facility self-assessment, ancillary psychiatry staff consisted of one psychiatry assistant. Given the remaining 72 clinical hours available per week, this computed to 302.4 hours per month (utilizing 4.2 weeks per month) for clinical services. With a current caseload of 198 individuals, this equated to a total of 66 monthly medication reviews, an average of 16.5 quarterly medication reviews and an average of 16.5 annual comprehensive reviews per month for a total of 280 clinical contacts per month. This computed to a total of 65 minutes per clinical contact. This computation assumed that all of the available hours would be spent in clinical consultation. Add to this the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and any other clinical activity. And then, add to this the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology. Based on this, the current assigned FTE doe not appear adequate. Over time, the facility may consider workload indicators to objectively determine the need for additional clinical consultation. The monitoring team can be available to further discuss the determination of optimal FTEs if the state would like.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	Per a review of the facility self-assessment, psychiatric evaluations per Appendix B had begun in August 2010. Thus far, 14 individuals have undergone evaluations using this format. Of these 14, eight were complete and followed the Appendix B format. The other six were performed by prior treatment providers and were not of the same quality. The facility lead psychiatrist described plans to review these six evaluations and update them to comply with the requirements of this provision. While it was apparent that the psychiatrists were making efforts to provide services in substantial compliance with all of the items of this provision, there were many areas in need of improvement. For example, as discussed in J8, the two current psychiatrists inherited numerous cases from prior providers with extensive polypharmacy, indeterminate diagnoses, and a lack of historical information review. They were attempting to systematically review these cases to determine diagnoses and need for behavioral supports, however, in some cases, they had determined that reported behavioral challenges were actually medication side effects. In an effort to address this	Noncompliance

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		issue, 59 individuals were in the process of medication tapers at the facility, The facility did not have current policy and procedure outlining the process for psychiatric clinic. There was a draft policy and procedure authored by the facility lead psychiatrist that included a new psychiatry clinic form as well as quarterly addendum notes inclusive of treatment planning regarding the use of psychotropic medications. The draft policy and procedure had been piloted on one home, however, as stated in other areas of this report (J12 and J13), there were barriers to the full implementation of the policy. These (appropriately) included increased number of clinics, longer clinics, need for increased information provided for clinic, and increased documentation requirements for all clinic attendees. As these new procedures infringed on the schedule of other staff disciplines (e.g., psychology, nursing, QMRP), there had been some resistance to change. The active participation of all disciplines is vital to psychiatry, and psychiatry will not meet the requirements of this provision without implementation of new policy and procedure. As stated in the previous monitoring report, the facility was poised for a cultural change with regard to overall mental health treatment that appropriately included a combined collaborative approach to treatment with both pharmacological and behavioral interventions in order to comply with generally accepted professional standards of care. Furthermore, the psychiatry department's desire to work in an integrated manner was directly in line with the intentions of the Settlement Agreement, DADS, and DOJ. The success of this process may set the stage for similar integration of clinical services across the entire facility and might even serve as a model for other SSLCs across the state. During this onsite review, three psychiatric clinics were observed (for additional information regarding this please see the discussion regarding J8). In all three instances, the physician, along with the assigned psychologist, nurse case manager or direct care nurse, direct care staff, and QMRP, met with the individual for psychiatry clinic. In two instances, the clinical pharmacist was also in attendance. Appropriate clinical observation/discussion lasting anywhere from 30 to 60 minutes was held with the team and each individual. It was obvious from the interaction, that the individual was an active participant in the clinic. In all three clinic observations, the physician appeared to be familiar with the individual's history, and had the medical record open, reviewing documents from the record during clinic. In all three observations, other staff, including the nursing case manager or direct care nurse, QMRP, psychology, and direct care staff were in attendance. In all three observations, the psychiatric practitioner led the discussion and	

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		interacted with other team members, but primarily with the individual. In two clinic observations, the clinical pharmacist was in attendance, and contributed greatly to the overall clinic experience. A review of the documentation related to psychiatry clinic revealed improvements over the prior monitoring review. Specifically, with regard to the determination of diagnosis, rationale for treatment with a specific medication, and target symptoms for monitoring. Further review of psychiatric clinic documentation revealed improvements in the review of weight and vital signs, laboratory examinations, side effect monitoring, review of behavioral data, and inclusion of other information provided by team members during clinic.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	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 four Reiss Screens on new facility admissions in the previous six months. All four of these individuals were referred for a complete psychiatric evaluation, which occurred an average of 8.5 days following the Reiss screen (range 2 – 18). The Director of Psychology remained uncertain regarding the utility of the instrument for this facility because it was facility practice to perform psychiatric evaluations on all new admissions regardless of their psychotropic medication status upon admission. The Director of Psychology reported that all individuals residing on campus who were not enrolled in psychiatry clinic had undergone the Reiss Screen. She also indicated that the Reiss Screen has been utilized in the case of individuals who were experiencing behavioral exacerbations and were not currently enrolled in psychiatry clinic. The Director reported that while the Reiss Screen was being utilized, she was uncertain as to the process for referral of an individual for a psychiatric evaluation following a determination of need. This was illustrative of the importance of both the development and implementation of policy and procedure regarding psychiatric treatment at the facility.	Noncompliance
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to	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. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the collaboration between the disciplines, while improved since the prior visit, was still limited to the psychiatric clinical encounter and	Noncompliance

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	integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	sporadic psychiatry participation in the PSP process. During this review, there was increased time for team discussion during psychiatry clinic, where target symptoms and behaviors for monitoring were defined, discussed, and reviewed. There was some basic discussion regarding the coordination of behavioral and pharmacological treatments. While the comprehensive psychiatric evaluation documents reviewed noted recommendations for non-pharmacological interventions (e.g., individual therapy, dialectical behavioral therapy, behavioral support), there was no combined assessment or case formulation occurring, therefore, this provision item was rated as being in noncompliance. While some of the data 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 both the accuracy and validity of the identified individual target behaviors. Staff reported slowly reviewing individual cases with respect to the identification and definition of target symptoms. This process was complicated, however, by both new psychiatrists having an influx of patients when the prior treatment providers left the facility. These new cases had complicated medication regimens associated with a lack of documentation, a situation that was reviewed in the previous monitoring report. As such, the new physicians had an uphill course with respect to addressing specific psychopharmacological regimens that required a great deal of time and energy. As noted by one of the psychiatrists, "things are in flux…because there is a need to adjust the medication and actually figure out what the diagnosis is…due to the number of medications some individuals were taking, it was tough to know what was working…and if the behaviors were side effects to the medications to begin with." Staff gave an example of an issue that occurred with Individual #216. This individual had a history of a diagnosis of insomnia, however, on further review of the prescribed medication regimen, it was determined that the difficulties with sleep were due to an activating antidepressant prescribed in the late afternoon. After the new psychiatrist adjusted the timing of the dosage, the individual was able to sleep, no further medications were needed, and the diagnosis of insomnia was invalidated. In all clinic observations performed during this monitoring review, the data provided to the physician regarding target symptom monitoring was at least three weeks old. Per staff interviews, this was due to the facility staff compiling data monthly. This was not adequate. For psychiatry to make appropriate determinations regarding response to medications that are data based, data collection and analysis must be up to date at the clinical encounter. Staff interviews revealed plans to increase the frequency of data collection.	

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		Per observation of psychiatry clinic and staff interview, psychology had not begun to graph behavioral data presented to the physician. The Director of Psychology reported plans to begin data graphing. In order for these graphs to be useful during the clinical encounter, they must include accurate data, that is specific and defined for the individual, and that includes 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 health-related variables (e.g., illnesses, allergies, medications). Please see section K of this report for further discussion regarding this topic. The facility did not have a system to integrate pharmacological treatment with behavioral and other interventions. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings. There were also opportunities for interaction during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review and were a base upon which to build integration. Medication decisions made during clinic observations conducted during this onsite monitoring review were based on lengthy (minimum 30 minute) observations/interactions with the individuals as well as the review of information provided during the time of the clinic. In the three clinic observations conducted during this onsite review, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them and discussed the plan, if any, for changes to the prescription regimen. This was good to see, and must continue and expand. 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	Per interviews of both psychiatrists and psychology staff, the psychiatrists did not routinely attend meetings regarding behavioral support planning, and they were not regularly involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. To meet the requirements of this provision item, there	Noncompliance

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	individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	needs to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. Psychiatrists verbalized a willingness to become more involved, but indicated that until recently, a lack of clinical contact time had made this impossible. There was concern that even with the addition of a second full time psychiatrist, 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 some 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. Even so, per interviews and observations performed during this monitoring review, it was apparent that there were some improvements in coordination of care between psychiatry and psychology. While psychology was not providing up to date data during clinic (data presented was over three weeks old in some cases), psychology staff reported plans to increase the frequency of data reporting, while simultaneously questioning the accuracy of data. It was notable that given the slower pace and more reasonable schedule for individuals in psychiatry clinic, there was ample time for discussion, review and definition of specific target symptoms for monitoring, and discussion of possible behavioral interventions. The positive behavioral support plans and psychiatric documentation for 18 individuals prescribed psychotropic medication were reviewed. In no case was the signature of a psychiatrist included. It was difficult to determine collaboration between the disciplines via a review of this document. The psychology staff had not yet begun to utilize graphs for the reporting of behavioral data trends over time. For psychiatry, these graphs would be most useful if they included specific time markers (e.g., start dates of medication, stop dates of medication, dosage adjustments, specific life stressors that may affect behavior) and if they included data up to the date of the psychiatric review. This was only one of numerous areas where psychiatry and psychology will need to develop methods to share information and collaborate regarding the treatment of the individuals at the facility.	
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	A review of the records of 18 individuals at the facility who were prescribed various psychotropic medications as well as information provided regarding the psychiatric clinics performed during this monitoring review, and information provided regarding informed consent revealed numerous examples of completed forms entitled "New Psychotropic Medication Initiation Form." This form was reportedly initiated 11/1/10 in order to document the risk/benefit	Noncompliance

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	physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	analysis with respect to new medication prescriptions. While it was positive that psychiatry had begun to provide information to the team regarding medications, additional work was needed in this area. For instance, the "New Psychotropic Medication Justification Form" did not review medications that the individual was already prescribed; it only took new medications into account. The following are several examples of the documentation included on the "New Psychotropic Medication Justification Form." • Individual #95 – On 12/29/10, Prozac was prescribed emergently for symptoms associated with Major Depressive Disorder. Per the documentation, "Paxil was discontinued three and a half weeks ago and depressive symptoms have reoccurred. Would not resume Paxil as has many potential drug interactions compared to Prozac, also using with Zyprexa may help neurovegetative symptoms of depression including change in appetite, sleep, refusal of self care, concentration...self injurious behavior…since starting dose, may need to titrate before full therapeutic effect – most effects can take 4 – 6 weeks." The treating psychiatrist and three other team members, including the individual, signed the document. Complicating this issue, however, was the fact that this individual was also prescribed Olanzapine, Trazodone, and Lorazepam. • Individual #281 – On 1/20/11, Risperidone was prescribed emergently for "impulsivity related to borderline personality disorder…positive behavioral support plan (PBSP) has continued to be revised along with her psychotropic medication regimen…minimally successful...PBSP not likely to be as effective if staff not fully consistent due to her…impulsivity in the form of unprovoked self injurious behavior and unprovoked aggression…this is being given temporarily given her acute decompensation and will need this while Risperdal Consta is being titrated." The treating psychiatrist and four additional team members signed this document. This individual was also prescribed Cymbalta, Klonopin, and Clonidine. She also has complicating medical diagnoses, including hypothyroidism, hypertension, diabetes, and idiopathic scoliosis. A review of the comprehensive psychiatric evaluation revealed that the psychiatrist had also recommended a trial of dialectical behavioral therapy for this individual. • Individual #246 – On 12/13/10, Depakote was prescribed emergently to address "Intermittent Explosive Disorder and aggression related to autistic disorder…current medication regimen is only partially effective and behavioral program has been minimally effective as well… monitor… aggression in the form of hitting, scratching, biting…robust effect may not	

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		be seen until further titrations occur, but may start to see within 1 – 2 weeks." The treating psychiatrist and three additional team members signed this document. This individual was also prescribed Lorazepam and Olanzapine and had complicating medical diagnoses including a history of seizures, hyponatremia, and leukocytosis. As noted above, the new form addressed newly prescribed agents, but did not address previously prescribed agents, or the interaction between medications in the total regimen, in some of the cases. There were also elements of informed consent that were not addressed by this form alone. At the time of the review, the form was not included in policy and procedure. While the above noted innovations were a good start, and indicated the involvement of both the team members and the psychiatrist in the analysis of risk/benefit for a particular medication, they also illustrated the need for an organized response. As discussed with facility staff during the monitoring review, the success of this process of developing an organized response will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that	Per staff interview, observation, and documentation, the facility had a monthly Pharmacy and Therapeutics Committee meeting. At the time of this review, there was not a separate monthly meeting to review psychiatric polypharmacy; rather, these issues were reviewed during the existing monthly meeting. Per a discussion with the facility Pharmacy Director, there were plans to add a monthly meeting specifically for review of psychiatric issues and polypharmacy during the summer of 2011. The facility had recently recruited a clinical pharmacist who was an excellent addition to the psychiatry clinic. The clinical pharmacist and psychiatrists worked well together. Documentation of the pharmacy quarterly drug regimen reviews together with the psychiatric clinic notes revealed conscientious monitoring of side effects as well as improved justification for treatment with psychotropic medications, and parsimonious decision-making regarding medication regimens.	Noncompliance

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	the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	It was recognized by the monitoring team that the current psychiatric providers had assumed the psychiatric care of individuals from other physicians where documentation of the rationale for a particular medication regimen was either non-existent or insufficient. A review of the records revealed vast improvements in the documentation regarding rationale for a particular medication in association with justification of a particular diagnosis. For further information regarding this issue, please see the discussion for J13. Regardless, there were multiple regimens where the current physicians were not able to justify the medication and, as such, medication tapers were in progress, prompting the facility to adopt an additional metric in polypharmacy reporting, specifically "tapers." At the time of this monitoring review, there were 59 individuals reported in the process of a psychiatric medication taper. This category, however, did not include individuals in the process of a taper of benzodiazepines. This metric was reported separately and included 19 individuals who had a decrease in benzodiazepine total dosage between September 2010 and February 2011, where that dosage was indicated for a psychiatric diagnosis. Per discussions with the clinical pharmacist and the facility psychiatrists, a review of medication classifications for purposes of the determination of polypharmacy had been performed. In doing so, the facility psychiatry leadership had reassigned medications according to their pharmacological properties. This resulted in additional classifications of medication as follows: Antidepressants, Buproprion, Antipsychotics, Anticonvulsants, Lithium, Benzodiazepines, Buspirone, nonbenzodiazepine hypnotics, stimulants, Modafanil, Atomoxetine, Naltrexone, Clonidine, Guanfacine, Beta-Blockers, Acetylcholinesterase Inhibitors, and Memantine. As discussed during the monitoring review, this reclassification will skew polypharmacy reporting statistics because it will reduce the number of individuals meeting criteria for polypharmacy due to the prescription of two medications in the same class. It will not affect those individuals who meet polypharmacy classifications due to the prescription of three or more psychotropic medications. The medication classification information had been submitted by the facility lead psychiatrist to DADS in October 2010 for comment, however, per facility staff, guidance was pending. In the interim, the facility had implemented the new classification system for medications. Using this system, at the time of the monitoring review, there were 47 individuals at the facility meeting criteria for polypharmacy due to the prescription of two medications from a single class (reduced from 49 the month prior) and 108 individuals meeting criteria for polypharmacy due to the prescription of three or more	

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		psychotropic medications (increased from 105 the month prior). Per a review of the data, observations made during the review, and staff interviews, it was apparent that psychiatric staff were making efforts to address both the justification of medications regimens where they were able, or beginning medication tapers to reduce the medication burden. The medication reclassification must be addressed because this changes the data reporting for this facility and for comparison between facilities.	
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 as clinically indicated (e.g. for those individuals prescribed antipsychotic medication, with a recent discontinuation of antipsychotic medication, at risk for Tardive Dyskinesia or having a diagnosis of Tardive Dyskinesia). Per the facility self-assessment, two in-service trainings, dated 9/1/10 and 10/27/10, were conducted by the facility lead psychiatrist for the nursing staff responsible for completion of these scales. Per interviews with psychiatry staff, observation of psychiatric clinic, and review of 18 records available off site, psychiatric physicians were reviewing the MOSES and DISCUS rating scales, and tallying the final rating scale scores for inclusion into clinic documentation. The psychiatric clinic form, which was used to document clinical contact with the individual, had been revised to include, among other information, current and previous MOSES and DISCUS results that would serve to document the inclusion of this information in clinical decision making. This revised form had been piloted in selected homes. Per discussion with psychiatric providers, nursing staff, and other disciplines, there were barriers to full implementation of the draft policy and procedure regarding psychiatric clinic and documentation. One need that was apparent to the monitoring team was for there to be greater collaborative work between nursing and psychiatry. As noted above, this will require the direct involvement and support of the facility's senior leadership, including the facility director.	Noncompliance
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	At the time of the onsite monitoring review, the facility psychiatrists were participating in the PSP process as they were able. A review of the documentation regarding their participation in this activity revealed 13 examples of psychiatry participation in the PSP process between the dates of 10/20/10 and 2/8/11. Given the manner of the data request, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended.	Noncompliance

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	treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The psychiatrists did, however, have contact with the PST members during psychiatry clinic. During this monitoring review, three clinic observations were conducted. During these observations, extensive, detailed, and appropriate discussions regarding the individual and their treatment plan were observed. The lead psychiatrist had been working to develop a facility specific policy and procedure regarding psychiatric services. This policy was in draft form at the time of this monitoring review, however, had been piloted in one home. Interviews with both facility psychiatrists and the Director of Psychology revealed that the responsibility for the development of the risk/benefit analysis and the treatment planning regarding psychotropic medication was being transitioned from psychology to psychiatry. Per the document request regarding information for the last 10 individuals prescribed psychotropic medication, psychiatric treatment reviews and progress notes were provided. A new form entitled "New Psychotropic Medication Justification Form" was included. This form has reportedly been implemented across campus. Also, the lead psychiatrist presented another form entitled "Quarterly Clinic Addendum – Treatment Plan Review." This form had reportedly been piloted in the selected home. The "New Psychotropic Medication Justification Form" included information regarding emergency or non-emergency basis for the start of a particular medication, the name of the medication and dosage, the diagnosis/indication for the medication, a risk benefit analysis, the alternatives to treatment with the medication, psychiatric symptoms/behavioral characteristics to be monitored, the expected timeline for therapeutic effects to occur, and documentation regarding either attempts or completed contact with the individuals legally authorized representative. Issues regarding informed consent are discussed further in J14. A review of completed "New Psychotropic Medication Justification Form" documents for Individual #4, Individual #95, Individual #316, Individual #333, Individual #214, Individual #177, Individual #194, Individual #246, Individual #111, and Individual #232 revealed some variability in the quality of documentation that may be attributable to its novelty. Further, peer review and feedback will likely result in additional improvement. The majority of the documents, however, gave good detail regarding the rationale for treatment with a particular psychotropic medication. The following is an example of good documentation: • Individual #4 – "Saphris Black Cherry Formulation 5 mg at bedtime…Bipolar I, most recent episode mixed with psychotic features…attempted to use Abilify but appears too activating for her as evidenced by increased agitation, yelling. Behavioral approaches have been minimally successful…monitor mood swings,	

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		aggression and irritability that may be related to a mixed episode and psychosis in the form of paranoia, laughing to self…this is a starting dose, so may not see full robust effect until further titration." The new "Quarterly Clinic Addendum – Treatment Plan Review" form included information regarding medication effectiveness, justification for the use of the current medication regimen to include justification for use of polypharmacy and/or mediations dosed above the maximum dosing guidelines, and Axis I and Axis II diagnostic formulation. Examples of the "Quarterly Clinic Addendum – Treatment Plan Review" were received regarding Individual #347, Individual #244, Individual #9, Individual #163, Individual #7, Individual #34, Individual #246, and Individual #101. The documents reviewed provided good information regarding the prescribing practitioner's thought process and rationale for a particular medication regimen and diagnosis. For example: • Individual #244 – Diagnoses were Obsessive Compulsive Disorder, Autism Spectrum Disorder, Intermittent Explosive Disorder, and Generalized Anxiety Disorder. Medications included Olanzapine, Ativan, and Depakote ER. The psychiatrist wrote, "medications appear to be fully effective at this time with no apparent side effects as evidenced by improvements in all target behaviors…this regimen was started by a previous psychiatrist…In general, I do not agree with long term use of benzodiazepines for generalized anxiety disorder… given her diagnosis of autism and current provisional diagnosis of bipolar, I would have to be more cautious in considering use of SSRI for her…previous psychiatrist's…notes…reflect increased agitation with moderate doses of SSRIs… Depakote ER was started 11/10 and titrated to its current dose and has appeared helpful for Intermittent Explosive Disorder symptoms." The physician went on to provide the rationale for a diagnosis of Autistic Disorder, per an extensive review of the DSM-IV criteria. The physician then documented treatment team concerns regarding symptoms of Obsessive Compulsive Disorder and Intermittent Explosive Disorder. The physician documented ongoing attempts to verify the presence or absence of a diagnosis of Generalized Anxiety Disorder and concluded by invalidating the diagnosis of Bipolar Mood Disorder with documentation of the rationale for this decision. As evidenced by the above, the facility psychiatry staff were making strides with regard to developing a treatment plan for psychotropic medication that identified a clinically	

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		justifiable diagnosis, the expected timeline for the therapeutic effects of the medication to occur, and the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy. They also initiated a psychiatric treatment planning process. This process, while in the infancy stage, was a good start. What was notable was the documentation of a thoughtful, planned approach to psychopharmacological interventions. These procedures need to be codified in policy and procedure and fully implemented across the facility.	
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. Per review of the policy, psychology staff were responsible for obtaining consent for psychotropic mediations. During the review, it was apparent that the psychiatry staff had made positive changes with respect to the manner of obtaining informed consent for treatment with psychotropic medications. These changes were not codified in policy and procedure. Per interviews with psychiatry, clinic observation and document review, a new practice started at the facility in late October 2010. Specifically, the psychiatrists contacted the legally authorized representative (LAR) via telephone regarding planned medication changes. The staff created a form entitled "New Psychotropic Medication Justification Form" which reviewed the medication, indication for same, target symptoms, the risk/benefit analysis for the medication, and documentation of either contact with, or attempts to contact, the legally authorized representative. If the psychiatrist was unable to reach the LAR, then, per the directions on the form, "PST member will attempt at a later time." As a follow-up to the psychiatrist's contact with the LAR, information regarding the prescribed medication should be sent to them. Per interviews with team members and psychiatry staff, there had been increased contact with LARs over the past several months. Anecdotes of multiple telephone conversations with the LARs of several individuals were discussed. 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 remained a parallel process occurring with regard to informed consent, that with the addition of the psychiatric documentation, added up to a three way consent process for some individuals. There were consent forms located in the records that reviewed the medications prescribed to the individual, but delineated	Noncompliance

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		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 this review, the majority of the responsibility for informed consent for psychotropic medication was still delegated to psychology staff. Evidence of this process was located in 15 examples of informed consent documentation provided per the document request. A review of the documentation of this process revealed that none of the current consent forms were in keeping with generally accepted professional standards of care. 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 always included (of a total of 15 examples, only five included team signatures). Also, the list of side effects included for each identified medication was incomplete. For example, in one psychology-derived document, side effects listed for the antipsychotic medication Quetiapine (Seroquel) stated, "anxiety, restlessness, behavior problems, constipation, drowsiness or dizziness, dry mouth, shakiness, weight gain, swelling in feet or ankles." There was no mention of other deleterious side effects of this medication, which would include Tardive Dyskinesia and Neuroleptic Malignant Syndrome, among others. While the efforts of the psychiatry staff with regard to completion of the "New Psychotropic Medication Justification Form" and contact with the individuals LAR were laudable, and hopefully indicative of a transition toward appropriate practice, the informed consent policy and procedures, and the informed consent practices at the facility, were not consistent with generally accepted professional standards of care that require that the <u>prescribing practitioner</u> 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 then be documented in the individual's record. Given the importance of informed consent, the development of an updated facility policy and procedure regarding this topic should be considered. In an effort to address the deficit in these informed consent practices, it was recommended that the facility consult with the state office that, in turn, should consider a statewide policy and procedure outlining appropriate informed consent practices that	

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		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 two facility psychiatrists and the facility medical director, attempts to coordinate treatment efforts between primary care, neurology, and psychiatry had stalled. Previously, the facility had increased neurology consultation hours to two half-day clinics per month, for a total of six hours. The consulting neurologist had reportedly been ill, and the last neurology/psychiatry clinic was held 11/30/10. Both the lead psychiatrist and the facility medical director reported the start of negotiations to obtain onsite consultative services via a contract with the University of Texas Health Science Center at San Antonio (UTHSCSA). A neurologist in that system had been identified and was willing to perform onsite consultations one time per month. More recently, individuals had been transported to UTHSCSA for consultation, however, this was a stopgap measure, utilized for those individuals who needed immediate consultation. Other routine consultations were awaiting the return of the prior neurology consultant, or the start of the contract with UTHSCSA. Collaboration between neurology and psychiatry is imperative as evidenced by the number of individuals with concomitant psychiatric illness and seizure disorder. During the facility review, the total population was 281 individuals. Of these, 167 individuals had a diagnosis of seizure disorder with 64 individuals reported as having "uncontrolled epilepsy." There were a total of 192 individuals with Axis I psychiatric diagnosis. Of these, 91 individuals were prescribed an anti-epileptic medication for a psychiatric indication, and an additional 71 individuals prescribed psychotropic medications had a comorbid seizure diagnosis. This did not include those individuals with seizure diagnosis who were not also prescribed psychotropic medication. Given the clinical need identified in the paragraph above, it would be challenging for the neurologist to follow these individuals with the limited amount of clinical consultation time proposed (one onsite clinic per month), much less participate in regular coordination of treatment with other professionals.	Noncompliance

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		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. The facility should continue the consideration of 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 currently contracted in other DADS facilities. Of the 18 records reviewed, five had a diagnosis of seizure disorder. A review of these five records revealed two documented neurology consultations dated within the previous six months. One, regarding Individual #188, was performed on campus 8/16/10 and another regarding Individual #259 was performed on 10/26/10. Both of these consultations were noted as dictated by the consulting neurologist, but did not bear his signature. They did have the signature of the facility medical director as well as the signature of the lead psychiatrist, indicating review of the documents. Unfortunately, the psychiatric physicians were not fully integrated into the PSP process at the facility. Given the lack of neurology resources, it would be necessary for the psychiatrist to provide information to the PST that resulted from this clinical consultation. Currently, the facility had two full time psychiatrists, which was not sufficient to allow for participation in the PST process regularly. A review of documentation requested regarding the psychiatry participation in the PSP process revealed 13 examples of psychiatry participation in the PSP process between the dates of 10/20/10 and 2/8/11. Given the manner of the data request, it was not possible to determine what percentage of total PST meetings the psychiatrists had attended. It can be deduced that given their attendance at 13 meetings in the course of three and one half months, this would extrapolate to attendance at 44 meetings over the course of the year, far below the total number of individuals on the psychiatric caseload, which numbered 192.	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include the continued involvement of 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. Continue cross discipline consultation regarding pretreatment sedation options.

3. 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.

4. Review the need for additional ancillary staff for psychiatry clinic. This staff could gather data and other information necessary for monitoring while allowing psychiatrists more time for clinic and other activities directly related to patient care.

5. Finalize the draft and implement policy and procedure governing psychiatric clinic at the facility.

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

7. Continue to utilize the Reiss screen for new admissions as well as those individuals who do not have a current psychiatric evaluation, or who are not enrolled in psychiatry clinic and are experiencing challenges. Determine the mechanism for referral for psychiatric evaluation following a positive Reiss Screen.

8. 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, timing of data collection) 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).

9. Improve coordination between psychiatry and psychology, specifically with regard to case conceptualization, identification and justification of diagnoses, the identification and definition of specific target symptoms for monitoring, and the monitoring of the response to treatment with psychotropic medications.

10. Improve coordination between psychiatry and nursing, specifically with regard to psychiatry clinic schedule, documentation of laboratory examinations and other clinical information necessary for the psychiatrist during psychiatry clinic.

11. Formalization of the PSP process to review risk/benefit ratios for the prescription of psychotropic medications, the responsibility for the creation of same is currently in the process of transition to psychiatry.

12. Institute a monthly psychiatric polypharmacy committee meeting.

13. Review the method of reporting polypharmacy data for accuracy and completeness; determine if the new classification system for psychotropic medications, which has been submitted to DADS for review, will continue.

14. Continue efforts to improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

15. Improve documentation of psychiatric review and clinical use of DISCUS and MOSES examination results via implementation of the new psychiatry clinic documentation where this information is included.

16. Continue to improve psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis.

17. Continue use of the "New Psychotropic Medication Justification Form" and the "Quarterly Clinic Addendum – Treatment Plan Review." Finalize and implement policy and procedure regarding psychiatric services at the facility.

18. 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.

19. Individualize the process for Informed Consent, ensuring that the prescribing practitioner obtains consent for all prescribed psychotropic medications.

20. Consult with DADS administration regarding a statewide policy and procedure for Informed Consent.

21. Continue efforts to integrate psychiatry into the PSP process.

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

The following are offered as additional suggestions to the facility:

23. Consider continuing to track the psychiatrist's participation in the PSP process.

24. Consider appointing a mentor for the facility psychiatrists, specifically a psychiatrist at another facility who is familiar with the requirements and challenges of working in the DADS system.

25. Develop a recruitment/retention plan for psychiatry. The facility should consider the development of a "pearls of wisdom practice" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff.

26. 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.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Positive Behavior Support Plan (PBSPs) for: • Individual #95 (10/25/10), Individual #216 (1/11/11), Individual #276 (1/25/11), Individual #349 (12/13/10, Individual #80 (9/7/10), Individual #146 (11/30/10), Individual #255 (8/9/10), Individual #333 (9/13/10, Individual #185 (9/1/10), Individual #104 (5/13/10), Individual #225 (6/21/10), Individual #218 (2/1/10), Individual #278 (6/12/10), Individual #51 (1/25/11), Individual #23 (6/10/10), Individual #86 (1/11/11), Individual #11 (9/1/10), Individual #178 (9/13/10, Individual #75 (9/7/10), Individual #200 (9/20/10), Individual #83 (12/6/10), Individual #17 (2/7/11), Individual #244 (2/7/11), Individual #111 (1/11/11), Individual #291(11/15/10) o Functional Assessments for: • Individual #216 (12/16/10), Individual #349 (12/14/10), Individual #80 (9/2/10), Individual #146 (9/21/10), Individual #255 (8/13/10), Individual #278 (5/27/10), Individual #23 (6/10/10), Individual #218 (3/5/10), Individual #185 (7/6/10), Individual #225 (6/17/10), Individual #104 (6/16/10), Individual #83 (2/2/11), Individual #95 (10/25/10), Individual #291 (9/23/10), Individual #86 (12/1/10), Individual #333 (1/13/11), Individual #11 (8/17/10), Individual #178 (8/30/10), Individual #200 (12/10/10), Individual #51 (11/18/10) o Six months of PBSP progress notes for: • Individual #98 (1/10-11/10), Individual #23 (6/09-4/10), Individual #278 (5/10-12/10), Individual #104 (5/09-4/10), Individual #225 (6/09-4/10), Individual #185 (7/10-12/10), Individual #349 (1/10-10/10), Individual #146 (10/09-9/10), Individual #80 9/09-8/10) o Psychological Assessments for: • Individual #304, Individual #7, Individual #148, Individual #138, Individual #87, Individual #83, Individual #3, Individual #274, Individual #18, Individual #232, Individual #279, Individual #72, Individual #115, Individual #257, Individual #51, Individual #227, Individual #40, Individual #152, Individual #291, Individual #253 o Spreadsheet of BCBA coursework completed for each psychologist, dated 1/11/11 o Behavior Therapy/Peer Review Committee minutes for 7/5/10, 7/12/10, 7/19/10, 8/2/10, 8/9/10, 8/16/10, 8/24/10, 9/1/10, 9/7/10, 9/13/10, 9/20/10, 10/11/10, 10/25/10, 11/1/10, 11/8/11, 11/30/11 o Internal Peer Review minutes, undated o External Peer Review minutes, undated o Reduction Data Sheet, dated 9/30/10

	o Data sheet for time sampling, dated 1/13/11 o Spreadsheet of all individuals for whom a functional assessment has been completed, undated o Spreadsheet of all individuals with psychological assessments, undated o Spreadsheet of all individuals with a PBSP, undated o Psychological Services Referral Form, dated 7/13/10 o List of Individuals seen by Outside Therapist, undated o List of Individuals participating in "Circles," undated o List of Individuals participating in "Anger Management," undated o List of Individuals participating in "Problem Solving," undated o PBSP Implementation Competency Tool, dated 10/26/10 o Inservice tracking log for Homes 668, 670, 671, 672, 766, 665, 674, and 673 Interviews and Meetings Held: 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: Rosalia Rodriguez, Associate Psychologist; Melanie Rodgers, Associate Psychologist; Mark Boozer, Associate Psychologist; Gary Sarli, Associate Psychologist; Steven Boncek, Associate Psychologist; Charles Obi, Associate Psychologist; Bill McCarthy, QMRP; Laura Lewis, Associate Psychologist; Barbara Smith, Psychology Technician; Daisy Ellison, Psychology Director; Alan Almogela, Associate Psychology • Individuals presented: Individual #150, Individual #276, Individual #174, Individual #244, Individual #55, Individual #128, Individual #17, Individual #41, Individual #43, Individual #250, Individual #13 o Internal Peer Review Meeting: • Staff present: Daisy Ellison, Psychology Director; Laura Lewis, Associate Psychology; Alan Almogela, Associate Psychology; Steven Boncek, Associate Psychology; Mark Boozer, Associate Psychology; Charlotte Fisher, Associate Psychology; Charles Obi, Associate Psychology; Miguel Phillips, Associate Psychology; Gary Sarli, Associate Psychology; Melanie Rodgers, Associate Psychology; Rosalia Rodriguez, Associate Psychology; Barbara Hayes, Psychology Assistant; Tiffany Nash, Psychology Assistant; Connie Ramos, Psychology Assistant; Brandon Bailey, Psychology Assistant; Justin Lizcano, Psychology Assistant; Barbara Smith, Psychology Technician; Linda Francis, Psychology Technician • Individual presented: Individual #95 o Psychology Department Meeting: • Staff present: Daisy Ellison, Psychology Director; Laura Lewis, Associate Psychology; Alan Almogela, Associate Psychology; Mark Boozer, Associate Psychology; Charlotte Fisher,

Associate Psychology; Charles Obi, Associate Psychology; Miguel Phillips, Associate Psychology; Gary Sarli, Associate Psychology; Melanie Rodgers, Associate Psychology; Rosalia Rodriguez, Associate Psychology; Barbara Hayes, Psychology Assistant; Tiffany Nash, Psychology Assistant; Connie Ramos, Psychology Assistant; Brandon Bailey, Psychology Assistant; Justin Lizcano, Psychology Assistant; Barbara Smith, Psychology Technician; Linda Francis, Psychology Technician

- Psychiatry Clinic:
  - Staff present: Dr. Vale, Psychiatrist; Ashley Smith, Pharm.D.; Charlotte Fisher, Associate Psychologist; Diana Fox, QMRP; Dawn Campbell, RN
  - Individuals presented: Individual #8, Individual #218, Individual #324
- Observations occurred in every day program and home 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:

SASSLC's Plan of Improvement (POI) indicated noncompliance for each item of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI findings of noncompliance in all areas.

The 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 likely 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.

Summary of Monitor's Assessment:

Although none of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was progress in several items. These include:

- Addition of internal peer review (K3)
- Introduction of a new, simplified data system (K4)
- The expansion of the current data system (K4)
- The use of more sensitive data presentation (K4)
- Increase in the number of individuals with Psychological Assessments (K5)

For the next review the monitoring team will be looking for the following:

	• Documentation demonstrating that peer review is occurring at least weekly (K3) • The implementation of the new simplified data system across all homes and day programming sites (K4) • The beginning of IOA (K4) • The routine use of the graphing of data in intervals necessary to make treatment decisions (K4) • An increase in the percentage of functional assessments that include all the necessary assessment components and have a clear summary of the variables hypothesized to affect target behaviors (K5) • An increase in the percentage of Positive Behavior Support Plans (PBSPs) that are based on the hypothesized function of the target behavior, and specify clear, concise antecedent and consequent interventions (K9) • Generally simplified PBSPs that attempt to consolidate target behaviors that serve the same function, and are consistently written in a style that would likely be understood by DCPs (K11)

#	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 at SASSLC were not demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the lack of consistent quality of the positive behavior support plans (see K9). At the time of the onsite review, no members of the Psychology Department were board certified behavior analysts (BCBAs). Seven of the department's 11 psychologists, however, were enrolled in course work toward becoming BCBAs. Two of these psychologists anticipated sitting for the national exam in the fall of 2011. The facility provided supervision of psychologists enrolled in the BCBA program by contracting with two consulting BCBAs from the community. To achieve compliance with this item of the Settlement Agreement the department needs to ensure that all psychologists writing Positive Behavior Support Plans (PBSPs) attain BCBA certification.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology	This provision item was rated as being in noncompliance because the director of psychology was not a board certified behavior analyst and did not possess other licensure or certification in a relevant field of psychology. The director of psychology possessed an advanced degree (Masters Degree) and over 20	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 or other licensure or certification in a relevant field of psychology. Psychology staff reported positive interactions and professional support from the Director of Psychology. Additionally, the director has begun several new initiatives to improve clinical outcomes and achieve compliance with this provision (see summary of monitors' assessment above).	
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.	SASSLC had recently begun a second internal peer review meeting to provide psychologists the opportunity to present individual cases for review that were not progressing as expected. At the time of the onsite review, however, this internal peer review meeting had just begun to occur, and the facility did not have monthly external peer review in place. Therefore, although the establishment of internal peer review represented an important improvement from the last facility review, this item is rated as being in noncompliance. The facility had been conducting Behavior Therapy Committee/Peer Review (BTC/PR) meetings that contained many elements of internal peer review necessary to attain substantial compliance with this provision item. During the BTC/PR meeting observed by the monitoring team, there was active discussion, and opportunities for psychologists to share strategies and suggestions to better improve the effectiveness of PBSPs presented. The BTC/PR meetings however, reviewed only PBSPs that required annual approval. The newly established internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The new peer review meetings also allowed more time to discuss cases. During the peer review meeting observed by the monitoring team, the PBSP of an individual not achieving her treatment objective (e.g. Individual #95) was presented. The peer review resulted in the identification of several new antecedent and consequent procedures to address her target behaviors. Review of minutes from these meetings indicated that both BTC/PR and internal peer review meetings were attended by the majority of psychologists in the department. Additionally, meeting minutes indicated that BTC/PR meetings occurred weekly, while internal peer review meetings had just begin at the time of the onsite review. It is recommended that the facility ensure that internal peer review meetings that contain all of the elements identified above occur weekly. At the time of the onsite review, the facility began to have the BCBA consultants (see K2) attend BSPC/peer review meetings. The monitoring team agrees that this represents an appropriate use of the consultant's time, and is an excellent way to improve the overall quality of the PBSPs. Because the consultant will help oversee and develop the facility's	Noncompliance

#	Provision	Assessment of Status	Compliance
		PBSPs, however, the monitoring team would not consider this to be an example of external peer review. External peer review involves review by other professionals who are not directly responsible for the development and implementation of the PBSPs, such as external peer review by other Texas DADS BCBAs and supervisors (perhaps by teleconference). The monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of professionals familiar with applied behavior analysis (ABA) and outside SASSLC. The monitoring team remains available to DADS to further discuss ways to set up an external peer review system. Operating procedures for both internal and external peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team was encouraged by the improvements in this provision item since the last onsite review. More work, however, is necessary before the facility achieves substantial compliance. As recommended by the monitoring team in the last report, the facility had developed a plan to simplify the current data system. The new data system was designed to document target behaviors in 30-minute intervals. The previous system required direct care professionals (DCPs) to record antecedents and consequences in addition to the target behaviors (i.e., ABC data). Additionally, in the new data system, DCPs will be required to record a zero or a line (or an explanation of why there were no data) in each recording interval if target behaviors did not occur. This method will ensure that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. The requirement of a recording (i.e., either indicating the frequency of the target behavior, or a zero/line indicating that the target behavior did not occur) in each interval of the data sheet allows the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified. It is recommended that SASSLC implement the new target and replacement data system in each home and day program. Additionally, it is recommended that data collection compliance be collected at regular intervals, acceptable levels of data compliance be established, and feedback and training be provided to DCPs to ensure they attain and maintain those levels. As discussed in the last onsite review, the immediacy of the recording of target behaviors can also affect the integrity of data collected. If DCPs do not record target behaviors immediately after they occur, they increase the risk of recording the data incorrectly, or forgetting to record it at all. One of the advantages of the introduction of the individual data books is that they contain all data sheets and are to be with the individual at all times. This arrangement increases the likelihood that target behaviors will be recorded immediately after they occur. The monitoring team found, as was found during the last	Noncompliance

#	Provision	Assessment of Status	Compliance
		review, that many of the data books continued to be in locked rooms. For example, four of 10 data books reviewed (40%) were located away from the individuals and DCPs in locked rooms. Some homes, on the other hand, organized the data books so as to make them most accessible to DCPs. For example, home 672 West stacked the data books on shelves with wheels, and moved them to where the individuals were located. This arrangement allowed staff to immediately record data, and did not leave individuals unsupervised when DCPs went to the area where the data books were kept. It is recommended that the individual data books be readily available to DCPs, and data be recorded as soon after it occurs as is possible. Also see discussion in V4 below. As discussed in the last review, the most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex for some DCPs to collect data reliably. Under those conditions, the data system may need to be modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the onsite review of SASSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors and replacement behaviors is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. The facility had begun to enhance the flexibility of its data system since the last onsite review. In addition to the new frequency data system described above, the facility was planning to use a time sampling procedure to more accurately capture high frequency behaviors. Additionally, SASSLC has begun to use ABC data in its functional assessments to better identify the conditions under which a behavior occurred. For example, Individual #146's functional assessment included ABC data that suggested his physical aggression may be related to a change in medication and maintained by negative reinforcement. It is recommended that the facility continue to expand its data system to include duration measures of target and replacement behaviors. As recommended in the last review, SASSLC had begun to graph data in increments based on individual needs (rather than all individuals' data graphed in increments of one month, as found during the last review). For example, Individual #255's disruptive behavior was graphed in 30-minute increments to better understand the behaviors relationship to meal times. The monitoring team was encouraged by these improvements in the data system at SASSLC, and looks forward to seeing more examples during the next onsite review. Finally, none of the graphed data reviewed included replacement data. It is recommended that SASSLC graph target and replacement behaviors at a frequency sufficient to make databased treatment decisions.	

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		SASSLC had improved the process of documenting PBSP modifications. The facility had added a box to each PBSP indicating if this report was new, an annual review, or a revision due to lack of progress. In reviewing six months of PBSP data for nine individuals, however, five (Individual #218, Individual #23, Individual #278, Individual #104, and Individual #80), or 55%, indicated no obvious improvement in severe behavior (e.g., aggression or self-injurious behavior) and no indication of a change in the PBSP prior to the annual review. For example: • Individual #80's aggression and self-injurious behavior (SIB) increased substantially over the last three months of the review. • Individual #23's SIB continued at a rate well over the rate identified as the treatment objective for most of the year. In fact, none of the 25 PBSPs reviewed indicated a revision due to lack of progress (other than at annual reviews). It is important that when individuals' data trend in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes be made to the PBSP as needed, and that any discussion and intervention changes be documented in the progress notes.	
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 every individual at SASSLC, and due to the need for the content of most functional assessments to be more comprehensive and complete. Psychological Assessments A spreadsheet including psychological assessments completed indicated that approximately 60 of the 283 individuals at SASSLC had psychological assessments. This represents an improvement over the 15 psychological assessments completed at the time of the last onsite review. Twenty psychological assessments were reviewed by the monitoring team. • All 20 (100%) included a standardized assessment of intellectual and adaptive ability, and an assessment of psychopathology. • Nineteen of 20 (95%) psychological assessments contained a medical diagnosis. • One (5%) of the psychological assessments reviewed contained an assessment of medical status. • Eighteen (90%) contained a personal history. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical	Noncompliance

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		status. Functional Assessments All individuals at SASSLC with a PBSP had a functional assessment of the variable or variables affecting the individual's target behaviors. Twenty functional assessments were reviewed to assess compliance with this item of the Settlement Agreement. Fourteen of these functional assessments were completed since the baseline review and, therefore those were used to evaluate changes in this provision item. Review of these functional assessments indicated that the majority of issues identified in the last review still existed. As reported in the last two reviews, multiple formats of functional assessments were found. • Individual #291's functional assessment format was different than the other 13 functional assessments reviewed. This format did not include direct measures of the functional assessment, or include a summary statement identifying the variable or variables maintaining the target behavior. It is recommended that all functional assessments at the facility use the same format. The remaining 13 functional assessments conducted since the last onsite review did contain all of the necessary elements of a functional assessment identified in the last report. The quality of some of these elements, however, was insufficient for the functional assessments to be as effective as they could be. All functional assessments should include both direct and indirect measures. As discussed in the previous monitoring reports, ideally the indirect component of a functional assessment would reveal some common themes that then can lead to working hypotheses concerning the variable or variables affecting an individual's target behaviors. These hypotheses could then be further refined (or abandoned) based on the results of direct assessments (e.g., ABC measures) of the functional assessment. If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment remain unclear, or if the PBSP is not producing the desired results, the behavior analyst should then attempt to use other functional assessment tools, such as a functional analysis (i.e., experimental investigation of variables affecting the target behavior) to better understand the variables affecting the target behavior. The direct functional assessments of four (i.e., Individual #80, Individual #83, Individual #200, and Individual #349) of the 13 assessments reviewed (31%), were not complete	

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		because they did not specify antecedents prior to the target behavior(s) and/or consequences after it occurred. Some of these direct assessments (e.g., Individual #83) contained ABC observations, but did not conduct them long enough to observe the target behaviors and provide any additional information about relevant antecedent or consequent events affecting the target behavior. On the other hand, four (31%) of the direct functional assessment measures reviewed (i.e., Individual #255, Individual #146, Individual #11, and Individual #86) appeared to be particularly useful for identifying potential variables affecting the target behavior. All included ABC data that were collected long enough to observe examples of the of the target behavior (Individual #11's and Individual #86's direct functional assessment were conducted across several months). Again, many, but not all, of the functional assessments reviewed identified potential antecedents and consequences of the undesired behavior. Some of the identified events, however, were not operationally defined and, therefore, not useful for understanding the variables maintaining the behavior. For example: • Individual #216's functional assessment concluded "(Individual #216's) behavior is very reactive to environment and interaction. He exhibits a high level of behavioral instability and emotional labiality similar to cases of individuals with Axis II cluster B traits. It appears that a chaotic environment that includes danger to self and others is a systematic form of homeostasis for (Individual #216)…." It is unlikely that this conclusion would result in a clear, concise hypothesis of the events affecting Individual #216's target behaviors. • Individual #291's functional assessment concluded that the function of his verbal aggression was "…to intimidate staff…and to control his environment." These general statements would likely have different meanings to different people and therefore are not very useful for understanding the function of Individual #291's verbal aggression. • Individual #178's functional assessment concluded that his target behavior is "….directly related to his diagnosis of Bipolar Disorder, Manic Type." Individual #178's undesired behaviors may be related to his psychiatric diagnosis, however, a functional assessment is most useful when it focuses on the identification of the variable or variables that are affecting the target behavior (and in Individual #178's case, perhaps his Bipolar disorder), rather than simply concluding that his undesired behavior is the function of a psychiatric condition. • Individual #80's functional assessment concluded that his undesired behaviors were "…manifested through his diagnosis of intermittent Explosive Disorder and Schizophrenia." Two of the 14 functional assessments reviewed (14%) did not include a summary	

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		statement. 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. Seven of the remaining 12 functional assessments (58%) reviewed included summary statements that were not based on operational behaviors identifying the variable or variables maintaining the target behavior (e.g., see above comments on Individual #216's and Individual #178's functional assessment), or the summary statement did not appear to be consistent with reported results. For example: • Individual #255's summary statement included negative reinforcement (i.e., escape or avoidance of unpleasant activities) as a function of his undesired behavior, however, negative reinforcement was not mentioned in the findings of the direct or indirect measures. • Individual #333's direct and indirect assessments repeatedly identified staff attention as a function of his self-injurious behavior (SIB) and physical aggression, however, his summary statement did not clearly identify staff attention of undesired behavior as a function of these behaviors. Clearly, when comprehensive functional assessments 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 clearly and concisely integrate the information into a summary statement identifying the variables (both antecedent and consequent) that were hypothesized to affect the behavior. Replacement behaviors were included in nine of the 14 PBSPs (64%) reviewed (Individual #146, Individual #83, Individual #200, Individual #178, and Individual #291's PBSPs did not contain replacement behaviors). PBSPs should include replacement behaviors when the reinforcer for the target behavior is identified, and providing that reinforcer for alternative behavior is practical. In other words replacement behaviors should be functional; they should represent desired behaviors that serve the same function as the undesired behavior. The monitoring team found that only three of the nine (33%) functional assessments with replacement behaviors were functional. An example of a functional replacement behavior was: • Individual #86's undesired behavior was hypothesized to be maintained by avoidance of unpleasant activities. His replacement behavior included teaching him to use a communication device to ask for help and communicate his desires. This was a good example of a functionally equivalent replacement behavior	

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		because it provided the same reinforcer (i.e., a way to escape non-preferred activities) as hypothesized to be maintaining the target behavior. Examples of replacement behaviors that were not functional included: • Individual #95's targeted behaviors were hypothesized to be primarily maintained by attention. Her replacement behavior included increasing her participation in activities, such as setting and cleaning the dining table. These may be important skills and activities for Individual #95, however, they were not functionally equivalent to the purposed function of her target behaviors, that is, staff attention. • Individual #51's replacement behaviors consisted of participation in activities before and after lunch. Her target behaviors, however, were hypothesized to be maintained by task termination. An example of a functional replacement behavior would include teaching her an appropriate way to postpone or terminate a demand. All of the PBSPs reviewed included a section called "Replacement Behavior Training." As recommended in the last review, all replacement behaviors should be written as specific skill acquisition plans. Moreover, these plans should be included into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. 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 no evidence that functional assessments at SASSLC were reviewed and modified when an individual did not meet treatment expectations. 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. Functional assessments should be reviewed when an individual does not meet treatment expectations, with a maximum of one year between reviews. Two (Individual #86, and Individual #11) of the fourteen functional assessments reviewed (14%) were evaluated to be comprehensive and clear. As discussed above, however, several additional functional assessments contained excellent components that should also be modeled for future reports. Those include: • Individual #255's direct assessment of the relationship between mealtime and undesired behavior. • Good comprehensive summary statements for Individual #83, Individual #51, Individual #86, and Individual #11	

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		• Excellent ABC direct functional assessments for Individuals #146, Individual #95, Individual #86, and Individual #11 • Functional replacement behaviors for Individuals #333, Individual #86, and Individual #11	
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.	SASSLC's psychological assessments were not based on complete clinical and behavioral data (see K5 and K7) and, therefore, this provision item was rated as being in noncompliance.	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.	Psychological assessments were not completed for every individual at SASSLC (see K5) and, therefore, this provision item was rated as being in noncompliance. Additionally, 15 of the 20 (75%) psychological assessments reviewed included intellectual assessments that were more than 10 years old. DADS and the monitoring team are determining the conditions for conducting new assessments. Future reviews will evaluate the timeliness of psychological assessments based on those guidelines. SASSLC was not consistently conducting annual psychological updates at the time of the onsite review. It is recommended that all individuals receive annual psychological updates. The purpose of the annual update is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should 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. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions (Individual #83 and Individual #51) to the facility indicated that this component of this provision item of the Settlement Agreement, as in the last review, was in substantial compliance.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided	There were several improvements in this area since the last review, however, more work is needed to be done before this provision item can be considered to be in substantial compliance. The facility has begun to improve documentation of psychological services by the introduction of a referral form for individuals referred for these services. During the	Noncompliance

#	Provision	Assessment of Status	Compliance
	in such a way that progress can be measured to determine the efficacy of treatment.	current onsite review the monitoring team found examples of psychological assessments (e.g., Individual #304) and or PBSPs (e.g., Individual #83) that did document the need for psychological services other than PBSPs. Not all individuals receiving psychological services (e.g., Individual #51) other than PBSPs did have the need for services documented. It is recommended that needed psychological services (other than PBSPs) be documented in the each individual's psychological assessment or PBSP. At the time of the last review, 16 individuals participated in "Circles." At the time of current onsite review, 15 individuals participated in Circles, and the facility substantially expanded psychological services by offering a Problem Solving group (serving 34 individuals), and an Anger Management group (serving 17 individuals). As reported in the last report, each of the "Circles" 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 service plans did not 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, or a process to generalize skills learned to living, work, leisure, and other settings. Additionally, there was no documentation provided the monitoring team that the "Problem Solving" and "Anger Management" groups included goal directed services with measurable objectives and treatment expectations. All psychological services (other than PBSPs) at the facility should include: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
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	This item was rated as being in noncompliance because not all PBSPs reviewed contained all of the components necessary for an effective plan, and many of the interventions appeared general and were not clearly based on functional assessment results. Of the 25 PBSPs reviewed, 20 were completed or updated since the previous review, and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	therefore, were the focus of this review for evaluating improvements since the previous report. Every PBSP reviewed had the necessary consent and approvals. All of the PBSPs contained descriptions of data collection procedures, baseline data, and treatment expectations and timeframes. All PBSPs reviewed included descriptions of target behaviors, however 20% of these were not operational. For example: • Individual #216's PBSP defined suicidal threats/attempts as "…verbal or gestures with intentions to cause physical harm to self." This definition required the reader to infer if Individual #216 did indeed have an intention to harm himself. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior (e.g., saying he wants to hurt himself, or engaging in specific self-injurious behavior). • Individual #276's PBSP included a target behavior of delusional thinking. It was defined as "making the assumption that everything that happens in her environment… directly relates to her. Thinking she is being treated unfairly…" This definition also required DCPs to infer Individual #276's intentions. On the other hand, the following represent operational definitions that were operational, clear, and complete: • Individual #86's physical aggression was defined as biting, scratching, choking, hitting, pinching, kicking, or pushing others. • Individual #51's disruptive behavior was defined as sliding out of her chair, bucking in her chair, screaming, and/or stripping. All PBSPs should include operational definitions of target behaviors. All 20 recent PBSPs described antecedent and consequent interventions, but only nine (45%) were rated to be useful for weakening an undesired behavior. Examples of ineffective interventions included: • Individual #185's PBSP hypothesized that his aggression was maintained by negative reinforcement (i.e., a way to escape unpleasant activities), but his intervention following aggression included moving him to the leisure room or his bedroom. If his aggression was maintained by negative reinforcement, then this intervention would encourage, rather than discourage, his undesired behavior because it would allow him to escape unpleasant activities. • Individual #178's PBSP appeared very general and not related to the function of	

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		his undesired behavior. His PBSP stated that when he engaged in hyperactive behavior, staff should (1) say "calm down," (2) ask him to lower his voice, and if he continues, (3) say "that's not right." • Individual #276's interventions section of her PBSP was seven pages long, and likely would not be implemented with integrity by DCPs (see K11). Examples of PBSPs that were concisely and clearly written and based on the hypothesized function of the targeted behavior and, therefore, likely to result in the weakening of undesired behavior were: • Individual #11's PBSP hypothesized that his physical aggression functioned to obtain edibles, and avoid work. Antecedent interventions included reinforcing alternative, desirable behaviors with the same events maintaining his aggression. For example, his PBSP specified that he should often be asked if he was hungry, and if he indicated he was, he was to be given a small amount of food. Similarly, if during work he indicated that he wanted a break, he was allowed to briefly avoid work (e.g., he was taken for a 10 minute walk). • Individual #146's PBSP stated that his physical aggression was most likely a function of gaining attention from others. His PBSP included the provision of verbal praise and social interaction of staff when he was not displaying target behaviors. Additionally, his PBSP specified that he would be removed to his room (or otherwise away from others) following aggressive behavior. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. None of the PBSPs reviewed included a history of prior interventions strategies. It is recommended that all PBSPs include a brief history of interventions used. All of the PBSPs reviewed included a list of reinforcers for each individual. Many of the lists were very specific and therefore could be easily incorporated into the plans. For example: • Individual #11's PBSP listed specific foods that he preferred, types of music (including the type he did not like), and preferred locations on campus that were all incorporated into his PBSP. The monitoring team encourages the development of specific lists of preferences for all individuals at SASSLC, and the clear incorporation of these potential reinforcers into each individual's PBSP.	

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		Overall the monitoring team identified eight (Individual #146, Individual #349, Individual #83, Individual #51, Individual #244, Individual #75, Individual #333, and Individual #11) of the recent PBSPs (40%) to be good examples of plans that had operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. It is recommended that the facility build on these eight PBSPs and, for the next review, focus on increasing the percentage of PBSPs that are representative of clear, concise plans based on the results of a functional assessment.	
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 review (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, the facility had begun to graph some individual's data in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors), and the facility is encouraged to ensure that all individuals data are graphed and presented in increments that would be sensitive to individual needs and situations. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	This provision item was rated as being in noncompliance because, at the time of the onsite review, the facility did not demonstrate that PBSPs were reliably implemented by DCPs. As discussed in the last report, the monitoring team continued to find several PBSPs that were very long and complicated, and therefore would not likely be implemented by DCPs with integrity. For example: • Individual #276's PBSP contained nine target behaviors, and seven pages of interventions following undesired behavior. • Individual #216's PBSP had 12 target behaviors. • Individual #95's PBSP contained six target behaviors and was written in a style not likely understood by most DCPs. For example her interventions included "…should receive verbal, tactile, and tangible reinforcement. When she is engaging in behavioral malfeasance she will not receive any of the reinforcement."	Noncompliance

#	Provision	Assessment of Status	Compliance
		It is recommended that SASSLC review each PBSP and eliminate unnecessary target behaviors, ensure that all plans are written concisely, and simplify the language used. The only way to ensure that PBSPs are implemented as written is to implement a system to monitor treatment integrity. As discussed in the last report, SASSLC had made progress on this provision item by introducing a system to monitor and ensure treatment integrity. 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. 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. There were no integrity data available for review during the onsite review. The monitoring team looks forward to the opportunity to review integrity data during the next onsite review.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. The trainings reportedly were conducted by psychologists and psychology assistants prior to PBSP implementation, and whenever plans changed. Review of the training logs revealed that many DCPs remained untrained for most individual's PBSPs, and therefore this item was rated as being in noncompliance. The facility had, however, made several improvements in this area since the last review. SASSLC has centralized the training logs so that it is possible to identify staff requiring training. Additionally a competency-based assessment component has been added to the initial PBSP inservice to evaluate if staff understands the plan. The facility reported that they were working on a system 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, the facility will require documentation that all staff assigned to work with an individual has been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. Additionally the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	Noncompliance

#	Provision	Assessment of Status	Compliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SASSLC had a census of 283 individuals and employed 11 psychologists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants and two psychology technicians. None of these psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 10 psychologists with BCBAs.	Noncompliance

Recommendations:

1. The facility should ensure that all psychologists responsible for writing PBSPs attain BCBA certification.

2. Peer review meetings that contain the opportunity to discuss individual cases that are not progressing as expected should occur weekly.

3. The facility should establish external peer review.

4. Operating procedures for both internal and external peer review committees need to be established.

5. It is recommended that SASSLC implement the new target and replacement data system in each home and day program. Additionally it is recommended that data collection compliance be collected at regular intervals, acceptable levels of data compliance be established, and feedback and training be provided to DCPs to ensure they attain those levels.

6. It is recommended that the individual data books be readily available to DCPs, and data be recorded as soon after it occurs as is possible.

7. It is recommended that the facility ensure that IOA for all target behaviors and replacement behaviors is consistently collected in each home and day/vocational site.

8. It is recommended that the facility continue to expand its data system to include duration measures of target and replacement behaviors.

9. It is recommended that SASSLC graph every individual's target and replacement behaviors at a frequency sufficient to make databased treatment decisions.

10. It is important that when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes are made to the PBSP (when relevant), and that these changes are documented in the progress notes.

11. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status.

12. It is recommended that all functional assessments at the facility use the same format.

13. 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.

14. Replacement behaviors should be functional.

15. All replacement behaviors should be written as specific skill acquisition plans.

16. 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.

17. All individuals should receive annual psychological updates.

18. It is recommended that needed psychological services (other than PBSPs) be documented in the each individual's psychological assessment or PBSP.

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

20. All PBSPs should include operational definitions of target behaviors.

21. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior.

22. It is recommended that all PBSPs include a brief history of interventions used.

23. It is recommended that SASSLC review each PBSP and eliminate unnecessary target behaviors, ensure the plans are concisely written, and simplify the language used.

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

25. Ensure that all staff assigned to work with an individual have been trained in the implementation their PBSP prior to PBSP implementation, and

at least annually thereafter. Additionally the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.

The following are offered as additional suggestions to the facility:

26. In addition to the long-term POI goals, it may be useful for the psychology department to establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

27. It is suggested that external peer review be extended to other Texas DADS BCBAs and supervisors (perhaps by teleconference).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 7/20/10 o DADS Policy#006: At Risk Individuals, 10/5/09 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o The SASSLC Medical Services Policy and Procedures, 11/11/10 o SASSLC Bowel Management Program 10/27/10 o SASSLC Seizure Management, 12/1/10 o Medical Quality Improvement Documents • Constipation 2010 • Dermal Infections and MRSA Infections • Aspiration Pneumonia • Urinary Tract Infections o Quarterly Medical Monitoring audit tool o Mortality Reviews for individuals who died between 2010 and January 2011 • Clinical Death Review • Administrative Death Review • Physician Death Summary • Death Certificate • QE Death Review of Nursing Services o Listing, Individuals with seizure disorder, status epilepticus o Listing, Individuals diagnosed with pneumonia o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Individuals with osteoporosis and osteopenia o Listing, Individuals with diabetes mellitus o Listing, Individuals diagnosed with cancer o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o DEXA reports for individuals with osteoporosis and osteopenia o SASSLC Seizure Clinic Notes for the past 6 months o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records,

	MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #311, Individual #300, Individual #336, Individual #212, Individual #99, Individual #20, Individual #194, Individual #35, Individual #312, Individual #201, Individual #344, Individual #197 Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o David Hazlett, MD, Primary Care Physician o Albert Thomason, MD, Primary Care Physician o George Howland, MD, Psychiatrist o Ida Perez, RN, Acting Chief Nurse Executive Observations Conducted: o Medical clinic o Cottages and dorms o Day services areas
	Facility Self-Assessment: The facility rated itself compliant for provision items L1, L3, and L4. Problems were noted in the areas of physician medication orders, compliance with some preventive care guidelines, and seizure management. A formal and defined medical quality program was not in place. There was tracking of some medical indicators, but a comprehensive medical quality program had not been implemented or defined in policy. Medical policy had been revised and included seizure management and bowel management guidelines, but a comprehensive set of policies and guidelines had not been developed. Moreover, in those areas where guidelines had been developed, implementation had just recently occurred. These findings resulted in the monitoring team's rating of noncompliance in all areas of this provision.
	Summary of Monitor's Assessment: Progress was noted in the operation and service provision in the medical department. Overall, individuals received appropriate routine care. Preventive services were provided, although there were some deficits noted in areas, such as colorectal cancer screening and osteoporosis screening. There was no database available to easily track preventive services. Management of chronic medical problems was generally adequate. A seizure management policy was created, but there had been no onsite clinic at the facility for two months and individuals were not seen off campus. Seventeen individuals were identified as having intractable seizure disorder, yet none of them had been evaluated for more aggressive treatment. Monitoring for side effects related to AED drug use was inconsistent. There were also problems noted related to follow-up of medical conditions.

	The external reviews of medical care had not been completed at the time of the onsite visit. The medical director completed a limited number of quarterly audits in December 2010 and those audits indicated compliance with acceptable standards of care. Mortality reviews were being completed, but lacked a true evaluation of medical care completed by a physician. The five mortality reviews completed resulted in zero recommendations related to medical care. The medical director tracked some important medical quality indicators, but a comprehensive and defined quality improvement system had not been implemented.

#	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.	**Overview** 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 2.0 FTE. 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. 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. 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 4:00 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 record sample, listed above in the Steps Taken section of this report, was chosen using the following methodology: • Records were randomly selected from the various lists of individuals submitted by the facility. • A request was made for all seizure clinic notes for the past six month.	Noncompliance

#	Provision	Assessment of Status	Compliance
		General Medical Care and Documentation Annual Medical Assessments Annual medical assessments were found in every chart reviewed. The assessments were completed within the required timeframes and were based on a standardized format. The documents provided detailed information related to the individual's health status. The annual assessments were difficult to follow due to formatting. The format had been altered to eliminate underlining all text in an effort to make the document more readable. Even so, the document contained cumulative laboratory and diagnostic information in a small print format that was difficult to read. The content varied among physicians, but many assessments contained routine lab data such as TSH levels and complete blood counts dating back to the 1980s. The annual assessment contained a number of sections, however, a review of the document did not provide an adequate snapshot of the health of the individual. The information needs to be better organized. Inserting an interval history (i.e., what has occurred since the last annual assessment) provides one way of doing that. Discussion in an individual's interval health history should be organized by active health problems with information presented chronologically. All history – illnesses and other events, diagnostic tests, surgeries, interventions, consultations, medication trials – should be documented in the discussion of each active health problem. Health issues that are related to each other (e.g., dysphagia, aspiration, pneumonia) should be discussed together. In addition to the interval history, consideration should be given to adding a section on medical risks (e.g., osteoporosis, aspiration). Physicians should assess for risks, look for ways to mitigate risk, and implement plans of care. This should be done within the framework of the facility's at-risk processes, but a summary should be included in the annual medical assessment. When individuals have off campus appointments, vey little information left with them – annual assessment, active problem list and current medications. These documents should be accurate and complete to assist in the appropriate evaluation. Active Problem List Active problem lists were found in all of the records contained in the record sample.	

#	Provision	Assessment of Status	Compliance
		The problem list did not always agree with the annual medical summaries. <u>Integrated Progress Notes</u> Notes were written in SOAP format, timed, and dated. There was frequent documentation in the records by the medical staff. Consults were often briefly summarized and abnormal findings noted. <u>Quarterly Summaries</u> Standardized quarterly medical summaries were noted in the records reviewed. The summaries were brief and did not adequately capture the events since the previous summary of annual medical assessment. <u>Physician Orders</u> Physician orders were signed, timed, and dated. With regards to medication orders, there were occurrences of incomplete orders. The most notable problem appeared to be related to a lack of stop dates and appropriate indications for drug use. The current medication dispensing system did not provide Single Patient Intervention Reports for these incidents. These problems are discussed further in section N below. **Routine and Preventive Care** There was no formal process for tracking the provision of preventive care procedures. No database tracking method had been implemented. The preventive care flow sheets had been revised and the medical director had started to complete quarterly audits of medical care. The completion of the preventive care flowsheet was a metric of the audit tool. There were problems noted in the area of follow-up of routine issues and chronic medical problems. Laboratory monitoring for individuals receiving antipsychotic drugs and AEDs was lacking for several individuals. <u>Screenings</u> • 12 of 12 records contained documentation of appropriate vision and hearing screenings • 4 of 4 records documented screening for prostate cancer <u>Breast Cancer Screening</u> • A list of all females over the age of 40, date of last mammogram, and reason for noncompliance was provided • 53 of 66 females had completed breast cancer screening	

#	Provision	Assessment of Status	Compliance

		• 9 of 66 females were uncooperative for testing
		• 3 of 66 females had not been scheduled
		• 1 of 66 females had a bilateral mastectomy
		
		Colorectal Cancer Screening
		• A list of all individuals over the age of 50, date of last colonoscopy, and reason for colonoscopy was provided
		• 25 of 81 (31%) individuals had completed a colonoscopy
		    o 6 of 25 (24%) of individuals had completed colonoscopies > 10 years age
		• 56 of 81 (69%) of individuals had never had a colonoscopy
		    o 62 of 81 (77%) of individuals had either never had a colonoscopy or were past due
		• The following indications were listed for completing the colonoscopy:
		    o Positive fecal occult blood 10
		    o Routine screening 8
		    o Anemia 2
		    o History of polyp 1
		    o Rectal bleeding 3
		    o Hirschsprung's disease 1
		
		Immunizations
		• There was evidence of compliance with guidelines for administration of Influenza, H1N1, and pneumococcal vaccinations.
		• Vaccination against varicella or a statement related to history of infection was seen in most records. In those cases were immunity was presumed, there was no obvious serologic documentation of immunity.
		• There was evidence of compliance with guidelines for administration of Hepatitis B vaccination. Documentation of continued immunity was lacking in most records.
		
		Medical Management
		
		GERD
		• 4 of 12 individuals were diagnosed with GERD
		• 4 of 4 individuals with GERD received appropriate medical therapy
		
		Osteoporosis
		• A list of all individuals with osteoporosis and osteopenia was provided
		• 20 individuals had a diagnosis of osteoporosis	

#	Provision	Assessment of Status	Compliance
		• 3 individuals had a diagnosis of osteopenia There were marked discrepancies between the list of individuals with a diagnosis and individuals receiving medications. Given the relatively high incidence of osteoporosis among persons with developmental disabilities, a total of 23 individuals with low bone mineral density likely represented a lack of screening. <u>Hypothyroidism</u> • 6 of 12 individuals had a diagnosis of hypothyroidism • 6 of 6 individuals received treatment with thyroid replacement hormone • 5 of 6 individuals had appropriate laboratory monitoring <u>Diabetes Mellitus</u> • 2 of 12 individuals had a diagnosis of diabetes mellitus • 1 of 2 individuals had appropriate monitoring o This finding was noted in the audits completed by the medical director <u>Bowel Management</u> • 7 of 12 individuals had a diagnosis of constipation. • 6 of 7 individuals had polypharmacy noted for bowel management A bowel management program was implemented in October 2010. The guidelines for bowel management focused on non-pharmacologic and pharmacologic methods of preventing constipation. <u>Hypertension</u> • 5 of 12 individuals had a diagnosis of hypertension • 5 of 5 individuals received appropriate monitoring of blood pressure and labs **Do Not Resuscitate (DNR)** The DNR list contained 25 individuals with active DNR orders. The majority of these individuals had out of hospital orders to prevent resuscitative efforts. The medical director reported that the proper procedures were utilized including involvement of the ethics committee and LAR. This process will require further assessment during the next onsite review. The facility needs to ensure that all individuals with DNR orders meet the appropriate criteria. **Seizure Management**	

#	Provision	Assessment of Status	Compliance
		Neurology clinic was held for two half-days each month. During the months of December 2010 and January 2011, there was no on campus neurology clinic. The medical director reported that neurology clinic would resume the normal schedule of two half-day clinics each month. There were eight on campus clinics held from 6/29/10 – 11/30/10 and 59 patient visits were completed. A seizure management database had been established since the last onsite visit, and this was good to see. Creation of this database allowed the medical director to determine that 17 individuals had intractable seizure disorder. The medical director reported that individuals with intractable seizure disorder would begin seeing an epileptologist at the University Health Sciences Center. At the time of the onsite visit, this had not occurred. The seizure clinic notes reviewed were brief and focused on medication regimens and seizure control. There was a consistent lack of documentation related to the following issues: • The impact of AEDs on cognitive function and quality of life • Recommendations for calcium and Vitamin D supplementation due to AED use • Recommendations for screening for osteoporosis • Recommendations for eye exams and monitoring for metabolic acidosis when indicated There were several individuals with documented medication adverse drug reactions but no corresponding ADR report completed (Individual #292, Individual #255, Individual #133, Individual #344). None of the neurology clinic notes provided utilized data from the side effect rating tools – MOSES and DISCUS. None of the individuals with a diagnosis of intractable seizure disorder were referred to an epileptologist for more aggressive interventions.	

	Individuals With Seizure Disorder
Individuals with Seizure Disorder	138
Individuals On Seizure Meds	117
Individuals With Intractable Seizure Disorder	17
Individuals With Intractable Seizure Disorder undergoing VNS Work-up	0

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Individuals With History Status Epilepticus	6
Individuals With VNS	9
Phenobarbital, Dilantin	33

Total Number of Individuals on Seizure Meds	117 (85%)
Individuals on 1 Drug	60 (51%)
2 Drugs	32 (27%)
3 Drugs	16 (14%)
4+ Drugs	9 (8%)
Phenobarbital, Dilantin	33 (28%)

A comprehensive seizure management policy was implemented in December 2010. The facility will need to ensure that neurology clinic hours are adequate to care for a substantial number of persons with the diagnosis of seizure disorder that receive medications. Greater attention is needed related to the monitoring for the side effects of drugs. Those individuals with intractable seizure disorder should be under the care of a qualified epileptologist.

#	Provision	Assessment of Status	Compliance
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.	Medical Reviews There had not been any medical review by a non-facility physician at the time of the onsite visit. The medical director reported that reviews by an external physician were scheduled to be completed the week following the onsite visit. A quarterly medical monitoring tool was developed by the medical director to assess the quality of care and compliance with the health care guidelines. A limited sample of charts had been reviewed and the medical director reported compliance with standard medical practice. The review criteria included: • Active problem list/annual medical summary present in chart • Progress notes in SOAP format • 90 day medical review in chart • Lab/x-rays reports signed and dated • Consultation reports signed/dated. Progress notes corresponding with non-facility physician • Medication orders with indications • Preventive are flow sheet utilized • Health Care Guidelines followed for routine and urgent care issues.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The medical director reported that audits were completed in December 2010 and showed compliance with healthcare guidelines and generally accepted professional standards of care. The audits completed included only process measures and should revised to capture clinical outcomes in addition to process measures. Documents and records reviewed by the monitoring team indicated several issues related to: • Incomplete active problem lists • Incomplete medication orders and lack of appropriate indications for medications • Low compliance with some screenings such as those for colorectal cancer and osteoporosis • Lack of adequate monitoring for diabetes mellitus • Lack of prompt follow-up of medical concerns Those findings are discussed further in sections L1 and N. <u>Mortality Reviews</u> Mortality Reviews were another type of case review completed by the facility. 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. There were seven deaths recorded in 2010. The ages ranged from 30 years to 77 years and the mean age of death was 52 years. There was one death in 2011 at the time of the onsite review. The causes of the deaths were listed as: • Pneumonia • Sepsis • Acute respiratory failure • Ischemic bowel • Cardiac arrest The mortality documents for five deaths listed in the documents section above were reviewed. The Clinical Death Review Committee and Administrative Death Review Committee meetings were conducted per state policy. The final meeting, the	

#	Provision	Assessment of Status	Compliance
		Administrative Death Review, was completed within 30 working days for all of the deaths reviewed. The Clinical Death Review Committee meetings were conducted via scan call. The SASSLC medical director, attending physician, and a community physician participated in all five meetings. The state medical services coordinator participated in all but one of the meetings. Other participants included the QE nurse and chief nurse executive. Of the five cases reviewed, the clinical death reviews did not make any specific recommendations related to clinical care. Two cases involved recommendations to have death certificate amended to more accurately reflect the cause of death. The administrative death reviews concurred with the finding of the clinical death reviews in each case. <u>Mortality Review Management at SASSLC</u> The mortality review process was discussed with the medical director and acting chief nurse executive. The acting CNE had not participated in the process at the time of the onsite review. Although mortality reviews were completed per state policy there were several areas of concern: • The current process did not require a written physician review of the case. The medical director reported that all documents were provided to the physicians involved in the committee, but there was no physician assigned to complete a through review of all records, inclusive of the integrated record to determine if there was compliance with the standards of care of medical practice. Such a review should be comprehensive and cover all aspects of medical care. The product of such a review would be a written document that highlighted both positive and negative aspects of care and made recommendations for improvement. • The QE Nursing Review frequently mentioned concerns and/or recommendations, but there was no process for tracking implementation of those recommendations. It was also not clear why none of the QE recommendations were documented in the Clinical Death Review. Some of these recommendations were related to issues of medical care. • The medical director reported that there was no official tracking system to follow-up on implementation of concerns and recommendations brought forth in the QE Reviews.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a	The facility had not implemented a comprehensive formal medical quality program at the time of the onsite visit. The medical department was tracking data related to bowel management, skin infections, pneumonia, and urinary track infections. Data were assessed for trends and corrective actions taken. For example, approximately 10	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individuals were referred to acute care facilities due to constipation from January 2010 to August 2010. As a result of this, a bowel management program was developed that focused on prevention of constipation. A comprehensive medical quality program would define a mix of process and outcome quality data elements that could include key seizure data, hospital admissions, length of stay for hospital admissions, hospital readmissions, emergency department visits, bowel obstructions, pneumonia , aspiration pneumonia, urinary tract infections, decubitus ulcers, medication variances, and adverse drug reactions. Data would be collected and analyzed for trends. Formal quality improvement projects would be initiated as needed based on data analysis. Essential to this concept is the development of clinical guidelines that define the expectations and metrics.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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. Also, DADS Policy #009: Medical Care was issued in July 2010. The medical director stated that the state office was in the process of developing clinical guidelines. Locally, SASSLC had developed and implemented guidelines related to bowel management and seizure management. These guidelines reflected current practice standards as referenced in the literature. The seizure management policy should be expanded to include more specific protocols for monitoring of individuals who receive AEDs. These elements should be captured in the facility lab matrix.	Noncompliance

Recommendations:

1. The medical director should not have primary responsibility for treatment of a caseload.

2. The caseloads of the primary care physicians should not exceed 100.

3. Consideration should be given to revising the preventive care flow sheets to include key immunizations such as influenza, pneumococcal, Td, varicella, and hepatitis. The varicella and hepatitis components should include documentation of immunity.

4. Mortality Reviews should include a detailed review of medical care completed by a physician. If an external physician cannot perform this task,

the medical director should complete the review.

5. The clinical death reviews should include a report that documents relevant information presented during the meeting.

6. A mortality recommendations log should be maintained by the facility. The log should include the recommendations generated by the administrative death review, the action steps to be taken, responsible parties, and timelines. This log should be reviewed with the facility administrator, medical director, CNE, and QE director on a regular basis.

7. The medical department should continue efforts to implement clinical guidelines. The initial impact should be on conditions that have the greatest impact on the individuals supported including pneumonia, aspiration, GERD, and osteoporosis.

8. The medical director should maintain a database of information related to preventive care such as colonoscopies, cervical cancer screening, breast cancer screening, prostate cancer screening, and bone mineral density.

9. The medical director should continue to perform quality audits and utilize this information to provide feedback to the medical staff. The audits should expand to cover process and outcome measures.

10. The facility must ensure adequate on campus neurology clinic hours. Eight hours per month of neurology hours is not adequate to serve the needs of the population.

11. A clinic template for neurology clinic should be developed. Clinic notes should address relevant issues including medication review, laboratory review, seizure control, previous trials of medications, side effect monitoring tool results, and adverse drug reactions.

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 and Table of Organization 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, revised 12/10 o DADS State Supported Living Center Policy: Care Plan Development (July 2010) o DADS State Supported Living Center Policy 006: At Risk Individuals including and accompanying Risk Guidelines, Risk Action Plan, Risk Process Flowchart, Risk Rating Documentation form (11/2/10) 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 – 12/31/10 o List of Fractures/Injuries Requiring Sutures/Dermabond 1/1/10 – 12/31/10 o List of Hospitalizations 1/1/10 – 12/31/10 o List of expired individuals since 1/1/10 o List of Skin Information from July 2010– December 2010 o List of Pneumonia Diagnoses 7/1/10 – 12/31/10 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 ≥ 10% o List of individuals with MRSA, Hepatitis A, B, and C, HIV, Positive PPD and converters, H1N1, C diff and STDs o Nutritional Management Committee meeting minutes from 8/25/10-12/22/10 o Weight reports from 674A for 2/11 o Draft sample Seizure Management HMP and Seizure Record with revised nursing assessment and follow-up o DADS Draft Protocol: Seizure Management 9/10 o DADS Administrative Death Review for Individual #21 o SASSLC Administrative Death Review for Individual #312 o DADS and SASSLC Administrative Death Review for Individual #182 o DADS Health Monitoring Tools and Guidelines for Use, Section M: Nursing o Internal Monitoring and Designated Monitoring Areas for Nursing, Revised HMPs for targeted

	monitoring areas-hypertension, pain, and diabetes mellitus o Health Monitoring Tools completed 10/10 and 12/10-raw data, no summary o SASSLC Infection Control Antibiogram-Urinary Tract Infection Organisms' Changing Susceptibility Patterns o SASSLC Infection Control Antibiogram-MRSA, changing susceptibility patterns 2006-2010 o SASSLC Infection Control Monitoring Tool o Texas Dept of State Health Services, Initial Provider, Infectious Disease Report o SASSLC Employee Health, Targeted Tuberculosis Surveillance Monthly Reports June 2010-November 2010 o SASSLC Infection Control UTI Data Base o SASSLC Facility Acquired Infections and Trend Analysis Report for July 2010-November 2011 o SASSLC Infection Control Prevention, New Employee Orientation, and completed posted infection control training 10/10-1/11 o SASSLC Bowel Management Program dated 10/27/10 o SASSLC Bowel and Bladder Record, revised, and Bowel Management Monitoring Instructions o SASSLC QE Nursing Report, 12/10 o Nursing 24 hour staffing reports for July 2010 through December 2010 o The last six months, minutes from the following meetings: Infection Control, Nursing Management, Pharmacy and Therapeutics, and Medication Error Committees 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 incidence list o Medication Administration Competency Checklist form and completed checklists for 7/1/10 o Medication Errors FY 2010 Rolling Trends and the Medication Error Synopses through December 2010 o Med Error Reduction Committee meeting minutes 1/5/11 o Medication Error Reports, most recent 10 errors o Emergency competency check list o Mock Medical Emergency Drill checklists completed August 2010 through December 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 Enteral review list and enteral reviews 7/10-1/11 o Daily oxygen and emergency equipment inspection reports completed July 2010-December 2010 o Meeting notes, Nursing Meeting 8/10/10-12/22/10 o SASSLC Self Assessment and POIs January 2011 o SASSLC Nursing Department Self-Assessment and POI 1/26/11 o SASSLC Meeting Schedule for week of February 2011 and updates o Records of: • Individual #311, Individual #300, Individual #280, Individual #99, Individual #218, Individual #95, Individual #12, Individual #37, Individual #227, Individual #89, Individual

	#91, Individual #81, Individual #200, Individual #106, Individual #324, Individual #225, Individual #185, Individual #236, Individual #306, Individual #40 Interviews and Meetings Held: o Immediate Past Chief Nurse Executive, Janet Adams, RN o Acting/Interim Chief Nurse Executive and Nurse Manager for 668, 670 and 671, Ida Perez, RN o Hospital Liaison Nurse, Gayindria Collier, RN o Nurse Manager for 673 and 674, Lola Faulkner, RN o Quality Enhancement Nurse, Mandy Pena, RN o Nurse Educator, Clara Wallace, PhD o Infection Control Nurse, Sam Lee, RN o Medical Director, Carmen Mascarenhas, MD o Nurse Case Manager 766, Dorothy Shannon, RN o Nurse Case Manager 674, Gabby Szettella, RN o Nurse Case Manager 673, Connie Vasquez, RN o Nurse Case Manager 670, Eleanor Cordova, RN o Nurse Case Manager 671, Kathy Turner, RN o Home 665: Laura Esparza, MRA2, o Home 668: Gladys Rogers, MRA2, Kelsey Hanson, QMRP o Home 670: Diane Fox, QMRP, Joslyn Jackson, MRA1 o Home 671: Ellen Lawler, QMRP, Frances Perez, MRA3 o Home 672: Cynthia McLaughlin, Home Supervisor o Home 673: Marissa Martin, RN/Direct Care Nurse, Patricia Frances, MRA1,Bonnie Riggins, MRA1, and Shirley Coleman, Shift Supervisor, Brenda Mills, RN/Direct Care Nurse, Alma Garza, LVN, Patricia Jones, Home Manager, Zakia Wilson, MRA1, Debbie Rogers, LVN, Kelsey Hanson, QMRP o Home 674: Amanda, MRA3, Shift Supervisor, Artelia Hall, Active Treatment Specialist, Karla Baker, QMRP, Rick Mangaccat, LVN, Race Crespin, MRA2 o Home 766: Pamela Walker, MRA3, Nequisha Smith, MRA3/Shift Supervisor , Gevona Hicks, QMRP o PSP Meeting for Isabel Villarreal on 2/9/11 o Informal group meeting with available nursing management staff to discuss progress and priorities and review findings; meeting participants were Chief Nurse Executive, Janet Adams, Gayindria Collier, Hospital Liaison Nurse, Lola Faulkner, Nurse Manager, Mandy Pena, Quality Assurance Nurse, and Mary White, SASSLC QA Nurse o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator, telephone interview regarding HMPs and IPNs Observations Conducted: o PNMT meeting 2/10/11 o Clinical Services Review meeting 2/10/11 o Medication passes on 2/8/11 @ 12:00 pm in Bldg. 673W and 4:00 pm in Bldg 674E o Nebulizing treatments (670, 673) o Enteral nutrition (670, 673 and 674)

- Glucometer blood glucose check (673)
- Breakfast (670W)
- Dinner (674E)

Facility Self-Assessment:

At the time of the review, the facility provided a POI updated 1/27/11 to provide a description of the steps the facility was taking to assess compliance with regard to the specific sections of the Settlement Agreement related to Section M: Nursing Care. The POI indicated that there was not compliance with each provision item in section M of the Settlement Agreement and the monitoring team concurred. The updated POI described numerous system and process changes in progress to address each of the provisions. They have initiated audits targeting nursing care and treatment related to hypertension, pain, and diabetes mellitus. Improvement in the timeliness and completion of assessment items on the assessment form was noted but there continued to be a lack of quality of the data and summarization and analysis of the data. The POI involved nursing staff at all levels and the Quality Enhancement Nurse.

Summary of Monitor's Assessment:

SASSLC had been undergoing significant changes in nursing management staff and continued to be faced with multiple challenges in communicating and enforcing expectations for performance improvement. Several of the upper level management positions, including the Chief Nurse Executive, Nursing Operations Officer, one of three Nurse Managers were vacant. The nursing staff members, however, remained dedicated to providing quality care and individualized supports and services. During the conduct of this review, 19 individuals were visited, and the records of 20 individuals were reviewed. There was ample evidence across the 20 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 674E and 673W and for medications administered via the enteral route on 670, 673, and 674. During all observations, nurses 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. There were three infection control errors related to medication/treatment administration. Omissions (i.e., holes or blanks) on the MARs remained greatly reduced from the previous review, however, there were several areas of medication administration practice that did not meet acceptable professional standards, such as appropriate follow-up for response to treatment with PRN medications, accurate and consistent administration of insulin and Accuchecks for finger stick glucose levels as prescribed, and consistent vital sign monitoring related to administration of antihypertensive and other medications with potentially negative effects on blood pressure.

All 20 individuals reviewed had annual and quarterly nursing assessments filed in their records. The

	assessments were conducted by RN Case Managers and Nurse Managers and were completed in a timely manner. Nursing assessments were more complete and had begun to provide more informative assessment summaries. Notwithstanding these positive findings, problems were noted with the conduct of nursing assessments, 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 remained inconsistent and incomplete. All 20 individuals reviewed had most 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 primarily generic and more appropriate to address acute episodes or use as a guide for training direct support staff on specific conditions than for individualized long term management of a health risk or problem. The health management plan development process, and the mostly generic plans in place at the time of this review were in dire need of complete review and revision in order to promote progress toward the achievement of this provision of the Settlement Agreement. One issue with the HMPs and ACPs was due to identification of health problems that were not in need of a HMP. Another issue was due to the application of generic/standard care plans or protocols to health problems that instead required individualized approaches and interventions. At SASSLC, there were a number of monitoring and training efforts underway within the Nursing Department and across the facility. These included targeting three areas addressed in the Texas Health Monitoring Tools for quality improvement. Internally designated nurses were starting to monitor hypertension, pain, and diabetes mellitus. There were yet to be implemented plans for summary and analysis of results and validation of monitoring results in these areas by the Quality Improvement Nurse.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	With the initial implementation and refinement of many new systems and procedures, SASSLC was making some progress towards meeting this provision item, 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. During the onsite monitoring review, 19 individuals were visited, and the records of 20 individuals were reviewed. In addition, the monitoring team met with the Hospital Liaison Nurse to discuss Individual #91, who was hospitalized at the time of the review. Records were all consistently organized with the recordkeeping system the facility was in the process of completing (see section V). Nurses' notes (i.e., nursing IPNs) were not consistently in the SOAP format. It was a rare occurrence to find a record note that was	Noncompliance

#	Provision	Assessment of Status	Compliance
		illegible, improperly signed and dated, and/or not designated as a late entry, when needed. The time notes, however, were again not consistently present in the records reviewed (see section V of this report). There was ample evidence across the 20 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). Exceptions are noted below and in M3, M4, and M6. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Across all 20 individuals reviewed, Integrated Progress Notes (IPNs) and other health status tracking systems failed to document that 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 the 20 individuals indicated the seriousness of this problem at SASSLC and extended to all phases of the nursing process from assessment to evaluation of plan effectiveness. Examples are presented below. These involve problems that emerged over the last quarter as well as existing problems that were reassessed and tracked using the new procedures during the last quarter. • Individual #99 toileted independently. He had bowel movement records maintained daily that generally noted "I" for independent without an indication the nurse had questioned either the individual or direct support staff. His bowel management records were incomplete: 1/11 had nine blank shifts, 12/10 had 11 blank shifts, and 11/10 had six blank shifts. Records indicated he had a high fecal impaction with associated mild ileus that resulted in hospitalization from 12/5/10-12/7/10. On 11/4/10, an IPN indicated the nurse was not able to ascertain when his last bowel movement was. His abdomen was distended and firm. There was no follow-up assessment or note related to bowel elimination until 12/5/10. At that time he had had repeated emesis episodes with appropriate and timely assessment, notification of the physician and transfer to the ER for evaluation. Upon discharge, his laxative regimen was changed and Golytely increased to 100 cc bid. There was a nursing assessment / follow-up documented in an IPN on 12/8/10. There were no changes made to the method of monitoring bowel movements. No nursing interventions were changed. Also	

#	Provision	Assessment of Status	Compliance
		on 12/8/10, a risk rating change from low to medium for constipation was appropriately requested and changed on 12/9/10. There were no changes to his plan. The next nursing assessment / follow-up was documented in an IPN on 12/14/10. • Individual #218 had high-risk characteristics related to her challenging behaviors and injury, among others (also discussed in Sections M2, M3, and M6). She had been receiving more frequent chemical restraint in 1/11. She also had dental pain, starting with a cracked tooth on 12/27/10 treated with as-needed Tylenol and appropriate dental follow-up the same day. Consent for an extraction was sent to her mother and was received by the facility on 1/3/11. She was evaluated again at the dentist on the morning of 1/3/11 for dental pain with Motrin 600 mg every six hours PRN for pain prescribed. On 1/3/11 at 1300H, after consent was received, the dentist extracted a right lower tooth and changed the Motrin order to 600 mg four times daily for three days. On 1/4/11 and 1/5/11 she received emergency chemical restraints (also on 1/19/11). She was again treated for pain related to the tooth extraction on 1/9/11. Motrin 600 mg four times daily for dental pain for three days was ordered by the dentist then changed to three times daily and warm oral rinse twice daily using eight ounces of warm tap water and ½ teaspoon of salt to oral surgery area. There was no documentation on the MAR or IPN of implementation of salt water rinses or educating direct support staff. There were no further notes until 1/13/11 when there was follow-up by the dentist and pain was noted resolved. • Individual #127 was evaluated on 1/6/11 at the ER for a right leg limp. His 1/6/11 1905H IPN reported "morning staff reports Individual #127 took a fall at 10:33 am. Per the AM nurse, no injuries found." There was no IPN or documented results of an assessment post fall from the morning at 1033H. The staff reported he was limping when he walked and the RN assessment documentation was "on assessment could not find obvious injury. Limping while walking." He was referred to his physician and the plan was to monitor him. There was no documentation of directions to direct contact staff and the next note reported he was back from the ER on 1/7/11 at 0045H returning after X-rays were negative for a fracture and with a diagnosis of a contusion and scabbed abrasion of the left knee. The scabbed abrasion to the left knee was noted by the physician, but not identified during nursing assessment or addressed in nurses' notes. Another episode on 1/29/11 in a nursing IPN reported a bruise to his right temple discovered by the nurse and monitoring continued with refusal of a full assessment by the individual. At 1550H, an IPN noted vital signs within normal limits and completion of a "neuro checksheet" (but this was not included in the documents provided to the monitoring team for this case). The plan was to continue to monitor throughout the shift. An IPN	

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		documented at 2130H noted he refused a full assessment and was reported to be "alert and combative." The next note was on 1/30/11 at 1915H and then on 2/1/11, "bruises right temple/eye show much improvement." There were no documented revisions to his HMP or directions to direct support staff. • Individual #185 was hospitalized from 1/8/11-1/11/11 for cardiac failure. He had fluid restrictions of 2500 cc daily. He was weighed daily. He had twice daily blood pressures and heart rates ordered. He had orders to report gains of "3-4# in 1-2 days or 2# overnight." On 1/7/11 at 2300H he had +1 upper extremity pitting edema bilaterally, but no vital signs were recorded in an IPN or the vital sign record. Palpable popliteal pulses and bilateral breath sounds were noted. The quality of the breath sounds was not noted. A previous note at 2135H reported he complained of pain to his right rib and 650 mg of acetaminophen PRN was given and "fair" results and "no further reports c/o pain" were noted. The next note was 1/8/11 at 0555H with complaints of shortness of breath with appropriate vital sign monitoring and referral to the RN. There was no follow-up assessment of the edema and peripheral pulses or full respiratory assessment. There was no notation or assessment by the RN supervisor charted. The nursing IPN for referral to the hospital on 1/8/11 at 0730H reiterated only the physician's findings and the accompanying nursing assessment form was blank. He was sent to the ER 1/8/11 at 0730, after physician evaluation at 0648H that reported dyspnea, periorbital edema and 4+ bilateral leg edema, bilateral rales, wheezing, and rhonchi. On 1/11/11, the post hospitalization assessment was completed and a HMP for congestive heart failure was implemented, but the intervention page was missing from the copy provided. After his hospitalization, daily vital signs were documented on the vital sign record, but did not include the time of day the measures were taken. After his post hospitalization assessment at 1540H, the next vital signs were recorded on 1/12/11 at 2130H, with a low pulse of 57 and blood pressure of 100/69, followed by vital signs within normal limits on 1/13/11 at 0815H with no complaints of chest pain. Also upon his return from the hospital, orders to report weight changes to the physician changed to report weight change of 1-2# overnight. On 1/17/11 his weight was 128# and on 1/18/11 it was 133.5# (5½# gain) and on 1/28/11 his weight was 130# and on 1/29/11 it was 135.5# (5½# gain) without documented reporting to the physician. On 1/12/11 at 2130H he complained of chest pain and was given acetaminophen though he had nitroglycerine tabs sublingual for "angina" prescribed. His plan did not identify how angina was defined for this person (e.g., how was it different than "chest pain?").	
M2	Commencing within six months of	A revised nursing assessment form and state policy and procedure on nursing	Noncompliance

#	Provision	Assessment of Status	Compliance

	the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	assessment was initiated at SASSLC in June 2010 and had been fully implemented over the last six months. Continued refinements had been made to the nursing assessment data recorded. Timely nursing quarterly and annual assessments were present in each of the 20 individuals' records reviewed, and were signed and dated appropriately by an RN. Timeliness and completeness of the annual and quarterly nursing assessments were monitored by the QE Nurse with individual feedback provided to nurses and corrections made based on the feedback. Nursing assessments had been updated and were generally more complete than those reviewed by the monitoring team in 8/10, however, several of the nursing assessments were not complete and most were not comprehensive enough to provide a complete and accurate review of individuals' health status and address health issues that existed for individuals at the time. It was difficult for the monitoring team to determine how the current annual nursing assessment summaries were functional for the QMRPs and PST for development of the individual's PSP including identification and rating of health risks.
		
		Twenty individuals reviewed had annual and quarterly nursing assessments completed and filed in their records. All 20 included completed Braden Scales to rate skin integrity risk and more recent assessments included the Braden Scale scoring key rating the individual's skin integrity risk. The assessments were conducted by RN Case Managers or Nurse Managers and for those completed since 10/10 included the actual date of the annual or quarterly assessment and the date the nurse signed the assessment.
		
		Annual and quarterly nursing assessments completed in December 2010 through February 2011 utilizing the new format had significantly improved in the completion of the assessment items and showed some improvement in providing a summary of baseline assessment data related to current nursing problems identified. Some assessments, however, continued to lack the comprehensive health care data needed for analysis to identify changes, patterns and/or trends and provide a foundation for appropriate diagnosis and planning. Comments regarding the most recent quarter's assessments are presented below.
		• Regarding assessments across a number of individuals:
		    o Oral hygiene ratings from the dentist and current oral hygiene status items assessed by the nurse were blank for several individuals, including those with oral hygiene problems and periodontal disease.
		    o Physical assessment of the tympanic membrane requiring use of an otoscope was frequently not completed and there was no indication of the individual's refusal or strategies used to gain cooperation for the exam. The assessment item was not completed in the most recent assessments for 11 of the 20 records reviewed (55%): Individual #311, Individual #300, Individual #280, Individual #37, Individual #227,	

#	Provision	Assessment of Status	Compliance
		Individual #91, Individual #81, Individual #106, Individual #236, Individual #306, and Individual #40. o Baselines established regarding individuals' bowel elimination most often did not include the individual's usual bowel elimination pattern, prescribed routine laxatives and/or nutritional strategies 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. • Individual #300's most recent quarterly nursing assessment completed 12/7/10 contained a number of omissions, including a list of her current medications and their purpose and effectiveness. Osteoporosis and recurrent pneumonia were not included in her history, urinary and bowel elimination patterns were not identified, no bowel management plan was included, and kyphoscoliosis was not identified and described. No examination of her ear canals or tympanic membrane was present, although she had chronic otitis media. • Individual #280's quarterly nursing assessment was dated 12/17/10. The assessment data did not include the dose, route, and frequency of his current medications. He had a medium risk rating related to polypharmacy. • Individual #218's annual assessment was dated 1/5/11. Assessment data did not include the frequency of administration for all her current medications. She had a high risk rating related to polypharmacy. • Individual #127's annual assessment was dated 12/5/10. Assessment data included current medication, and purpose and effectiveness, but the frequency of administration was not included for all the medications. He had a medium risk rating related to polypharmacy. • Individual #37's quarterly assessment was dated 1/22/11. Assessment data did not include the number of seizures she had had over the past year or the past quarter. Although vision impaired (i.e., blind), no vision impairment was noted in the history or eye section of the assessment. She had periodontal disease and good oral hygiene rated by the dentist, but no nursing assessment of oral hygiene status. • Individual #227's quarterly assessment was dated 12/27/10. Assessment data did not include current medications or a physical examination of his throat (or refusal of the exam). • Individual #324's annual assessment was dated 12/19/10. Assessment data did not include the frequency of administration of current medication or her Braden Scale skin integrity risk rating. "No constipation" was checked, but constipation was noted as a current nursing problem; no bowel management plan or bowel elimination pattern was identified. • Individual #200's quarterly assessment was dated 11/30/10. Assessment data	

#	Provision	Assessment of Status	Compliance
		did not include suprapubic catheter information, including size, date last changed, and stoma site condition. Assessment data also did not include his Braden Scale risk rating. • Individual #106's annual assessment was dated 11/16/10. Assessment data did not include his Hepatitis B immunization status, bowel elimination pattern, urinary elimination pattern, and Braden Scale risk rating. • Individual #225's annual assessment was dated 11/9/10 and did not contain a nursing assessment of oral hygiene. • Individual #236's quarterly assessment was dated 1/27/11 and did not include Hepatitis B immunization status. • Individual #306's annual assessment was dated 1/8/11 and did not contain a nursing assessment of oral hygiene status or the condition of her gastrostomy stoma site. The annual nursing assessments had begun to contain more narrative summary information, but for most individuals they continued to not provide a comprehensive description of an appropriate summary data, data analysis, and current health status, as well as active nursing problems and the course of nursing care over the previous period. Generally for each of the individuals' records reviewed, the summaries were missing, non-specific or incomplete. For example: • Individual #37's quarterly assessment of 1/22/11 did not summarize and update each area of identified active nursing problems and HMP goals for the status of her SAM goal, compromised skin integrity, constipation, or oral hygiene deficits. • Individual #91's 2/4/11 annual assessment included more data in the summaries, but there was no analysis or recommendations particularly for persistent problems, such a frequent pneumonias (four in the previous 12 months, and two in the previous quarter). Most of the summary information had to do with changes in physician orders and medical treatment. Other as-needed nursing assessments that did not meet the nursing care needs of individuals and/or the assessment procedures outlined in the Health Care Guidelines were identified. Often initial assessments were incomplete and/or lacked appropriate objective assessment data. Examples include the following: • Frequently bowel sounds were assessed by reporting bowel sounds present, but did not indicate the quality of the sounds, such as normal, hyperactive, or hypoactive, as well as their presence in all four quadrants (e.g., Individual #311, Individual #127, Individual #106, and Individual #40). • Individual #311 had a low pulse of 49 at 1415H on 1/27/11 with the next documented assessment of pulse on 1/28/11 at 0400H that noted another low	

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		pulse of 57. At the 2300H, his pulse was 56. There was no action taken, untimely follow-up assessment, and no indication these were within his usual pulse range. On 10/9/10 he had a straight urinary catheterization at 1300H for no urination for 13 hours. The follow-up nursing assessment included vital signs, notation of adequate output, and a hard and distended abdomen. The IPN did not record the time it was written. The next IPN documenting follow-up assessment was on 10/10/10, but the entry was also without a time and indicated his abdomen was soft. • Individual #300 had no initial assessment (e.g., size, exact location, depth, color, presence drainage) of a 2/6/11 right forearm lesion being treated with ketoconatone cream for four weeks. The condition was entered on a flow sheet for ongoing monitoring, but entries noted "S" for "same" with no initial assessment findings to be compared to. The next note was on 2/7/11, a "lesion on R forearm is better and improving. Very little redness," which was again an inadequate follow-up assessment and description of the skin problem. • Individual #95 on 11/17/10 at 1500H received PRN acetaminophen for pain/discomfort for abdominal pain/holding stomach. At 1620H, she vomited a moderate amount with adequate assessment. She had a follow-up assessment at 2100H that noted she had eaten dinner with no further complaints of pain. There was no notation of the possibility of the acetaminophen potentially causing an upset stomach and no action taken for future administration (e.g., with food). From 1/19/11-1/31/11 she was prescribed Bacitracin ointment twice daily to SIB bites on her right hand until healed. There was incomplete initial assessment and inconsistent documentation of ongoing monitoring from 1/19/11 through 1/31/11 despite documentation of "increased damage to area" without an objective description. On 12/14/10, Bacitracin ointment topically to facial including left nostril scratches twice daily until healed was ordered. The scratches were noted resolved on the MAR on 12/26/10. Flow sheets and IPNs did not document an initial assessment on 12/13/10 and the condition was not documented as monitored to resolution. • Individual #37 had physician's orders to measure the depth of her gastrostomy tube and record in the IPN if she had an emesis. She had two emesis episodes on 1/9/10 with no g-tube depth measure noted in the IPN. She had had recurrent pneumonias and aspiration risk associated with her immobility and enteral nutrition. She had multiple coughing episodes from 11/10 through 1/11 that were not adequately assessed. She had orders for, and was treated with, guaifenesin/D-methorp+ syrup every four hours PRN for coughing without adequate follow-up assessment, including frequent lack of assessing breath sounds. Examples included coughing on 1/3/11 at 0715H, 1115H, and 1815H without objective results documented on the first two administrations and the	

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		third administration documented assessment of response as "+ just a while" with no time of entry/follow-up assessment for results. On 1/9/11 at 2025H, she had an IPN noting "coughing spell have been observed a couple of times." Although vital signs and PO2 Sats were assessed and within normal limits, there was no assessment of breath sounds and extra water was given. On 10/13/10, she experienced an elevated temperature of 100.1F, elevated heart rate of 106, and elevated respiratory rate of 26 with rales on inspiration on the right. She was evaluated by the physician and Keflex , an antibiotic, was ordered at 0706H. At an unknown/ undocumented follow-up time on 10/13/10 respiratory distress, T 100.4, P 106, R 26, BP 114/69, respirations shallow, and starting the antibiotics were documented by the nurse. There was no assessment of breath sounds from nursing documented for the next four days. • Individual #89 had an emesis on 12/3/10 while in bed that was reported by staff at 0410H. His abdomen was assessed without abnormal findings and his vital signs were within normal limits, but breath sounds were not included in the respiratory assessment. It was noted he had had a bowel movement the previous day and an antacid was administered. Follow-up assessments were at 0800H and 1330H with no notation for the third shift. Not all notes documented an abdominal assessment, respiratory assessment, vital signs, and analysis of intake and output. The next note was on 12/6/10 at 0805H communicating with the physician regarding use of a wedge for GERD that was put on hold. On 12/3/10 his weight was 191.6# and on 1/5/11 his weight was 182#, a 10.4# loss in one month with no accompanying IPN on acknowledgement or action taken. On 2/1/11 he weighed 184.4#. His daily food intake records were incomplete and frequently documented refusals without documentation of offering substitutes or snacks at a later time. • Individual #91 had a post-hospitalization assessment on 11/12/10, noting his gastrostomy stoma site was "red," but there was no further description to include presence of drainage, size, etc., and no further follow-up documentation was present. Most notes indicated his stoma care was completed or "done," which was already documented with initials on the MAR, but had not recorded the condition of the site at the time of treatment. • Individual #81 had recurrent lateral hip and right side groin dermatitis. Lotrimin topical cream 1% to folds above and below his pubic area and inner thighs was ordered twice a day for 14 days. The problem was first noted on 10/18/10, resolved, and was reported and treated again 11/2/10 and 11/23/10. There was no initial assessment documented in the IPN by nursing staff, though it was indicated completed on the flow sheet for the 11/2/10 and 11/30/10 episodes. Treatment continued from 11/23/10-12/7/10. The first follow-up note on 11/29/10 reported new open areas in skin folds in pubic area	

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		and inner thigh. His IPN on 12/8/10 noted "healed to lateral hip and groin and treatment discontinued." • Individual #106 was hospitalized with urosepsis from 10/12/10-10/17/10. His post hospitalization assessment did not note the condition of his suprapubic urinary catheter and stoma site that the catheter was present. On 10/31/10, a physician's IPN reported a temperature of 101.3F at 0737H that was a follow-up to an assessment by nursing at 0245H with a temperature of 100.4F and loose stools. The next IPN was at 1400H with a temperature of 98.7F and PRN Tylenol was given. There was not a complete set of vital signs, including temperature, monitored every four hours for a temperature elevation of 101 degrees or greater until the individual was afebrile for 48 hours. Weekly weights were ordered and inconsistently documented. Weights were not recorded from 10/20/10 to 11/24/10, and on 12/8/10. There were inconsistencies in his weight related to noting whether it was with or without his wheelchair. His weight on 7/14/10 was 140# with a wheelchair weight of 58#. On 9/29/10 his weight was 169# and 133# on 10/6/10. His weight one week after a hospitalization on 10/20/10 was 134# and 128# on 11/24/10. On 12/15/10, a weight of 161.5# was recorded with a drop to 126# on 12/22/10. All of this occurred with no notation or IPN addressing recognition and a plan of action. He had daily blood pressures ordered with instructions to "notify MD BP >or= to 140/90." On11/20/10 at 0800H, his blood pressure was 143/88 with no follow-up assessment or report to the physician documented. • Individual #185 was hospitalized for heart failure from 1/8/11-1/11/11. He had a previous diagnosis of congestive heart failure. A day after readmission on 1/12/11 at 2130H he complained of chest pain. He was administered as-needed acetaminophen for pain, though he had orders for nitroglycerine tabs sublingual for "angina." Vital signs and PO2 sats were recorded with a low heart rate of 57. Follow-up was documented and no presence of chest pain was noted at 1/13/11 at 0810H. He had orders for blood pressure and pulse measures twice daily, in the morning and the evening, and to notify the physician on rounds when systolic blood pressure was greater than 110 during the previous day. There was not documentation of reporting: 1/14/11 BP of 116/79, 1/15/11 BP of 118/89, 1/21/11 BP of 135/80, and 1/13/11 BP of 133/90. Full vital signs with PO2 sats, when documented, usually were not twice daily in the morning and evening. There were no vital signs recorded on 10/14/10, only one on 10/23/10, none the morning of 10/25/10 and 11/2/10, none the morning of 11/27-11/29/10, and none on 11/30/10. There was also a second set of daily vital sign records from 11/1/10-1/26/11 with no time of the assessment measures. Vital signs ordered every shift for three days, 10/5/10-10/7/10, were missing 2nd and 3rd shift measures on 10/7/10.	

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		• Individual #306 had a forehead laceration on 10/8/10 reported discovered by her 1:1 staff while rearranging the individual's oxygen mask. The physician was notified and evaluated her. Nursing started neurochecks and recorded the checks at timely and appropriate intervals. There was no initial assessment of the laceration documented by nursing.	
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 continued to implement the new (July 2010) state policy on care plan development over the last six months. 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 20 individuals reviewed had their health needs and risks referenced in a Health Management Plan (HMP) or Acute Health Care Plan (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 this review continued to be problematic and in need of review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. • One issue with the HMPs and ACPs was due to identification of health problems that were not "active nursing problems" in need of a HMP per the DADS Care Plan Development policy. • Another issue was due to the application of generic/standard care plans or protocols to health problems that instead required individualized approaches and interventions. General comments are presented below. • Across all individuals reviewed, HMPs and ACPs were consistent in format, completed in a timely way, signed and dated. • Across all individuals reviewed, HMPs and ACPs were in place to address most of the identified health care problems and risks, but were generally of poor quality. • The interventions in the HMPs were the same across many of the individuals	Noncompliance

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		even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. The HMPs were standard health care protocols generally more suitable for use in an acute care situation, such as management of a prolonged seizure, the healing of a fracture, or as a guide for training direct support staff on specific conditions than for individualized long term management of a health risk or problem. The protocols or generic plans provided the nurse a reference for 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, most plans were essentially generic health care protocols 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 (see examples below). • Although there were dates and signatures indicating timely reviews and HMP "updates," 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 documentation that, at least quarterly, individuals' nurses conducted a review of the individuals' HMPs and ACPs, but they did not 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, objective 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. • Individuals' records often contained many copies of various overlapping HMPs with various dates and no discontinuation date of the old plans. This made it difficult to readily identify what was current and what were the interventions nursing and direct support staff were to attend to and assure were implemented. Detailed examples from HMPs and ACPs of some individuals are presented below: • Several individuals had HMPs for conditions not in need of a HCP. It was reported by nursing staff at all levels that HMPs were to be developed and implemented for every condition for which the individual was receiving a medication and/or for every problem on the physician's medical problem list. o This resulted in HMPs developed for individuals receiving prescribed shampoo for dandruff (i.e., seborrheic dermatitis) and who were stable	

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		and without signs of dandruff. Interventions remained primarily administration of the shampoo by or with the assistance of direct support staff at the frequency prescribed, general observation and monitoring by staff and quarterly nursing physical assessment of the scalp and were already documented and included in routine aspects of health care already received. o Another example was the HMP for all individuals receiving medications for hypothyroidism. A plan to address this health issue for Individual #89, whose condition was lithium induced, was appropriate, but even interventions to address this could have been included in his HMP to address adverse effects of psychotropic medications. For most of the individuals with hypothyroidism, medical management (medications and laboratory studies), general observation for status changes, and at least quarterly physical assessments by nursing were the basic planned interventions and were already documented and included in routine aspects of health care already documented received by the individual. For almost all of these individuals hypothyroidism may be a medical diagnosis under treatment, but was not an active nursing problem or significant health risk. Individuals with these plans included Individual #311, Individual #280, Individual #99, Individual #218, Individual #324, and Individual #225. • Individuals with osteoporosis, some of whom were in need of a plan to address their fragile bones and high health risk rating in this area, had HMPs for "osteoporosis" that were generic in nature with most actions directed at interventions for an acute fracture or preventing potential fracture. Individuals with these plans included Individual #300, Individual #99, Individual #218, Individual #81, Individual #306, and Individual #40. In contrast, Individual #227 who was rated at high risk for osteoporosis and had had multiple fractures had only a HMP to address a previous acute fracture. • Individual #311 had worsening oral hygiene status, from fair to poor. He had a HMP identifying individualized interventions, including PNMP strategies, using a suction toothbrush, and reattempting in an hour if he refused. HMPs and their interventions for his constipation, seizure disorder, risk of impaired skin integrity, overweight status, heart condition and pneumonia, however, were all general in nature without clearly identifying specific interventions to be implemented. His HMP to address pneumonia had an intervention for "assessment of lung status to be spelled out in the nursing care plan either every 2, 4 or 8 hours" without specifying the frequency in his current HMP. Positioning and aspiration precautions with maintenance of his PNMP were included in instructions for direct support staff in a 1/11 update to his plan, but	

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		current treatments for chronic bronchiectasis were not included. • Individual #300 had a new diagnosis of hypertension 11/11/10 with a general ACP developed, but not individualized and updated after her 12/7/10 quarterly review. On 11/15/10 at 0940H, her BP was 168/86 with a follow-up evaluation of her vital signs and PO2 sat at 0950H within normal limits. The following day, 11/16/10, with an elevated BP of 160/101, no action or report to the RN or MD was made and the next evaluation of her blood pressure was not timely on 11/18/10 at 1025H. She had a HMP to address nutrition via gastrostomy that was generic and was similar to the facility's nursing procedure for providing nutrition by the gastrostomy route. Her physician's orders and monthly Enteral Flow Sheet and Diet Administration Record provided more detailed interventions, including stoma care and head elevation and alignment than her HMP. Typically, a HMP would be needed only if the gastrostomy was new or there were problems directly related to the enteral feeding process or stoma. Her intake and output records for 12/30/10-1/18/11 which included the number of voids was incomplete without consistent per shift or 24 hour totals. • Individual #280's HMP to address constipation was not individualized and did not include his current bowel management regimen. His HMP for chronic sinusitis was not individualized and there was no evidence of implementing the plan's general interventions, such as use of warm compresses and room air humidification. He was at high risk for aspiration with significant aspiration identified on an MBSS and a sister/LAR who didn't want oral intake to change. He continued to eat orally. He had no HMP for aspiration and choking risk. He had a medium risk rating for cardiac and other medical concerns. He had physician's orders for "daily BPs with notification of the MD for systolic measures >190 or diastolic measures <60 or >90." This was a 180-day order for the period 10/9/10-4/13/11. On 2/10/11 at 0630H, a blood pressure of 182/84 was documented without follow-up assessment. Low pulses often below 60 at 41, 43, 44, 45, 50 were not reported to the MD. • Individual #99's oral hygiene remained poor with his primary HMP interventions to continue brushing with assistance twice a day and select healthy snacks. The types of healthy snacks determined to be his preference were not identified. The HMP included an intervention to assess his oral status daily, but this was not documented as implemented. He was receiving phenytoin for seizures and had an associated diagnosis of gingival hypertrophy, a side effect of phenytoin therapy. In-servicing staff on the effects of phenytoin and the need for more frequent and thorough brushing, gum care, and possibly gum massage was not included. He had a HMP for seizures with his last seizure dated 1995; he continued to receive one AED. The HMP to address his seizures was general in nature, primarily restating seizure first aid steps. He had a HMP to	

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		address constipation. After hospitalization with a high fecal impaction 12/5/10-12/7/10 and an increase in his constipation health risk from low to medium, his HMP remained unchanged with the exception of physician's orders to increase his daily laxative, Golytely. His other medium health risk rating related to his overweight status, but his HMP was again generic without specific individualized interventions. Monthly weights were planned; the exact dates weight measures were taken were not recorded. His weight for 12/10 was 172#, for 1/11 was 167#, and for 2/11 was 163#. • Individual #218's generic HMP to address her morbid obesity remained unchanged over the last two quarters despite persistent lack of progress. Specific interventions were not developed, implemented as planned, monitored for effectiveness, or specifically updated and revised as needed. Her HMP to address her Diabetes Mellitus, Type 2, with sliding scale insulin was generic and even the general interventions were not implemented (e.g., rotation of finger stick and subcutaneous injection sites). Given her morbid obesity and diabetes, weekly weights and daily monitoring of the condition of her feet were included in the plan, but not implemented. On 11/4/10, there were physician's orders to start weekly weights, but monthly weight recording continued. Weights were recorded on 11/8/10 at 347#, 12/8/10 at 349#, and 1/6/11 at 350#. Her 9/10 monthly weight was not recorded. Her weights ranged from a low of 335# in 5/10 to the current high in 1/11 of 350#; she was gradually regaining weight 5/10 through 12/10 without changes to intervention strategies. Her Daily Food Intake Record indicated very consistent refusals of snacks in the afternoon and evening, with notations such as doesn't like celery and carrot sticks. Her 12/10 food record was inconsistently completed with 21 meals and over 30 snack entries missing. Given her frequent refusals of vital signs and the fact that she administered her own Accuchecks, the possibility of involving her in using an electronic blood pressure, pulse device to take her own vital signs could have been explored. Her HMP to address impaired skin integrity due to self-harm included instructions to follow her BSP addressing her high risk ratings for challenging behavior and injury. Her HMP related to the risk of adverse reaction related to psychotropic medications was not individualized, especially to include consistent nursing strategies when emergency chemical restraints were ordered. Despite persistently poor oral hygiene, no changes in interventions or strategies were made to her related HMP. Several other HMPs were not individualized, including those for hypertension, constipation and pain. She also had a HMP for her quarterly Depo-Provera injection, which was already ordered, and administered as ordered. The injection site was monitored and menstrual record was maintained without the need for a HMP and without documentation in her record to indicate this was an active nursing problem. Her bowel	

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		elimination record for 1/11 had not documented monitoring by nursing at least three days per week, 1/30-1/31/11 data were incomplete, and there was no code for self-reporting a bowel movement when asked on a daily basis. • Individual #95's HMP addressing the risk of adverse reactions related to psychotropic medications was not individualized, especially to include consistent nursing strategies when emergency chemical restraints were ordered. Her HMP addressing the risk of nutritional imbalance, a decrease in weight, was general and did not address her refusals to be weighed. Her weight range was established at 90-128. Weekly weights and graphing were planned, but not implemented. She was on a monthly weighing schedule. On 1/6/10 she weighed 107# and on 12/7/10 she weighed 153# (a gain of 46# or over 40% of body weight in one year). Monthly weights over the last quarter were 10/11/10 at 130# to 11/7/10 at 151# (gain 21#) to 12/7/10 at 153#, and 1/8/11 at 137# (loss of 16#). Her plan intervention was offering double portions, but she was reported to receive pudding at each meal and bedtime per her diet order. The plan in effect since 9/10 included identifying and listing preferred foods and fluids and specific snacks to offer which had not been documented in the plan. Ensure Plus or Plus pudding was ordered if she ate less than 50%, but was not documented offered and refused, or offered and consumed, for 50% or less intake or meal refusals 11/10 through 1/11. Her daily food intake records were incomplete: for 11/10 there were 31 meals undocumented and numerous meals with less than 50% intake without an indication a supplement was offered as prescribed. For 12/10, she consistently refused breakfast, but no alternative plan was identified, and two meals were blank; and, for 1/11 there were six meals missing, with all breakfasts refused. Her HMP for her risk of complications related to poor oral hygiene stated her oral status was to be assessed daily, but this was not documented. The plan did not identify how to promote or provide for regular flossing with this individual and stated the teeth were to be brushed four times daily when two times was reported implemented. • Individual #127 had an individualized plan for management of his fecalostomy, such as reporting no feces or presence of blood in the colostomy bag and preventing constipation. The plan did not include his specific bowel management plan interventions (i.e., eight ounces of prune juice daily, Milk of Magnesium for no colostomy output in 24 hours). Despite persistent weight loss, his HMP was not revised or updated. His HMP for risk of impaired skin integrity was reported related to dermatitis, SIB, and "aggression of others." There were no data presented to support, nor interventions to address, the "aggression of others" aspect of his needs nor the broader implications that he may have been a target of others. Despite persistently poor oral hygiene, no changes in interventions or strategies were made to his related HMP. Several	

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		other HMPs were again generic for "risk for falls" and "GERD" without revisions to his plan after acute episodes (e.g., after a fall with an ER evaluation and diagnosis of a knee contusion on 1/6/11). He was scheduled to be weighed monthly. On 1/11 his weight was 136# and on 2/11 138#. The exact date of monthly weight measures was not recorded. In 1/10 he weighed 136#, no weight in 2/10, in 3/10 he weighed 128#, and an increase to 140# in 4/10. He weighed 151# in 5/10 with a weight high of 158# in 9/10. In 11/10, he weighed 148# and in 12/10 he weighed 136#, a 12# weight loss, not documented as acknowledged or reported. • Individual #37 had a HMP for compromised skin integrity secondary to immobility and acne-form lesion on her left buttocks. The plan identified inservice training for direct support staff that was individualized, but nursing prevention and action interventions were not individualized. Several of her HMPs were generic and devoid of individualization or revision when acute changes had taken place (e.g., the HMP for seizures after several as-needed buccal lorazepam administrations for seizures were administered in 11/10). Her HMP to address recurrent pneumonias related to enteral nutrition via gastrostomy was not individualized, did not incorporate her PNMP, and was not updated after hospitalization for aspiration pneumonia 8/26/10. Positioning interventions in various HMPs referred to the PNMP, but the PNMP did not provide adequate direction or instruction for aligned, inclined positioning that could be maintained and keep her nephrostomy tube clear for drainage. She had recurrent episodes of UTIs and urosepsis (five times in the last year and twice in the last quarter, the most recent 12/31/10). The HMP remained essentially the same without revision and did not address her nephrostomy, direct support staff actions and inservice training needed, or positioning for emptying and maintaining clearance for drainage. She had documentation of irrigation of her nephrostomy drain every 12 hours with 5 ml of sterile normal saline twice a week, but there was no documentation of the condition of the site at the time of treatment and dressing change. There was no notation of the IC Nurse's involvement in monitoring nephrostomy care and tube changing across nurses providing her care. Her urinary output was often documented out of chronological order and incomplete, and there were no totals of daily output. Her HMP to prevent infection related to periodontal disease was generic. The plan did not identify how to promote or provide for regular flossing with this individual and stated the teeth were to be brushed four times daily when two times was reported implemented. There were no interventions for the safest position for oral hygiene for her or reference to obtaining guidance from her PNMP. It was difficult to determine the purpose of her HMP to address pain with the identified goal "not to be left in pain." The plan was generic without	

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		individualization. Her usual signs of pain were not identified. A HMP was developed and implemented to address her PPD conversion status 10/24/10. The plan was not individualized, but did specify staff inservice training and nursing assessment issues to be addressed at least in quarterly nursing assessments. Her recurrent as-needed treatment for a cough, 10/10-1/11, especially in 11/10, was not specifically summarized and analyzed in the quarterly progress reports and no changes were made to her HMPs related to pneumonia, respiratory illness, and/or allergic rhinitis. After two episodes of dehydration in 8/10, a HMP was implemented and reviewed 10/24/10. Interventions related to acute episodes were not updated to address prevention. The plan that remained in place at the time of this review included weighing her daily, but this was never documented at that frequency. She had physician's orders for vital signs every shift that were initialed on the MAR as completed, but actual measures were not available for review. Monthly weights and blood pressures were documented. On 2/5/11, she weighed 73#, on 2/7/10 it was 67.5# with a high of 76.4# on 10/4/10. From 76.4# on 10/4/10 to 70# on 11/7/10, an approximately 8% loss in one month was without documentation of acknowledgement or report of the change. • Individual #227 had a generic HMP for underweight status. He had orders for daily weights since 7/10, but his plan stated weekly weights. His weight records were maintained daily on his MAR and had two days missing for 1/11 and none missing for 11/10 and 12/10. He was hospitalized for aspiration pneumonia, dehydration, and hypernatremia 12/24/10-12/28/10 and returned to the hospital again 12/29/10-1/4/11 with a discharge diagnosis of a GI bleed. The resultant HMPs were generic. His aspiration risk rating was increased from medium to high on 1/6/11, but again there was no change to interventions including monitoring strategies. • Individual #91 had a generic HMP to address pneumonia without change after a 12/26/10-12/30/10 hospitalization for pneumonia. There was documentation of recognition and communication of an increased health risk rating, but no new action plan or intervention. There was no evidence of evaluation of current interventions for both implementation as planned and adequacy of interventions, (e.g., adequacy and appropriateness of positioning, which was reported slouched for the required 1½ hour upright well-aligned position needed after each slow bolus, gravity drip enteral feeding). He had vital signs and PO2 sats monitored twice daily for three days after the hospitalization, but evaluation results of assessing his breath sounds bilaterally per his goal and plan were not documented as implemented. He had orders for an abdominal binder to protect his gastrostomy stoma and tube and TED hose to prevent pedal edema. They were not documented on treatment or enteral feeding records nor	

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		were there IPNs related to scheduled application and removal of TED hose with assessment/observation for appropriate application by direct professional staff and for signs of pedal edema. • Individual #324's HMP to address her Diabetes Mellitus, Type 1, with routine and sliding scale insulin was general and the general interventions were not implemented (e.g., rotation of finger stick and subcutaneous injection sites). Weekly weights were planned and physician ordered. Only monthly weights were recorded and made available for review. From a 9/5/10 weight of 138# to a 10/5/10 weight of 129# there was an 11# loss without acknowledgement or action documented. Her daily food intake records were incomplete. She had a diagnosis of bipolar disorder with more manic and psychotic features treated with psychotropic medications (olanzapine and quetiapine). On 11/15/10 vital signs including body temperature were ordered daily with instructions to call the psychiatrist for body temperatures less than 96 degrees. Her 1/11 MAR/Treatment record transcribed the order in error for contacting the MD if her temperature was greater than (>) 96 degrees instead of less than (<) 96 degrees. Her body temperature was not recorded for four of the last 15 days of the month. During 1/11, her respiration rate was recorded taken only twice. She had a temperature of 95.8 degrees on 1/16/11 with time unknown and no documentation of retaking her temperature or contacting the physician. Her HMP related to glaucoma was not updated or changed after her related eye surgery (i.e., cyclodestruction of left eye) on 1/18/11. • Individual #81 had all generic HMPs that did not incorporate his PNMP or BSP. He had a generic HMP for "potential for injury from seizures" although he had not had a seizure since 1992 and took no antiepileptic medications. • Individual #200 had Diabetes Mellitus, Type 2, with routine insulin and three different sliding scales used at four times daily following Accuchecks. He had no related HMP. • Individual #106 had recurrent hospitalizations for UTI, urosepsis, and kidney stone related issues without revisions to ACPs and subsequent HMPs. Changes in interventions were not made after his health risk rating for UTI was raised from medium to high. The plan in place had an intervention to encourage fluid intake to 2-3 L when he had physician-ordered fluid restrictions. • Individual #185 had diagnoses of congestive heart failure, aortic stenosis, and a pacemaker. He was prescribed fluid restrictions of 2500 cc per 24-hour period divided 920 cc for nursing and 1080 cc dietary. He had a HMP for imbalanced fluid volume with no mention of his fluid restrictions, orders for daily weights or reporting weights with any gain of two or more pounds overnight or need for monitoring and intervening for pedal edema. His Fluid Intake-Output Records were inconsistently completed and without inclusion of the nursing fluid	

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		allotment. There was no documentation of how nursing divided administration of the 920 cc and there was inconsistent documentation of appropriate implementation of dietary fluid intake daily totaling 1080 cc (i.e., 36 ounces). Through 1/1/11, he had orders for daily weights and to report gains of three to four pounds in one to two days or two pounds overnight. The following weight changes were not documented as reported: 10/5/10-117# to 10/6/10- 122# (five pound increase overnight); 10/7/10- 118# to 10/8/10- 120.5# (two and a half pound increase overnight); 10/18/10-120.5# to 10/19/10-126# (five and a half pound increase overnight); 11/10/10-119.5# to 11/11/10-122.5# (three pound increase overnight); 11/14/10-119.5# to 11/15/10-123# (three and a half pound increase overnight); 12/6/10-120# to 12/7/10-128# (eight pound increase overnight); 12/20/10-124# to 12/21/10-132# (eight pound increase overnight); and, 12/29/10-125# to 12/30/10-134# (nine pound increase overnight).	
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, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator, Hospital Liaison, Infection Control Nurse, Quality Enhancement 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. The facility's 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. As noted, there were numerous issues, described above in sections M1, M2, and M3. Thus, the anticipated positive outcomes for individuals due to the implementation of assessment and reporting protocols were not yet evident in the records reviewed. An informal meeting was held between the monitoring team and nursing management staff to discuss progress and priorities. Meeting participants included the recently assigned acting Chief Nurse Executive, the recently resigned Chief Nurse Executive, the Hospital Liaison Nurse, one Nurse Manager, Quality Enhancement Nurse, and the Quality Enhancement Nurse from Abilene SSLC, Mary White. Significant changes in the nursing management staff had occurred or were in process. The CNE, Janet Adams, had recently left her position, but returned to assist during the week of this onsite review. The Nursing Operations Officer position was also vacant as well as one of three Nurse Manager positions. It was reported that interviews were in progress for the Nursing Operations Officer and Nurse Manager position, and recruitment for the CNE position had been initiated. Mary White from Abilene SSLC reported she was assisting with interviews and assisting the SASSLC nursing department in continuing their POI to address the nursing provisions of the Settlement Agreement. Additionally, it was reported that the two current Nurse Managers were within approximately one year of	Noncompliance

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		retirement. Assuring strong leadership and an organized transition to new leadership was the greatest challenge currently facing the nursing department. Other top priorities for the nursing department were described as continuing to assure the SASSLC nurses were knowledgeable regarding the Texas Health Monitoring Instruments, including the revisions and guidelines for their use from DADS. In an effort to move toward full implementation they had targeted three areas of nursing care: hypertension, pain, and diabetes mellitus. They agreed they were in the early stages of implementation. An additional priority was to fully implement nursing assessment and health care planning policies and procedures and complete quality assessments and plans in a timely fashion. Activities related to these priorities included involving the nursing staff in the process. Continued training and support for nurses was needed targeting their role and responsibilities in health risk rating determination as part of the PSP process as well as problem solving in the PNMT process. Internally designated nurses were starting to monitor hypertension, pain, and diabetes mellitus. Completion of all targeted monitoring was in progress with data summary and analysis to follow. There were yet to be implemented plans for validation of monitoring results in these areas by the Quality Enhancement Nurse. The SASSLC presentation on progress toward meeting the Settlement Agreement provisions provided to the monitoring team on 2/7/10 included progress in the nursing care provision presented by the acting Chief Nurse Executive, Ida Perez. Numerous initiatives and nursing team efforts were highlighted as well as progress toward each nursing provision. Several of these initiatives were (1) Development, implementation, and monitoring of effective implementation was reported for use of flow sheets, MOSES/DISCUS forms, hospital transfer forms, weight records and trends; (2) Many nursing staff had received training on the Physical and Nutritional Management Team process; (3) a Medication Error Reduction committee was established outside of the Pharmacy and Therapeutics Committee to evaluate controlled substance storing and administering methods; (4) a Bowel Management Committee was working to improve tracking and response while working with the Medical Director to implement a bowel management policy; and (5) Weekly Nursing Focus Topics sent out to the nurses to discuss in the huddles with direct support staff continued. 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 Nurse Managers, and the Nurse Educator. It was noted that future changes in nursing, as well as affiliated departments,	

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		needed to be monitored closely for the effects on demands for nursing time so that there was adequate staffing to meet the needs. It was noted during the 8/10 review that 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. At the time of this review, nurses were not participating in psychiatric clinic. During a meeting with the Nurse Educator, Clara Wallace, PhD, she reported several education and training efforts that were directed at Settlement Agreement provisions or reports on the status of nursing provisions. Some of the inservice training and education that was provided to nurses was on medication errors, administration of eye and ear drops, nursing related policies and procedures or requirements from DADS, such as annual nursing competencies and physical assessment. She coordinated the annual competencies skills fair as well as provided required new employee and annual training. Orientation training had been expanded to include MOSES and DISCUS administration, hemoccult procedures, physical assessment, and general questions on a written test regarding health care planning. The staff and resources to provide competency-based training on assessment, including physical assessment, and care plan development were recognized as not currently available . Emergency equipment competency training was completed for all the nursing staff with mock CPR drills. All but one LVN on medical leave had completed CPR/ACLS certification. Emergency CPR Drills were documented held for each residence each month. Competency-based training for skills, such as tracheostomy care and straight urinary catheterization were provided and completed in new employee orientation (NEO) and the annual 1/11 nursing skills fair, but there was no competency-based training for assessment and care planning. The monitoring team met with the Infection Control Nurse during the onsite review to discuss current infection control data and reports. Discussion focused on variance data and analysis in attempts to reduce urinary tract infections (UTIs). Comparisons across residences, male/female, device/non-device, and type of device had been made. In 2009, they began to use silver impregnated urinary catheters and have continued. Effective strategies were implemented. UTIs had seasonal trends identified requiring pushing fluids in the hot months of the year and use of UTI Stat high concentrate drink for individuals with repeat or chronic episodes. As is common, individuals with devices had higher rates of UTIs than individuals without devices. During 2010, use of an alternative self-lubricating catheter was piloted in order to attempt to reduce the opportunity for breaking sterile technique. The alternative self-lubricating catheter was designed for self-catheterization. Unfortunately the self-lubricating device was reported to work poorly from the assistive versus self-administering position. He had not considered comparing the factor of ambulatory versus non-ambulatory and evaluating the effects of	

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		positioning or other PNMP interventions to aid in kidney and bladder emptying. The Infection Control Nurse reviewed the infection control related documents and interviewed nursing staff regarding infection control issues and procedures. He 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, as well as collaborating with them regarding the needs, monitoring, and treatment of specific individuals. 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. He participated in the statewide Infection Control Committee that had met twice. He reported they had broken into work groups and contrasted and compared infection control policies and data collection and reporting techniques across all the SSLCs. They were reported further broken into subgroups to refine and standardize programs. 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 in written reports that were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. She was able to describe the current status of Individual #91, his hospital course, collaboration she had had with his hospital physician, and discharge planning efforts recently initiated. She reported collaboration and coordination with facility staff including physicians, Nurse Case Managers, and direct support staff in order to assure a safe and complete transition of the individual upon readmission. She was also identified as the "Skin Nurse" and reported she evaluated and collaborated with clinical and PST staff to address significant or persistent skin integrity issues. The Quality Enhancement (QE) 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 QE nurse was involved in all aspects of quality oversight of	

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		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 as the focus of discussion for this review. She had implemented several nursing service related data bases to monitor the timeliness of assessments, Braden Scale, MOSES/DISCUS, Dental exam, HMPs, fall assessments, skin assessments, SAM, and health risk assessments. She provided electronic reminders to Nurse Case Managers regarding quarterly and annual assessments and HMP development as well as feedback on missing items and components. The data as yet were not summarized and analyzed to identify improvement or to address the quality and comprehensiveness of some nursing process components such as nursing assessment summaries and health management plans. The QE Nurse had several other self-described responsibilities, including tracking and monitoring unusual incidents involving abuse allegations and high profile incidents, as well as completing mortality reviews. She performed validations for the CPR drills and assured corrective action, as necessary, was completed. She had not been able to start validating the nursing department's implementation of the Health Monitoring Tools for hypertension, pain, and diabetes mellitus. She was invited to and actively participated in all nursing department meetings. 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 observations and data through assessments (verbal and written) to members of the individuals' personal support team (PST). 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. There were health data tracking systems related to individuals' health status that were not consistently and appropriately implemented, including, for example, flow sheets. Flow sheets had been implemented at the time of the 8/10 review. They were utilized to track initial assessment and ongoing evaluation to resolution of changes in health status, such as an active skin integrity issue or change in psychotropic medications. The use of flow sheets, however, was not consistent with the state's policy and procedure, that is, to document in the IPNs only. Discussion occurred between the monitoring team and the DADS central office nursing	

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		services coordinator to clarify this. SASSLC should, therefore, discontinue the use of flow sheets and provide documentation in the IPNs as per state policy. Other tracking instruments, such as the new bowel management record and diabetic management treatment forms, were recently implemented.
		
		Examples of problems identified in assessment and reporting practices are provided below.
		• Diabetic management records of sliding scale insulin administration and finger stick glucose monitoring were revised. The number of omissions and errors were reduced, but there continued to be documented errors for five of the five (100%) individuals with diabetes mellitus monitoring during this review as described in section M6.
		• Implementation of the new seizure record form (6/10 version) was in place and had been implemented since August 2010. In the case of Individual #236, his seizure records provided more detailed characteristics of his seizures, but not necessarily pre-seizure behaviors/influencing factors. He had 27 seizures since 9/1/10 with all but two documenting an appropriate and timely follow-up by nursing staff. A 12/9/10 2257H administration of PRN buccal lorazepam oral concentrate was documented given on the MAR, but he had no accompanying seizure record, IPN, or narrative note on the MAR. On 12/4/10, it was noted at 1244H that he had a two minute 30 second seizure at 0036H with buccal lorazepam administration at 0040H. Initial assessment and action of the buccal lorazepam was documented on the seizure record and in IPN. Follow-up assessment for response was documented, but not the time of the assessment. On 12/21/10 at 2257, there was no IPN or record of initial assessment with administration of buccal lorazepam ay 10:55 pm after a one minute 38 second seizure at 2240H. There was no follow-up assessment for response or monitoring during buccal administration documented.
		• Bowel elimination data were to be documented daily and monitored by nursing staff daily to a minimum of three days per week. Daily monitoring and appropriate follow-up action by nursing was more consistently documented. Bowel elimination records were incomplete for Individual #280, Individual #99, Individual #95, Individual #106, Individual #225, and Individual #185.
		  o Individual #324 had no bowel movement documented 1/23/11-1/25/11 with no intervention. Her bowel elimination pattern was not monitored by nursing 1/24/11-1/31/11. During 12/10, there were 23 shifts of bowel elimination data missing, but there were almost daily checks documented by nursing. During 11/10, her bowel movement record had no documentation of review by nursing for the month.
		  o During 12/10, Individual #95's bowel elimination was not charted as	

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		monitored by nursing from 12/18-12/31/10 and 10 shifts had not charted bowel elimination. During 1/11, she was not monitored three times weekly during the last week of the month, and eight shifts of data were missing. o Individual #127's bowel movement record did not note he had a colostomy and emptying of his ostomy bag. He had a flow record tracking "colostomy," but it was unclear what was being tracked. • Weight record, vital sign record, diet intake records, and intake and output records also had inconsistencies in documentation identified and as discussed in section M3.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the 8/10 monitoring team review, 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. The recently revised process (i.e., 11/2/10 DADS At Risk Individuals Policy #006) was currently being implemented with a shift to initial identification and rating of health risks by the PST. The monitoring team observed this process for Individual #306 during her annual PST meeting on 2/9/11. The QMRP was implementing this new health risk identification process and the newly revised PSP process for the first time. With the assistance and facilitation of the HST Coordinator, Patricia Delgado, RN, the nurse on the PST read portions of the Aspiration Triggers Data Sheet, but did not appear to understand the purpose or process. The nurse on her PST did not contribute to the health risk rating discussion of the team. The monitoring team supports the role and responsibility of each individual's PST in fully implementing the new risk identification and tracking process. It was too early, however, to evaluate the effectiveness of the new process (see similar discussion in other sections of this report). What was evident was the need for the HST Coordinator to be available to collaborate and provide technical assistance to the PSTs, as well as continuing to facilitate the process throughout the facility. All 20 individuals reviewed had a completed Health Risk Assessment Rating Tool that was timely. Individuals' Health Risk Assessment Rating Tools completed more recently	Noncompliance

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		provided improved data summaries related to the health risk rating areas with the inclusion of less subjective data and criteria. All 20 individuals whose records were reviewed were also reviewed by the HST and had multiple risks identified that were related to their health and/or behavior. At the time of the previous reviews, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. At the time of this review, risk ratings were often being changed in a timely way in response to acute events and communicated to appropriate PST members but changes or revisions to health management plans other than physician's orders were grossly lacking. Please also see sections I and M1, M3, and M4 of this report.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The administration of medication and the management of the medication administration system at SASSLC continued to maintain significant improvement in the one area identified in the previous monitoring reviews: omissions (i.e., numerous "holes" or "blanks") on the MARs. As indicated in more detail below, however, there were additional areas of the medication administration management system found to be inconsistent with generally accepted professional standards of care. These areas would require additional analysis and intervention including proper completion of the MARs, management of the medications (routine and PRN) by the nurses, appropriate vital sign monitoring associated with medication administration, monitoring the need for and administration of sliding scale insulin, and in the oversight and correction of medication errors. The nursing department continued daily monitoring of the MARs by RNs. A review of 20 individuals' medication administration records (MARs) and treatment administration records for October 2010 through January 2011 documented maintenance of improvement over baseline similar to the results of the 8/10 monitoring team review. 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"). Even so, the following omissions were found during this onsite review: • Individual #311: 11/1/10, 1100H Ipratropium Bromide solution via nebulizer, 11/16/10, 2300H Levalbuterol 0.63M+ via nebulizer, 2/6/10, 0700H Loratadine, 1/26/11, 0800H Levalbuterol 0.63M+ via nebulizer, and 1/31/11, 1200H Calcium/Vitamin D • Individual #95: 11/19/10, 1900H Lorazepam for agitation/anxiety, 12/18/10, 1900H Sennoside for constipation, 12/3/10, 1600H Clonidine and 1/7/11, 0700H Lorazepam	Noncompliance

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		• Individual #127: 12/21/10, 0700H all blank • Individual #2271/19/11, 1900H Ferrous sulfate for anemia • Individual #324: 12/31/10, 1700H Atorvastatin • Individual #81: 1/17/11, 1900H Furosemide, a diuretic • Individual #106: 11/17/10, 1200H Levodopa • Individual #225: 1/28/11, 1200H Levothyroxine (Synthroid), 12/31/10, 0700H Topiramate for aggression, Quetiapine for psychosis and Fluticasone/salm+ inhaler for asthma, and 11/29/10 1900 Quetiapine for psychosis • Individual #236: 11/4/10 2000H Levetiracetum for seizure disorder Observations of medication administration were conducted on Homes 674E and 673W, for medications administered via the enteral route on Homes 670, 673 and 674 and for medications administered via nebulizer on Homes 670 and 673. During all observations, nurses identified the individuals receiving medications, presented the medication in the proper form, such as crushed mixed with applesauce or crushed mixed with water for gastrostomy administration, used adaptive spoons and cups to administer medication or fluids following oral medication, and they did not initial medications on the MAR prior to the individuals' receipt of the medications. For the majority of the observation time, nurses properly washed and disinfected their hands prior to medication administration and between individuals. Several observations of poor infection control procedure related to medication administration, however, were also noted. One occurred when the nurse retrieved and replaced an individual's nebulizer mask when self-removed after adjusting the socks of a roommate and not washing her hands (673E). Another occurred during administration of an eye medication and contamination of the eye cup (674W). Additionally, during the observation of nebulizer treatments a gastrostomy bolus syringe was found lying on a bed (673E). The medications administered on 674W at 1600H were given starting at 1600H daily because this was the time most of the individuals returned home from their day programs or activities. The medication pass took over one and a half hours and it was noted by the administering nurse and CNE that this was usual indicating some individual's medications were not typically being administered in a timely manner. Following the observation the pharmacist and physician were consulted by the CNE and medication pass times were adjusted to allow for future timely administration as ordered. Individuals receiving treatments such as glucometer (i.e., finger stick), blood glucose checks, or nebulized medications were ensured privacy and dignity in a second room of	

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		the nurses' station, or in their bedrooms. During the medication passes observed, there was general and individualized interaction with each individual regarding the medication, directions for administration, and personal interactions regarding their condition and events occurring in their lives. All medication administration observations were noted to use a person-centered process. 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 (670, 673, and 674), individuals' nurses checked their stoma sites and abdomens for signs of distension, pain, and skin breakdown, checked and adjusted the positions of the individuals and their feeding tubes, administered each medication separately, appropriately flushed and clamped their feeding tubes, and properly administered the individuals' medications in accordance with their physician's orders. A review of 20 individuals' MARs for October 2010 through January 2011, however, contained inadequate documentation of PRN (as needed) medication administration with potentially negative consequences to the individuals receiving, and/or 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 and/or did not provide a clear notation of the individual's response to treatment, including the date and time of follow-up assessment for effectiveness. o Individual #218: Acetaminophen 650 mg prescribed PRN for pain, given 11/20/10 for forearm pain with no documentation of follow-up assessment on the MAR or in an IPN. She received Phenol spray prescribed PRN for a sore throat on 12/2/10 and 12/6/10. The 12/6/10 administration was without documentation of the reason or response to treatment on the MAR or in an IPN. The 12/2/10 administration was documented given for a "cough," for which the medication was not prescribed. She received acetaminophen on 12/27/10 for pain from a cracked molar with no follow-up documentation/assessment documented on the MAR or in an IPN. o Individual #37: Lorazepam 1.5 mg oral concentrate, buccally for seizures >1 in 24 hours or a seizure > 1 minute was ordered. It was given on 11/19/10 at 0940H, 20 minutes after a two minute 30 second seizure. Vital signs were taken 10 minutes after administration with no further follow-up until 1900H. Guaifenesin/D-methorp+ syrup every four hours for a cough was ordered. It was administered four times in	

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		1/11, one time in 12/10, and nine times in 11/10. Frequently, there was no accompanying narrative assessment before and/or timely assessment after administration. Although this individual was at risk for pneumonia and aspiration, lung sounds were often not documented assessed either before or after administration. o Individual #89: Magnesium hydroxide, an antacid, for indigestion was administered after he complained of stomach pain. The effectiveness of the mediation was documented "yes" on the MAR without the time of follow-up assessment for response to treatment or assessment data. o Individual #200 had orders for bisacodyl suppositories for no bowel movement in three days. He was administered the bisacodyl on the following dates without adequate and appropriate documentation: 1/4/11 at 1630H with no narrative documentation on the MAR or in an IPN, 12/18/10 at 2100H with no response to treatment documented, 11/17/10 at (illegible time) with no response to treatment documented, and a 10/10/10 administration given at an unknown time and with no response to treatment documented. o Individual #185: Acetaminophen, prescribed for discomfort/pain, was given 19 times in 12/10 and six times in 1/11 without clear notation of reason or response for each administration. An antacid was administered for stomach discomfort 11/14/10, 12/21/10, and 1/15/11 without clear notation of reason or response for each administration. o Individual #236: Lorazepam 2 mg oral concentrate buccally or IM, or seizures >1 in 24 hours or a seizure > 1 minute was ordered. It was given via the buccal route three times in 12/10 and four times in 11/10 without consistent documentation of assessment including vital signs before and after administration. The time of buccal administration in relation to the time the seizure ended and assessing the individual's choking risk was not documented. For example, on 12/21/10 lorazepam oral concentrate was administered buccally at 2255H for a one minute 38 second seizure that occurred at 2240H. There was no documented follow-up assessment for response or monitoring during buccal administration to reduce choking/ aspiration risk. o Individual #306: Acetaminophen prescribed for headaches was administered 12/1/10 at 1130H. A follow-up assessment for response was documented indicating zero signs of distress, but there was no documentation on the reason for administration beyond "suspected" headache in a follow-up IPN. A 12/26/10 at 0925H administration had no narrative on the MAR or in the IPN describing the reason for	

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		administration or her response. o Individual #311, Individual #37, Individual #236, and Individual #306 had PRN orders for lorazepam administration for seizures of a specified length, usually over one minute, or more than one seizure within a 24 hour period. Orders were for buccal administration of oral concentrate or intramuscular administration. One order specified to use the IM administration when the oral concentrate was not available. Criteria for the choice of route and nursing assessment of full recovery, including potential for aspiration/choking after seizures, were not documented before buccal administrations. Buccal administration techniques of the oral concentrate were reported to vary. As discussed in M1, M3, M4, and M5, the care and treatment of individuals with diabetes mellitus was identified as a nursing priority for monitoring and quality improvement. The administration of insulin as prescribed and Accuchecks of finger stick glucose levels as prescribed were not consistently documented for five of the five individuals with diabetes mellitus included in this review. During 10/10 and 11/10, a Diabetic Record documented Accucheck glucose levels and administration of sliding scale insulin for these individuals formatted in a list; the information was also recorded on the MAR with inconsistencies across documents. One had to review and compare both documents to determine if insulin had been administered as prescribed, as well as if fingerstick glucose checks were administered as prescribed. A new Accucheck and sliding scale insulin record (i.e., diabetes management medication and treatment record) was implemented on 12/1/10 with a reduction, but not elimination in the number of Accuchecks not recorded and errors in sliding scale administration during 12/10 and 1/11. The new forms, however, were more conducive to concurrent and retrospective analysis of the data, but the new forms did not consistently document the initials of the nurse administering the Accuchecks and/or sliding scale insulin. Additionally, there were errors and inconsistencies in implementation of orders for treatment of hypoglycemia and administration of sliding scale insulin. Examples of diabetes related medication and treatment implementation errors included: • Individual #218: On 12/9/10, she refused insulin with a glucose level of 289 mg/dl and refused follow-up with no documentation in the IPN. She was supervised to administer her own finger sticks. The site of SQ insulin injections and finger stick sites were not consistently recorded, thus rotation of sites was not documented. Initials of the nurse witnessing self-administration of the Accucheck and recording of results by the nurse were not present in the record. On 10/15/10 at 1700H with a glucose of 170 mg/dl, 11/1/10 at 1700H with a glucose level of 184, and 11/9/10 at 1630H with a glucose level of 160, there was no documentation of one unit of sliding scale insulin administered as	

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		prescribed. On 12/27/10 at 0800H, with a glucose level of 180, there was no administration of two units as prescribed, and on 12/26/10 at 0800 for a glucose of 206, and 1/14/11 at 0700H for a glucose of 255, there was no administration of four units as prescribed. On 10/4/10 at 1630H, two units of sliding scale insulin were documented administered for a glucose of 157, but one unit was ordered for a glucose level of 151-200. She had Accuchecks ordered for twice daily, ½ hour before breakfast and dinner. There were no fingerstick glucose measures/Accuchecks recorded for 10/17/10, 10/20-21/10, 11/10-11/11/10, and 11/17/20. There were no fingerstick glucose measures recorded before breakfast on 10/12/10, 10/22/10, 10/23/10, 10/25/10, 10/27/10, 10/30/10, 11/2/10, 11/8/10, 11/10/10, 11/14/10, 11/15/10, 11/18-11/21/10, 11/23/10, 11/27-11/28/10, 12/16/10, 12/28/10 and 12/31/10, 1/1/11, 1/25/11, and 1/31/11. There were no fingerstick glucose measures recorded before dinner on 10/6/10, 10/14/10, 10/13/10, 10/19/10, 10/24/10, 10/26/10, and 10/28/10. • Individual #324 received both routine and sliding scale insulin at the same administration times. Although the routine insulin was initialed on the MAR by nurses indicating it was given, it appeared that sliding scale insulin recorded given included a total of both the routine and the sliding scale dose resulting in charting giving more than the prescribed sliding scale dosage of insulin. Accuchecks were ordered for before meals, at bedtime with a 0200H check added on 11/24/10. Sliding scale insulin was ordered three times daily before meals. There were no fingerstick glucose measures recorded on 10/19/10 at 1200H, 11/10/10 at 1630H, 11/11/10 at 0730H and 1130H, 11/14/10 at 0730H and 1130H, 11/15/10 at 0730H and 1130H, 11/17/10 and 11/18/10 at 0730H, and 1130H with unlabeled late entries for 11/19/10-11/20/10 at 0730H and 1130H, 12/17/10 at 0200H, 12/22/10 at 0700H, 12/28/10 at 1200H, and 12/31/10 at 1200H. There were numerous errors in sliding scale insulin administration including: 11/20/10 at 0700H a glucose of 208 required four units of insulin with zero units charted given; 11/7/10 at 1630H a glucose of 321 required eight units for level from 300-349, but six units were documented administered; and 10/31/10 at 1200H a glucose of 386 with 10 units given but eight units were ordered; 12/13/10 at 1600H a glucose of 361 had 10 units ordered and eight units were given; 12/20/10 at 1600H a glucose of 181 had two units ordered and six units were given; 12/23/10 at 1600H a glucose of 222 had four units ordered and six units given; 12/27/10 at 1600H a glucose of 282 had six units ordered and 10 units given; 12/22/10 at 1200H a glucose of 382 requiring 10 units of sliding scale Insulin Lispro which was not documented administered; 1/2/11 at 1200H a glucose of 265 had six units ordered and zero given; 1/3/11 at 1200H glucose of 243 had four units ordered and zero given;	

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		1/3/11 at 1630H a glucose of 153 had two units ordered and zero given; 1/6/11 at 1630H a glucose of 180 had two units ordered and zero given; 1/7/11 at 1200H a glucose of 190 had two units ordered and zero given; and, 1/7/11 at 1630H a glucose of 283 had six units ordered and zero given. There was also documentation of giving six units of sliding scale insulin on 1/11/11 at 1630H but documentation on the MAR indicated the two units of routine Lispro insulin was given and six units of Lispro sliding scale was given. She also had orders for Glucogel for glucose levels below 60 ordered 11/24/10. • Individual #200 had routine Insulin Lispro 100 Units/ml ordered before breakfast and supper with several dosage changes. He had three different sliding scales, the first for breakfast, the second for lunch and supper and the third for bedtime. His 1/11 MAR, including the new medication/treatment record for diabetic management, was poorly organized to identify the correct sliding scale to be followed per physician's orders, with the three different sliding scales as well as routine insulin twice daily. The 12/10 record was organized to include all orders and included the nurses' initials, but did not provide complete and correct documentation. Several of these errors included: 1/4/11 at 1630H a glucose of 109 with one unit ordered per sliding scale and none given; 1/4/11 at 1630H a glucose of 214 with three units of insulin ordered and four documented given; 1/5/11 at 1630H a glucose of 184 with two units ordered and six units given; 12/12/10 at 0630H a glucose of 97 with two units ordered and zero units given; 12/16/10 at 0630 a glucose of 126 with three units ordered and zero units given and 12/16/10 at 1130H a glucose of 154 with two units ordered and zero units given; and, 12/17/10 through 12/21/10 at 1630H glucose measures were at levels requiring sliding scale administration and zero was documented administered. Sliding scale insulin given and Accuchecks for 10/10 and 11/10 on the previous diabetic record also contained multiple errors. • Individual #225 had Accuchecks ordered twice daily before breakfast and two hours after dinner to monitor her non-insulin dependent Diabetes Mellitus, Type 2. She received prescribed daily oral medication, Metformin, for her Type 2 diabetes. During 10/10 and 11/10, documentation of Accuchecks was missing numerous times (e.g., 10/2/10 at 0700H, 10/3/10 at 0700H, 10/6/10 at 1900H, 10/10/10 at 0700H, 10/11/10 at 1900H, 10/14/10 at 0700H and 1900H, 10/17/10 @ 0700H, 10/24/10 at 1900H (the day after a return from a hospitalization), 10/25/10 at 1900H, none for 10/26/10, 10/29/10 at 0700H, 10/31/10 at 0700H, 11/15/10-11/17/10 at 0700H, 11/19/10 at 0700H, 11/27/10 at 0700H, 11/29/10 at 0700H, 11/30/10 at 1900H). The new diabetes management a treatment form started 12/10 was complete with the exception of nurses' initials on the first two mornings. Her 1/11 diabetic	

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		management record had missing documentation on 1/2/11 at 0700H and 1/30/11-1/31/11 at 0700H. The actions taken by the nurse when Accuchecks were refused were inconsistently documented, not documented or did not describe the method used (e.g., at 0700H on 1/3/11 and 1/11/11). Her Accucheck records also documented inconsistent administration of chocolate milk or orange juice for glucose levels from 70 to 74. There was no order or intervention established in her HMP to take action for glucose measures at these levels. • Individual #40 had 10/20/10-2/22/11 orders for Accuchecks every three hours with sliding scale Insulin-Lispro coverage. She was prescribed and received Insulin-Glargine (Lantus) 100 Units/ml, 10 units, subcutaneous injection, once daily. It was noted boldly NOT to mix with other insulins. Errors in administration of her sliding scale insulin and omissions of Accuchecks per the physician's orders using the new diabetic management form for 12/10 and 1/11 included: 12/2/10 at 0700H a glucose of 70 with zero units ordered and one unit given; no glucose measures recorded at 2200H on 12/2/10 and 12/8/10, and on 12/7/10 at 1300H; 1/7/11 at 1000H a glucose of 181 with three units ordered and one unit given; 1/10/11 at 1600H a glucose of 156 with three units ordered and one unit given; and, 1/13/11 at 0100H a glucose of 245 with three units ordered and two units given. Sliding scale insulin given and Accuchecks for 10/10 and 11/10 on the old diabetic record also contained multiple errors. Another area identified by nursing as a priority for monitoring and quality improvement was treatment and prevention associated with hypertension. Several individuals whose records were reviewed had hypertension or an associated condition requiring frequent blood pressure and/or full vital sign monitoring. The vital sign monitoring associated with direct administration of specific medications and reporting parameters established by the physician were generally documented with the following exceptions. See sections M3 and M4 for further discussion of complete, appropriate, and timely vital signs monitoring. • Individual #300 had orders on 1/9/11 at 0500H for administration of Captopril 50 mg x1 now for a BP of 157/99, then her 0800H dose was held with a BP of 136/83. The order included monitoring her BP at the time of her 1200H 75 mg dose. There was no assessment before the 1200H administration and the previous BP measure of 136/83 was documented in the 1352H IPN without indicating the time it was taken in relation to her Captopril administration. On 11/15/10, she had vital signs ordered before and after Captopril administration (all doses) x 1 week (i.e., 11/15/10 through 11/22/10). Administration times were 0700H, 1200H, and 1900H. Vital signs were not recorded for 11/18/10, 11/19/10, and 11/22/10, and 11/20/10 at 1900H either before or after	

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		administration. On 11/12/10, she had orders changing her Captopril dose to 50 mg am, 75 mg noon, and 50 mg at bedtime with physician ordered vital signs before each dose and PRN. She had been evaluated and treated at the ER for elevated blood pressure with a discharge diagnosis of hypertension. The post discharge nursing plan to monitor her BP closely every shift and continued plan to monitor once per shift and PRN was not consistently documented implemented as panned for the first 72 hours nor was it continued over the next several weeks per her plan of care. • Individual #218 had 11/15/10 orders for vital signs on the first day of the month one hour before and one hour after administration of clonidine. Documentation of full vital signs was not present for five of the six measurement times ordered. Additionally, on 9/24/10 there were orders to monitor her vital signs every morning and bedtime before and after scheduled medication times for seven days. The order was noted on the vital sign record but the measures were not recorded at the frequency prescribed and often did not include temperature; vital signs were taken 14 of the 28 times prescribed and only three of the 14 included temperature. • Individual #89 had 11/19/10 orders for vital signs on the first day of the month one hour before and one hour after administration of propranolol. The vital signs were documented for 11/10 but not 12/10 or 1/11. Additional medication administration issues identified include: • Individual #311, Individual #300, Individual #227, Individual #81, Individual #200, Individual #127, Individual #37 and Individual #185 had physician's orders for breathing treatments via HHN (Hand-Held Nebulizer), several with specific physician's orders for respiratory assessment before and after each treatment. Respiratory treatment records were not provided for review. • Individual #300 had physician's orders on 12/3/10 for "vital signs before each HHN tx" and "please have vital sign record available for my review, 12/4, 12/5 and 12/6." She received HHN treatments four times daily at 0700, 1100, 1500, and 1900. The vital sign record did not document measures four times daily. Specifically, the vital sign records for 12/4/10-12/6/10 were labeled as "VS's before each HHN" indicating there should have been four sets of vital signs recorded each day. Vital signs were recorded twice on 12/4/10 and 12/5/10 and once on 12/6/10. • Individual #218 had 1/16/11 orders to "clean right breast lesions with (illegible word), dry and apply Bacitracin bid x 10 days" and "warm compress to breast lesion bid x 10 days." The order was not noted by nursing staff and was not documented implemented on the MAR/Treatment record. On 11/23/10, acetaminophen 650 mg one time was ordered at 2025H with no documentation	

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		of administration on the MAR or in an IPN. The next note was on 11/24/10 at 0615H with complaints of arm pain. Keflex 500 mg by mouth four times daily for 10 days was ordered on 11/18/10 and started with the 1600H and 2000H doses. Administration stopped at the 2000H dose on 11/27/10 and should have continued given through 1200H on 11/28/10. On 1/21/11, she received prescribed magnesium citrate, one bottle, before repeat diagnostic tests for a pin in her descending colon. The medication was noted given at 2000H on 1/21/10 with the plan documented as "still pending." The next note was on 1/22/11 regarding administration of her annual PPD. The next note was at 1305H on 1/23/11 regarding her discharge from the ER with a piece of nail file in her left arm. At readmission, she refused a full body assessment, but allowed treatment to her arm. Nursing initial assessment of the site was not recorded at time of initial and ongoing treatment. • Individual #37 had Fiber stat 15 cc and one teaspoon of salt dissolved in water flushes every day after the noon feeding ordered. Administration was not specifically documented for 12/10 and 1/11. Medication administration monitoring and observation by the nursing department included implementation of the Medication Administration Competency Checklist. Registered nurses periodically directly monitored medication administration. Checklists from July 2010 that were reviewed at the time of the 8/10 review were presented for the current review. As was noted in the 8/10 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. The presentation on 2/7/11 on the nursing department's progress on meeting the provisions in Section M, included changes in procedure in 11/10 for RN monitoring of medication administration to be for a complete pass and establishment of a Medication Error Reduction Committee. Of the 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. Correction and	

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		follow-up monitoring was not consistently evident. Medication error and variance data were presented, including Medication Errors FY 2010 Rolling Trends, Medication Error Committee meeting minutes, and the Medication Error Synopses through December 2010. For December 2010, the majority of the errors were related to pharmacy issues with robot or cart-fill errors and 100 more of these types of errors as compared to the totals for the previous five months and were errors that did not reach the individual. A significant number of these were omission errors reported as primarily related to pharmacy dispensing robot errors that were identified by nursing staff as a result of initiating a new process of counting all delivered medications and packaging them according to day and shift. One administering error was reported in 12/10 with the administration of a dose of olanzapine lower than prescribed and no administration errors were reported in 11/10. Other errors over the last six months related directly to administration included (a) one for wrong drug, (b) four for wrong dosage, (c) two for administering to the wrong person, (d) one for the wrong time, (e) eight for omissions of which two were related to untimely ordering, and (f) one for expired eye drops. Follow-up review and recommendations to address each were included in Pharmacy and Therapeutics Committee meeting minutes and some by the newly formed Medication Error Reduction Committee. Also see section N of this report. A Drug Utilization Review was completed 8/26/10 evaluating completeness of medication orders according to the Health Care Management Guidelines. The report identified that 123 medication orders were randomly selected with one third of the orders containing all the required components for a complete order. Based on analysis of the data strategies for minimizing this risk included education concerning what constitutes a complete order and reducing use of verbal orders. The impact of these findings on nursing notation of medication orders, receipt of appropriate and complete verbal orders and administration of medications or their involvement in continuing education was not addressed.	

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/generic 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 and ongoing monitoring on the appropriate and consistent documentation tracking specific health problems or issues from initial assessment to resolution.

6. The facility should continue to provide training and ongoing support for nursing staff on the appropriate preparation, facilitation and participation in collaborating with PSTs in determining health risk ratings and aspiration triggers and PNMTs to problem solve physical and nutritional management problems and/or track progress. Once the new system is implemented and individuals' risks are appropriately identified by PSTs, 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 continue to monitor 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 administration should assure observation of complete medication passes during implementation of the Medication Administration Competency Checklists is implemented as planned. The data should be aggregated and analyzed to facilitate corrective action.

10. The facility should provide nursing staff with training and follow-up monitoring on diabetes management and complete and appropriate documentation of medication and treatment related orders including for sliding scale insulin.

11. The facility should include the nurses in educational efforts to reduce errors in the completeness of physician's orders.

12. The nursing department in collaboration with other appropriate disciplines should assure the consistent administration of buccal medications, specifically instructions for buccal administration of lorazepam oral concentrate.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o SASSLC Policy and Procedure: Pharmacy Services, 1/1/11 o SASSLC Lab Matrix, 12/1/10 o SASSLC Pharmacy and Therapeutics Committee Policy, 12/1/10 o Pharmacy and Therapeutics Committee Meeting Minutes, dated 7/14/10, 8/25/10, 9/22/10, 10/27/10, 11/14/10, 12/22/10 o Medication Error Reduction Committee Meeting Minutes, dated1/5/11 and 2/9/11 o Single Patient Intervention Reports submitted during the onsite review o Single Adverse Drug Event Reports submitted during the onsite review o Quarterly Drug Regimen Reviews submitted during the onsite review o MOSES and DISCUS forms for the following individuals: • Individual #94 Individual #163, Individual #32, Individual #333, Individual #300, Individual #336, Individual #87, Individual #304, Individual #125, Individual #3, Individual #145, Individual #284, Individual #270, Individual #97, Individual #97, Individual #146, Individual #191, Individual #156, Individual #292, Individual #205, Individual #216, Individual #243, Individual #37, Individual #68, Individual #344, Individual #38, Individual #232 Individual #36,Individual #72, Individual #9, Individual #77, Individual #204, Individual #57 o Adverse Drug Reaction forms for the following individuals: • Individual #94,Individual #211,Individual #148,Individual #315,Individual #122,Individual #146,Individual #298,Individual #196,Individual #11,Individual #108Individual #1,Individual #155,Individual #4,Individual #166,Individual #150,Individual #36,Individual #259,Individual #9,Individual #200,Individual #142,Individual #14,Individual #225,Individual #265,Individual #133,Individual #314,Individual #233, Individual #250, Individual #89, Individual #299, Individual #286, Individual #194 o Drug Utilization Evaluation Summaries: • Medication Orders • Adderall XR and Proton Pump Inhibitors • Risperidone/Paroxetine - Do Not Crush DUE - Follow-up up for FDA designation of risperidone and paroxetine as hazardous drugs. Interviews and Meetings Held: o Sharon M. Tramonte, Pharm.D, Clinical Pharmacist o Ashley Smith, Pharm.D, Clinical Pharmacist

	o Carmen Mascarenhas, MD, Medical Director o George Howland, MD, Psychiatrist o Ida Perez, RN, Acting Chief Nurse Executive o Meeting with Pharmacy Director, Medical Director, and Acting Chief Nurse Executive Observations Conducted: o Informal observations of medication administration
	Facility Self-Assessment: The facility rated itself noncompliant in all sections of this provision. After conducting numerous interviews, reviewing records and numerous documents, the monitoring team found the facility's self assessment of noncompliance to be accurate.
	Summary of Monitor's Assessment: Medication orders were filled at the San Antonio State Hospital Pharmacy. This was an independent institution with an entirely different staff and this resulted in problems with regards to implementation of some specific requirements of this provision of the Settlement Agreement. Specifically, there were problems implementing the requirement to document all interactions between the pharmacists and the physicians. The SASSLC pharmacy department was staffed with two clinical pharmacists, one of whom was a long-term employee and the other newly hired in September 2010. The supervisory hierarchy of SASSLC placed the pharmacy department under the supervision of nursing. This structure was unique among SSLCs and is not considered standard practice. This structure likely contributed to problems in processes and a lack of adequate supervision of the pharmacy staff related to fulfilling some provisions of the Settlement Agreement. The clinical pharmacist reported that the state hospital pharmacy began documentation of physician contact in December 2010 with the "Single Patient Intervention Report," but this practice was reported as not consistent. Drug regimen reviews were completed in a timely manner, but there were issues related to the content and consistency of data elements reported. There was also no mechanism in place to track physician implementation in those cases where there was agreement with pharmacy recommendations. The MOSES and DISCUS tools were being completed, but there was little evidence that practitioners utilized them. The DUE system was implemented, but the selection of drugs for review was not congruent with the recommendations of the Health Care Guidelines. Medication error reporting increased due to a new reconciliation process. This process resulted in discovery of more than 100 robotic errors each month. Additional processes were implemented to address this new problem.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. The clinical pharmacist reported that the Single Patient Intervention Reports were used to document interventions, but it was acknowledged that this was not consistently done at the state hospital that was the dispensing facility for SASSLC. The facility's Plan of Improvement documented that prospective reviews were completed and interventions documented. Copies of the Single Patient Intervention Reports in WORx since the last onsite visit were requested. A total of 33 documents were received. • 31 of 33 (94%) documents were Single Patient Intervention Reports • 2 of 33 (6%) documents were Single ADE (Adverse Drug Event) Reports • 2 of 33 (6%) were reported by the state hospital staff Single Patient Intervention Reports • 27 of 31 documents resulted from participation by the clinical pharmacist in neurology or psychiatry clinic • 4 of 31 documents related to issues of emergency medications, drug regimen reviews, potassium form change or monitoring of labs Single ADE Reports • Suspected Zosyn allergy during hospitalization • Reaction to medical tape reported by a physician None of the reports were produced as a result of the prospective reviews completed by the dispensing pharmacist at the state hospital. As stated previously, the facility's clinical pharmacist reported that there was no consistent method of complying with this aspect of the Settlement Agreement. Additionally, the times on the forms submitted were not clear. On several reports, the date at the top of the form was the same as the date that the event occurred or one to two days following occurrence. The majority of the forms were dated 2/24/10.	Noncompliance
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist	The clinical pharmacists completed quarterly drug regimen reviews. Overall, the drug regimen reviews were completed in a timely manner, addressed many relevant clinical issues, and provided some good recommendations. The monitoring team was provided	Noncompliance

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	shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	copies of the "Quarterly Drug Regimen Review" (QDRR) form. There were some irregularities noted with regards to timeframes for review by the physicians. There was no policy in place that specified timelines for physician review. The following reviews are examples of timeframes that exceeded three weeks from pharmacy review date to PCP review date:	

	Review Date	Pharmacy Signature Date	PCP Signature Date
Individual #61	11/8/10	12/1/10	12/2/10
Individual #244	11/5/10	12/1/10	12/2/10
Individual #232	11/23/10	12/2/10	none
Individual #171	12/17/10	1/5/11	none
Individual #315	12/16/10	1/5/11	1/18/11
Individual #99	12/17/10	none	1/18/11

The following were general concerns related to the drug regimen reviews:

- In most instances, the reviews provided relevant clinical information and made good recommendations. Several reviews included monitoring guidelines in the comments section when it would have been more appropriate to include them in the recommendations section.
- There were also instances in which the reviews did not follow-up on previous recommendations.
- Inappropriate medication indications were frequently used. In some cases, the clinical pharmacist noted this, but in others, there was no comment. The Health Care Guidelines required an appropriate indication for prescribing and dispensing of medications.

The following are examples of reviews that contained recommendations/comments with clinical significance. Also included are findings that were not included on the reporting form, but should have been:

Individual #74, 9/30/10

- The individual received topiramate. The last CBC was recorded on 1/6/10.
- Comments included the need to monitor every six months.
    - For ease of identification and physician compliance, this should have been included in the recommendations section.

Individual #99, 9/30/10

- The indication for levothyroxine was "TSH."

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		Individual #315, 9/30/10
		• The DRR noted that the last TSH on 2/12/10 was 8.01, a markedly abnormal value.
		• The comments section included remarks on the need to repeat the TSH as well as CBC and CMP for appropriate monitoring during use of antipsychotics.
		
		Individual #78, 10/30/10
		• A recommendation was made to re-evaluate the current medication indications. Fluticasone nasal spray was prescribed for "ENT."
		
		Individual #130, 10/27/10
		• The DRR noted several issues with the medication regimen:
		  o There was no documentation of a recent eye exam.
		  o The individual was treated with new generation antipsychotics and was at risk for metabolic syndrome due to obesity and drug use.
		  o Guaifenesin was prescribed for chronic cough. A recommendation was made to assess the individual and consider the possibility of the ACE inhibitor as the etiology of the cough.
		
		Individual #14, 10/21/10
		• The individual was treated with olanzapine. The last EKG was documented in 2002. The recommendation was made to obtain an annual EKG.
		
		Individual #244, 11/5/10
		• The individual was treated with olanzapine. The most recent CMP and CBC was dated 1/19/10.
		
		Individual #278, 1/24/11
		• The individual received clozapine. No lipids were documented from 8/10 through 1/11. The serum glucose was 122 in 8/10 and no follow-up study was documented.
		• The recommendation was made to obtain these studies.
		
		Individual #238, 1/20/11
		• The indication for drug pantoprazole was "hemostasis."
		• There was no comment related to the indications for pantoprazole.
		
		Individual #201, 1/11/10
		• Famotidine was prescribed for anemia.
		• The pharmacist did not comment on the need for an appropriate indication.	

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		Individual #334, 9/25/10 • Nitrofurantoin was prescribed for "urology consult." • There was no comment from the clinical pharmacologist on the use of an inappropriate indication. Individual #50, 12/9/10 • The pharmacist requested an indication or clarification for use of testosterone since indication was listed.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	During the August 2010 monitoring team visit, the facility reported that no stat medications were used. The Pharmacy and Therapeutics Committee meeting minutes did not contain any discussion related to emergency drugs. The facility began documenting emergency drug use in the in the August 2010 P&T meeting minutes. The clinical pharmacist and medical director reported that the use of emergency drugs was discussed in the daily clinical services meetings and during the P&T meetings. Minutes for the daily clinical services meeting were recorded during the month of August 2010 and contained discussion related to emergency drug use. The practice of taking minutes in the daily clinical meetings was discontinued in August 2010. The P&T meeting minutes documented discussions of emergency drug use including the rationale for use and possible team strategies for reduction. The primary care physicians were not required to attend these meetings and, therefore, did not participate in the collaborative discussions with the pharmacists, though they did attend the daily clinical services meetings. At the time of the onsite review, the psychotropic polypharmacy committee had not been established. The clinical pharmacist anticipated formation of the committee by the summer of 2011. The quarterly Drug Regimen Reviews provided comments and information related to benzodiazepine use, anticholinergic burden, and polypharmacy. The DRRs also addressed endocrine and metabolic risks associated with the use of the new generation antipsychotic agents. Lab results were provided based on the facility lab matrix. The monitoring for endocrine risk did not consistently include some elements included in the lab matrix, such as weight and BMI. Monitoring for the metabolic side efforts was not consistently performed per the lab matrix or standard practice. These findings are discussed further in Provision N2.	Noncompliance
N4	Commencing within six months of	The Drug Regimen Review form was revised at the end of 2010 to provide	Noncompliance

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	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.	documentation of the physician's intent to follow the recommendations of the pharmacist. The signature box for the primary care physician and psychiatrist included check boxes. With regards to the recommendations of the pharmacist, each provider was to check "will consider' or "will not consider." When the decision was made not to consider the recommendations, the physician was to provide an explanation in writing. This revised form was implemented with reviews that were submitted to the physicians in December 2010. The majority of the DRRs reviewed were in the old format. Medical policy required the physicians to sign and date the reviews no later than the 21st day of the month following the month in which they were due.	
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 record sample listed above was reviewed for the presence of MOSES and DISCUS scales, when appropriate. In general, the forms in the sample were adequately completed, signed, and dated. The information did not appear to be utilized by most practitioners. The neurology clinic notes and annual medical assessments did not take into consideration side effects that were reported in these documents. One response from the psychiatrist was noted. In the case of Individual #194, the psychiatrist decreased the dose of thorazine due to the blue/gray discoloration of the individual's face reported in the MOSES document.	Noncompliance
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.	Approximately 38 ADRs were reported that involved 33 individuals and implicated 25 drugs. All of the ADR reports submitted for review were assessed for timeliness of submission, completeness of form, outcome of event, and corrective actions. The dugs implicated, number of times a drug was implicated, type of reactions are summarized in the table below:	Noncompliance

Drug	Number of Times Drug Suspected	Type of Reaction(s)
Chlorpromazine	5	EPS, blue skin, increased QT interval, drooling
Divalprolex	5	Thrombocytopenia, lethargy, macrocytic anemia, increased ammonia
Olanazipine	5	Increased agitation, EPS, impaired swallowing
Propranolol	3	Syncope, hypotension, bradycardia

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Haldol	2	Cog-wheeling, tremor, eyes roll up
Levetiracetam	2	Increased psychiatric symptoms
Lithium	2	Drooling and tremor
Topiramate	2	Decreased appetite and increased behavioral episodes
Bupropion	1	Decreased movement and appetite
Clonazepam	1	Aggression
Clonidine	1	Hypotension
Clozapine	1	Syncope
Dextroamphetamine	1	Increased SIB
Dilantin	1	Parkinson like symptoms
Doxepin	1	Akathesia
Escitalopram	1	Inappropriate sexual behavior
Fluoxetine	1	Lethargy
Hydroxyzine	1	Lethargy
Lidocaine	1	Methemoglobinemia
Lorazepam	1	Hypotension
Metoclopramide	1	Lip smacking
Oxcarbazepine	1	Hyponatremia
Pipperacillin	1	Swollen lips
PPD	1	Severe reaction
Quetiapine	1	Syncope

The majority of the reactions reported were considered to be likely adverse drug reactions, with severity ranging from mild to severe, and appropriate clinical actions were taken. There were instances in which the reaction warranted further investigation, but there was no documentation in the P&T minutes of such follow-up.

Discussions related to ADRs were focused on individual-level data. The P&T Committee did not contain any discussion related to data analysis and trending. This would be one of the next steps in an ADR reporting and monitoring system. The drug chlorpromazine was associated with five reports of adverse drug reaction. Additional data might warrant completion of a DUE related to the facility's use of this drug.

Reactions that warranted additional information included:

- Individual #148 experienced a moderate adverse drug reaction when a missed clonidine dose was given after receiving lorazepam 2 mg IM. The individual was hospitalized and received IV fluids.
- Individual #14 was hospitalized for four days after experiencing

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		methemoglobinemia and cyanosis. The individual received lidocaine during a community medical appointment. The individual had a genetic defect that results in lidocaine intolerance. o The documentation provided lacked essential information related to the preventable nature of this serious reaction. The key question that should have been addressed was whether this information was known prior to the event and was it adequately communicated to the treating community physician. • Individual #36 was reported to have swollen lips that the mother believed was due to Zosyn based on a history of Zosyn sensitivity. The PCP determined this was unlikely. • Individual #108 experienced a severe reaction to a PPD resulting in altered skin integrity. The documentation provided does not include any information on previous responses to the PPDs given. The clinical pharmacist indicated that additional training would be provided to staff on recognition and reporting of ADRs. Several ADRs were documented in neurology clinic notes without completion of the appropriate documents. The process for reporting adverse drug reactions was not codified in policy and procedure independent of the general pharmacy operations manual. The facility must draft a specific procedure related to this process and it should include a threshold for conducting an intense case analysis. Completion of an intense case analysis is necessary to determine systems issues that may likely result in repeat events of the same or similar nature. Such an analysis should be completed for all serious ADRs and ADRs that result in hospitalization.	
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	At the time of the onsite review, the facility had completed three reviews to meet this requirement of the Settlement Agreement. <u>Drug Use Evaluation #1</u> Drug Evaluated: Complete Medication Orders Date of Evaluation: 8/26/10 Objective of Evaluation: The objective of the review was to assess the risk for errors related to incomplete medication orders. Methodology: A random sample of medication orders was obtained by accessing charts located in each home area. Five or six charts were selected at random per location. For	Noncompliance

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	care with regard to this provision in a separate monitoring plan.	each chart selected, the last page containing a medication order was copied. A total of 123 medication orders were collected. Results: Of the 123 orders reviewed, 1/3 of the orders were considered complete.	

Components of Medication Order	#	%
Missing date	0	0
Missing time	15	12.2
Clarification order	20	16.3
Missing dosage form	24	19.5
Missing strength	9	7.3
Missing route	29	23.6
Missing frequency	8	6.5
Missing duration	19	15.4
Missing indication	35	27.5
Missing signature	10	8.1
Illegible orders	14	11.4
Telephone or verbal orders	58	47

The DUE report and P&T minutes dated 9/22/10 documented the findings. Both documents noted that strategies for minimizing the risk of incomplete orders included education concerning what constituted a complete order and reduction of verbal orders. There was no associated corrective action plan related to reducing verbal orders. There were no Single Patient Intervention Reports related to incomplete orders and pharmacy clarification of those incomplete orders.

Drug Use Evaluation #2
Drug Evaluated: "Risperidone/Paroxetine - Do Not Crush DUE"
Follow-up up for FDA designation of risperidone ad paroxetine as hazardous drugs.

A table containing a list of individuals on risperidone and paroxetine was presented as the DUE. The date of the review, objectives, and results were not documented.

The P&T minutes dated 10/27/10 contained a discussion related to risperidone and paroxetine being placed on the hazardous drug list by the CDC. The minutes further indicated that a list of individuals on these drugs who required crushed medications would be complied and presented at the next monthly meeting.

The minutes of the P&T Committee meeting dated 11/24/10 presented a summary of the

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		findings: • A DUE was conducted on all individuals currently receiving risperidone or paroxetine. • Each individual was assessed for his or her dietary texture restriction and requirements for crushed medications. • Individuals receiving the tablet formulation and who required crushed medications were identified. • Those individuals who required their medications be crushed and who were receiving the orally disintegrating tablet formulation did not need to have drug formulation changed. • There were seven individuals who required crushed medications and were receiving the tablet formulation. • The lead psychiatrist determined that each of these individuals would be assessed at his or her next psychiatry clinic to determine if the medication could be discontinued or if the dosage formulation needed to be changed. The P&T minutes dated 12/22/10 documented that all individuals requiring crushed medications who received risperidone or paroxetine have been taken off the medications or changed to a liquid formulation. The minutes further indicated that the CNE recommended that a DUE be completed to assess the interaction between Adderall and proton pump inhibitors. This recommendation was based on safety labeling changes published by the FDA in November 2010. <u>Drug Use Evaluation #3</u> Drug Evaluated: Adderall XR and Proton Pump Inhibitors Date of Evaluation: 12/27/10 Objective of Evaluation: "Proton Pump Inhibitors (PPIs) act on proton pumps by blocking acid production, thereby reducing gastric acidity. When Adderall XR (20 mg single-dose) was administered concomitantly with the proton pump inhibitor, omeprazole (40 mg once daily for 14 days), the median Tmax of d-amphetamine was decreased by 1.25 hours (from 4 to 2.75 hours), and the median Tmax of l-amphetamine was decreased by 2.5 hours (from 5.5 to 3 hours), compared to Adderall XR administered alone. The…and Cmax of each moiety were unaffected. Therefore, co-administration of Adderall XR and proton pump inhibitors should be monitored for changes in clinical effect. This DUE is being performed to identify individuals that may be affected by this drug interaction." Results: There were no individuals at SASSLC treated with Adderall XR at the time the DUE was conducted.	

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		Additional comments Although the facility considered three DUEs completed, none of the DUEs completed complied with the guidelines set forth in the Health Care Guidelines, Appendix A. 1. A review of the physician orders was an audit and not a DUE. 2. No individuals were treated with Adderall therefore a DUE was neither indicated nor possible. 3. The DUE related to paroxetine and risperidone was based on an FDA warning and a review of medication regimens was warranted based on an FDA warning. 4. No DUE calendar was generated as required by the Health Care Guidelines. The P&T Committee minutes dated 9/22/10 documented that DUEs would be conducted at least twice a year and additional DUEs would be performed as indicated. A topiramate data collection form was discussed and approved by the committee. The minutes also reflected the results of the DUE on medication orders. The medical director requested that the DUE results be presented to the medical staff at the clinical services daily meeting. There were no notes or attendance records related to that follow-up discussion. P&T minutes dated 10/27/10 presented the findings from the same DUE. The committee determined that the physician and nursing staff should be re-inserviced on the information obtained from the DUE.	
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 variances, collecting and analyzing data, and implementing corrective actions, and some progress was noted, particularly in the front-end reconciliation process following dispensing of medications from the state hospital. The Medication Variance was designed to be non-punitive and to encourage self-reporting and is summarized below: Reporting of potential errors started in August 2010 and reconciliation of medications following dispensing from the pharmacy was initiated during the last week of November 2010. A summary of medication variance data is presented below. These data were discussed during a meeting with the clinical pharmacist, medical director and acting chief nurse executive.	Noncompliance

	July	Aug	Sept	Oct	Nov	Dec	Jan
Total Errors	5	9	7	15	12	119	138

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Pharmacy						116	126

The substantial increase in pharmacy variances was due to errors made by the automated dispensing robot at the state hospital pharmacy. As a result of this, a weekly reconciliation and bagging process was implemented just prior to the onsite review. This required that nurses count medications weekly upon delivery and separate the medications for each administration period into baggies.

The Medication Variance System

Medication variances were reported to, and monitored by, the clinical pharmacist who stated that she discussed variances with the RN managers and CNE when necessary. She further stated that nursing management was generally aware of medication variances and was always aware of major errors due to the need for immediate corrective actions.

There were frequent meetings between the clinical pharmacist and nursing management to discuss issues related to nursing and medication administration, but there were no minutes produced during these meetings. There appeared to be two formal arenas for discussion of medication variances. One was the P&T Committee, the other was described to the monitoring team as a Medication Error Reduction Committee, but was later described by the facility as more of an ad hoc committee.

The medical director did not hesitate to point out that she had little information related to medication errors. Both the clinical pharmacist and medical director agreed that the P&T committee did not include any in depth discussion related to medical variations. Those discussions occurred in the MERC meetings.

Documents provided for review included P&T meeting minutes and MERC minutes as listed in the documents reviewed section. Two brief MERC meetings lasting 30 minutes or less were conducted in January 2011 and February 2011. The meeting on 1/5/11 was attended by five staff members, four RNs, and one LVN. The minutes of the meeting were captured in six bullet points and are summarized below:

- Committee meetings would occur every Wednesday.
- Many errors appeared to come from confusing lorazepam and clonazepam.
- Ideas were needed to reduce medication errors. Data related to medication errors was not provided to the committee.
- Drug books were outdated.
- The manner in which homes dispensed controlled medications needed to be reviewed.
- The committee would start reviewing newly submitted medication error data.

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		A second MERC meeting was conducted on 2/9/11 and was attended by four RNs and one LVN: • Baggies for sound-alike narcotics were distributed and in-services completed • Feedback on current weekly pill wrapping discussed that: o There was discord among nursing shifts due to the task being completed by day nurses. o Med counts were off with some baggies. o Nurses were pulled from patient care to wrap medications. • The committee was not aware of the effectiveness of the new baggie system. • Nurses would be asked to suggest alternatives to the baggie system. The minutes reflected the attendees' lack of knowledge of the problems and historical information. The following concerns were noted with the medication variance system: • The system was administered almost entirely by the clinical pharmacist. • The clinical pharmacist and medical director both acknowledged that the P&T meetings did not include an in depth discussion of medication variances. It was reported that was the function of the MERC had appeared to only meet two times since the last onsite visit. These meeting were brief and did not include any analysis or data review. The participants appeared to lack background and historical information. There was no continuity between the MERC, P&T and persons who administered the variance system. • The listing of medication variances contained incomplete information. There were several instances in which Essential information pertaining to medication given to the wrong individuals was omitted. • Corrective actions for the problems were not always clearly documented. • P&T minutes noted that there were no trends in nursing errors but there was a trend with regards to physician errors – incomplete orders. • Although the narratives pointed to trends in physician errors, actual physician errors <u>reported</u> were a small percentage of overall errors. • There had been no attention to reconciliation of meds at eh end of the month, • The medical director did not appear to have any substantial role in the medication variance system at the facility. • Since implementation of the dispensing reconciliation in November 2010, a large number of errors had been detected that were related to the automated dispensing process, which was completed at the state hospital. Some of these errors had the potential to be very serious. o Dispensed topiramate 50 mg for 25 mg tablet o Dispensed Levetiracetam 500 mg for pyrimidine 250 mg	

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Recommendations:

1. The state will need to determine how to achieve compliance with the requirement to document prospective reviews given the fact that medication dispensing occurs at another facility.

2. Physician compliance with recommendations should be tracked. If the physician agrees with the recommendation, there should be evidence that the recommendation has been implemented.

3. The Quarterly Drug Regimen Review form should provide additional data. If an individual receives medication for a condition and there is laboratory monitoring for that condition, the values should be reported. Individuals being treated with statins should have LFTs and lipid panel results reported for each review. Ordering of the labs would be per lab matrix or as clinically indicated.

4. The medication variance system must be reorganized in order to become a more collaborative effort. A variance system should involve all disciplines with a role in the medication use system. The MERC should be expanded to include input from the facility's quality department as well as the medical director. Data reported should be detailed and complete. The error table should always indicate the drug involved. This is particularly important when the wrong medication is given to an individual.

5. The medication reconciliation system must be expanded to determine if medications are being returned to the pharmacy. This will also provide valuable information on the effectiveness of the bagging process.

6. The P&T Committee should include a detailed report from the MERC so that the medical staff and other disciplines may have input on the issues.

7. The pharmacy should be placed under the direction of the medical department in order to achieve closer supervision of many of the processes relating to pharmacy practices and the Settlement Agreement. The medical director would have responsibility for reviewing reports such as DUEs to ensure that the process was completed appropriately.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **<u>Documents Reviewed</u>:** o Clinical Staff list and PNMT members o CVs for Margaret Delgado-Gaitan, MA, CCC-SLP, Allison Block, MA, CCC-SLP, Janet Adams RN, MSN, CNS o State license verification for clinical staff o Continuing education documentation for clinical staff o NMC Meeting minutes o PNMT Evaluations and PNMT action Plans for: • Individual #108, Individual #91, Individual #122, Individual #164 o High Risk Clients 12/10/10 o List of individuals reviewed by PNMT o List of completed Aspiration Pneumonia/Enteral Nutrition Evaluations since 1/1/11 o Integrated Risk Rating Forms, Aspiration Pneumonia/Enteral Nutrition Evaluations and PST Signature Sheet for Individual #263, Individual #18, Individual #311 o List of individuals receiving direct PT services o List of individuals with wheelchairs as primary mobility o List of individuals with transport wheelchairs o List of individuals with assistive ambulation devices o List of individuals with orthotics and/or braces o List of individuals with decubitus/pressure ulcers during the past year o Individuals with skin breakdown during the past 12 months o List of individuals who experienced a falling incident during the last three months o People who need assistance in the dining room o List of individuals with poor oral hygiene o List of individuals who receive enteral nutrition o Enteral Feeding Information o List of individuals with dysphagia o List of individuals with VFSS or MBS in the past year o Individuals with Fractures (1/1/10 – 12/31/10) o Individuals Having Falls from 1/1/10 – 12/31/10 o HST Risk Lists o All Risk Ratings (1/1/10 – present) o Hospitalizations list o Individuals with BMI Less than 20 o Individuals with BMI of Greater than 30

	- Individuals with Unplanned weight loss of 10% or greater over six months - List of choking incidents in last year - List of individuals with pneumonia incident in the past 12 months - List of individuals who receive nutrition through non-oral methods - Individuals on Modified Diets/Thickened Liquids - List of Diet Downgrades during the past 12 months - List of Emergency Room visits for the last year - List of competency-based PNM training conducted in the last 12 months - Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM - List of individuals with and without PNM needs - Templates of tools used for validation of PNM monitoring - Meal Trending graphs - Physical Management Trending graphs - Dining Plans submitted - OT/PT Assessment template - Physical Nutritional Management Wheelchair Clinic Progress Notes submitted - PNM maintenance log (1/7/11) - Habilitation Therapy Adaptive Equipment (1/5/11) - PNMPs submitted - Foundation al PNM training competency checklists - Completed Physical Management Observation Forms - Completed Mealtime Observation Forms - PNM curricula for training direct support staff - Personal Records for Sample of individuals including Sensory Skills Update, PSP and Addendums, PSP Reviews, Annual Physician Summary Evaluation, Active Medical list, hospital summaries, Health Risk Assessment, ENT consults, gastroenterology consults, orthopedic consults, integrated progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, documents in Habilitation Therapies tab, documents in Nutrition tab, documents in PNM tab, 12 month of PNMPs, 12 months of Dining Plans, three months of PNMP Observation forms and three months of Mealtime Observation forms for each of the following individuals: • Individual #311, Individual #306, Individual #122, Individual #108, Individual #164, Individual #335, Individual #239, Individual #259, Individual #126, Individual #197, Individual #243, Individual #309, Individual #19, Individual #40, Individual #211, Individual #146, Individual #54, Individual #95, Individual #208, Individual #135, Individual #127, Individual #93, Individual #227, Individual #234 and Individual #36. <u>Interviews and Meetings Held</u>: - Margaret Delgado-Gaitan, MS, CCC-SLP - Patricia Hajny, OTR, - Kelly Patrick, OTR

	○ Retha Skinner, MS, OTR ○ Edward Harris, PT, DPT ○ Raelynn Stolowsky, PT ○ Allison Block-Trammell, MA, CCC-SLP ○ Leona Bludau, MS, RD/LD ○ Ron Hoffmann, MS, CCC-SLP ○ Various Supervisors and Direct Support Staff ○ PSP meetings for Roberto Gomez and Michael Benton Observations Conducted: ○ Living areas ○ Dining rooms ○ Day Programs ○ Work areas
	Facility Self-Assessment: SASSLC's self-assessment rated noncompliance for all items of this provision. Systems were in the process of development particularly the new PNMT process. This self-assessment was consistent with the monitoring team's assessment of noncompliance.
	Summary of Monitor's Assessment: The PNMT process was initiated, but there was no assigned nurse, and the therapy clinicians also had other significant responsibilities as staff therapists. There was only one dietitian for the entire facility and there was no likely way that she would be able to adequately fulfill her role as the clinical dietitian for 281 individuals and also contribute significantly to the PNMT process. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The current system appeared to continue to come from a discipline-specific approach rather than an integrated comprehensive assessment process. There also seemed to be more of a review of existing supports to address the individual's risk status rather than a new examination and the development of a new plan. This team will continue to struggle with this as they serve as both the PST members and adjunct PNMT members and will have a difficult time looking at each case in a new manner. There continued to be implementation errors during meals, related to position and alignment as well as assistance techniques, adaptive equipment and diet texture and liquid consistency. Staff were not confident about the plans and often safely answered "aspiration" when asked why they did something rather than displaying an apparent understanding of the rationale. Staff consistently, but rotely, read the Dining Plans and diet cards prior to serving the individual. Often, however, they would proceed to leave out a step or use the wrong utensil.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** SASSLC had initiated the new process for the Physical Nutritional Management Team (PNMT) in November 2010, by report. The intended function of the team was to address individuals whose identified health status placed them at a high risk of potential or actual injury and/or illness. The initial step in this process was to identify PNMT members. The core members of the newly established Physical Nutritional Management Team (PNMT) included the following: • Kelly Patrick, OTR • Retha Skinner, MS, OTR • Patricia Hajny , OTR • Raelynn Stolowsky, PT • Allison Block-Trammell, MA, CCC-SLP • Margaret Delgado-Gaitan, MA, CCC-SLP • Leona Bludau, MS, RD/LD • Janet Adams, RN Each of the therapy clinicians was responsible for a large caseload requiring them to complete assessments, attend PSP meetings, develop intervention plans, and provide monitoring and review. There was only one dietitian for the entire facility, so she also served in dual roles as a member of this team. The RN had been the Chief Nursing Executive and was to retire after this onsite monitoring review. An alternate permanent nursing member had not yet been assigned. None of these clinicians were designated as solely assigned to the PNMT. Additional adjunct team members included Nurse Case Managers, Hospital Liaison, QMRPs, psychologists, and home managers depending on who the PNMT was reviewing at the time. There were approximately 252 (90% of the current census of 281) of individuals identified with PNM needs per the list submitted. It was of great concern to the monitoring team as to how these clinicians would be able to meet all of their regular duties for adequately meeting the PNM needs of the individuals at SASSLC while also appropriately addressing the issues of those at highest risk through the PNMT. No evidence of current licenses was submitted for any team members. Current licensure was verified online for Patricia Hajny, Kelly Patrick, Allison Block-Trammell, Margaret Delgado-Gaitan, and Janet Adams. It was not possible to verify licensure for Ms. Stolowsky or Ms. Skinner. CVs were submitted for Ms. Adams, Ms. Delgado-Gaitan, and Ms. Block only. The resume reviewed for Ms. Block-Trammel did not reflect her employment at SASSLC, but rather indicated that she currently worked at for the Karnes City Independent	Noncompliance

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	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.	School District in Falls City, TX. No other CVs were submitted as requested. Per the documentation submitted, participation in PNM- related continuing education for PNMT members since the previous review included: • Margaret Delgado-Gaitan, MA, CCC-SLP o At Risk Policy dated 12/29/10 (1.0 hour on 1/18/11) o Issues in Nutritional Management – Part 3 (2.0 hours on 12/15/10) o Dysphagia Evaluation: If You don't Measure, You Don't Know Dysphagia Rehabilitation: Move it to Improve It (2.0 hours on 7/16/10) o Issues in Nutritional Management (2.0 hours on 7/7/10) • Allison Block-Trammell, MA, CCC-SLP o At Risk Policy dated 12/29/10 (1.0 hour on 1/18/11) o Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (14 hours on 9/20 - 9/22/10) o Dysphagia Evaluation: If You don't Measure, You Don't Know Dysphagia Rehabilitation: Move it to Improve It (2.0 hours on 7/16/10) o Issues in Nutritional Management (2.0 hours on 7/7/10) • Retha Skinner, MS, OTR o At Risk Policy dated 12/29/10 (1.0 hour on 1/18/11) o PNMT – Introduction/Wound Investigation (2.0 hours on 8/13/10) o Dysphagia Evaluation: If You don't Measure, You Don't Know Dysphagia Rehabilitation: Move it to Improve It (2.0 hours on 7/16/10) • Kelly Patrick, OTR o 20th Annual Habilitation Therapies Conference (12 hours on 9/20 – 9/21/10) o PNMT – Introduction/Wound Investigation (2.0 hours on 8/13/10) • Patricia Hajny, OTR o At Risk Policy dated 12/29/10 (1.0 hour on 1/18/11) o 20th Annual Habilitation Therapies Conference (12 hours on 9/20 – 9/21/10) o PNMT – Introduction/Wound Investigation (2.0 hours on 8/13/10) o Dysphagia Evaluation: If You don't Measure, You Don't Know Dysphagia Rehabilitation: Move it to Improve It (2.0 hours on 7/16/10) • Janet Adams RN o At Risk Policy dated 12/29/10 (1.0 hour on 1/18/11) While Ms. Stolowsky had listed continuing education (3.1 hours) they were related to Texas ethics and professional responsibility and a course titled "Ready Bodies, Learning Minds," there were no specific PNM-related courses. There was no evidence that the dietitian had participated in any continuing education since the previous review. Several	

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		team members had traveled to Corpus Christi in October 2010 to observe how that SSLC had implemented the PNMT process there. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The previous NMC Committee meetings had been held monthly since the previous review on 8/28/10, 9/29/10, 10/27/10, 11/24/10, and 12/22/10 per the meeting minutes submitted. The number of individuals reviewed during each meeting ranged from 13 to 39. Approximately 65 individuals had been reviewed one or more times by the committee since the previous onsite visit by the monitoring team. Number of times individuals were reviewed by the committee was as follows: Number of Reviews / Number of Individuals: 1 / 37; 2 / 18; 3 / 9; 4 / 1 Individual #340 was reviewed four times. He had meal refusals and weight loss. With the newly implemented system, the PNMT had met more frequently and yet reviewed fewer individuals, though in a more in-depth manner. Previously, the committee had reviewed so many individuals they were not able to address any concerns in a thorough comprehensive manner. The fewer number of individuals reviewed will now permit greater problem-solving and improved integration of a comprehensive PNM assessment. The new PNMT will be challenged as this new system grows, however, to manage their existing caseloads and their additional roles and responsibilities as PNMT members. At the time of this review the PNMT had met regarding these individuals: • Individual #108 (11/16, 11/23 and 11/30/10) • Individual #164 (12/2, 1/4) • Individual #122 (12/16, 1/4) They also met regarding Individual #122, Individual #91, and Individual #164 during the week of the onsite review by the monitoring team.	

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		The team's ability to appropriately address change in status, assessments, clinical data, and monitoring results in a timely and comprehensive manner will need to be further evaluated during future onsite reviews.	
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.** Per a list submitted for this onsite review, there were 252 individuals identified with PNM needs at SASSLC. At this time, it was a standard practice that all individuals were provided a PNMP. Per the PNMPs submitted, this included individuals who were identified as independent with mobility, transfers, and positioning. Some had no precautions related to physical or nutritional management with little to no adaptive mealtime equipment. A new policy and process used to establish health risk levels had recently been implemented statewide. The goal was to have discussions of risk occur during each individual's PST meetings. Annual PST meetings were observed during the week of the onsite review for Individual #302 and Individual #311. The teams were also attempting to integrate the new PSP process and they struggled with how to integrate the two systems together. In the case of Individual #302, the PST began the meeting by discussing his interests and preferred activities and thereby naturally brought in discussion about his health risk issues. The process shifted to a more traditional method of risk review by going down the list of risk indicators, referring to the guidelines and making a judgment about his risk level. The elements of the PSP became less of a focus at that time. Generally, there was good discussion and all team members contributed. One of the direct support staff present was particularly helpful, offering information and opinions openly. Individual #311's PST attempted to integrate both processes, but again this was awkward and the flow of the meeting was difficult at times. The PSTs will require significant clinical instruction regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The new statewide system to identify and manage individuals at risk was outlined in policy number 006.1, At Risk Individuals, with an implementation date of 1/1/11. This policy was intended to identify individuals who were at risk for illness or injury as well as to identify actions and supports to mitigate the risks. The PST was to initiate assessment upon change in status for any individual to examine the existing support plans to ensure the appropriate measures were in place. The PNMT was defined as follows per this policy: "A team of specialists with knowledge and expertise in the development of	Noncompliance

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		Physical Nutritional Management Plans who meet to provide comprehensive assessment and determine appropriate intervention for persons whose identified health status places them at highest risk for potential or actual injury and/or illness. Members of the PNMT include the following disciplines: registered nurse, physical therapist, occupational therapist, dietician, speech pathologist and others as needed. All core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. As requested the team shall include primary care providers, nursing case managers, therapists, psychologists, QMRPs, home supervisors, facility support services staff and others as needed." The PST was to refer individuals at high risk to the PNMT who were not stable and for whom the PST required assistance in developing a plan. The PNMT was to begin assessment within five working days of referral to determine possible causes for the change in status, to analyze assessment findings, integrate recommendations and to propose an action plan with measurable goals and outcomes. The complexity of PNM-related risk indicators require comprehensive and collaborative team assessment, intervention plan development, implementation and monitoring. Existing risk concerns noted for individuals at SASSLC included the following based on the documents submitted by the facility to the monitoring team: <u>Choking</u> Per the list All Risk Ratings (1/1/10 – present) there were only two individuals identified at high risk of choking. Another 37 individuals were listed with a medium risk for choking. A list submitted reported that there were two choking incidents in the last year for Individual #304 (4/5/10) and Individual #171 (12/13/10). Each of these individuals was listed at only medium risk for choking per the list of most current HST ratings 12/31/10 submitted. The incident for Individual #50 was the only one documented since the previous review. He was reviewed by the NMC on 12/22/10. By report, he had a history of choking in 11/03 and 1/05 resulting in a food texture downgrade to ground foods. During this recent incident, he was reported to have choked on ground chicken though it was not confirmed as a "true" choking incident due to discrepancies in witness reports. At any rate, changes were made in his Dining Plan to include an infant spoon rather than a regular one, and staff were to offer two scoops of food on his plate at a time to control the rate at which he ate rather than the previous two to four scoops. Training was completed by the PNMPC the week of the incident. Individual #50 had a PNMP and Dining Plan that reflected these changes and stated that he should have direct staff assistance to promote a safe eating pace and that they were to prompt him through the	

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		meal to slow down or take smaller bites as needed throughout the meal. This required level of supervision and his recent history of choking were indicators that he should be considered at HIGH risk of choking per the new State SSLC Risk Guidelines and generally accepted professional standard of care. Individual #304 lived in Home 766 and was listed as having PNM needs, however, there was no evidence that she had a PNMP because none was submitted. Her supervision needs were not known, but with her recent history of a choking event she would be considered at HIGH risk at this time. These two individuals continued to be at risk of harm due to their history and yet they were not considered to be at HIGH risk for choking per the HST risk ratings. <u>Osteoporosis/Osteopenia</u> There were six individuals considered at high risk for osteoporosis and approximately 24 individuals considered to be at medium risk. There were 13 individuals listed with fractures since 1/1/10 through 12/31/10. HST risk ratings for those with fractures was as follows: • LOW Risk: Individual #213, Individual #1, Individual #65, Individual #232, Individual #36, Individual #19 and Individual #71 • MEDIUM Risk: None • HIGH Risk: Individual #93, Individual #7 and Individual #227 Individuals who had sustained a fracture in the last year included Individual #19, Individual #36, Individual #227, Individual #93, and Individual #7, each of whom were included in the sample for review by the monitoring team. For some of these individuals, the HST risk ratings and the supports provided to them were inconsistent with their history and apparent risk levels. For example: • Individual #19: His Annual Medical Summary, dated 7/1/10 reported that he had sustained multiple "seizure-related" injuries and had the following risk factors for osteoporosis he was 69 years old, white, completely immobile, had multiple fractures, and was anti-epileptic medication for more than one year. The physician stated that a humeral head fracture was detected on 4/30/09 and was considered "most likely due to osteoporosis." The physician reported a subacute left surgical neck fracture sustained on 5/12/10. Though this type of fracture of the proximal humerus is most often associated with osteoporosis, he was considered to be at LOW risk for osteoporosis. There was no diagnosis of osteoporosis or osteopenia and findings from a bone scan were noted in his personal record. The Comprehensive Nursing Assessment dated 8/3/10 did not include risk of injury due to fragile bones in the summary and no nursing care plan was developed. His PNMP did have a physical focus related to reduction of injury due to fragile bones, but there were no specific special precautions. He was at continued risk of harm, yet was not considered to be at HIGH risk per the	

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		current HST risk ratings. • Individual #227: He had a history significant for multiple rib fractures (2009 and again in 2010, dates reported were not consistent across record), right hip fracture requiring surgery (5/6/10), and a history of falls with injury. The OT/PT evaluation dated 10/5/10 reported his risk level as medium for osteoporosis. The All Risk Ratings 1/1/10 to Present spreadsheet submitted indicated that he had been considered to be at HIGH risk for osteoporosis since 5/20/10 following his hip fracture and continued to be at HIGH risk as of 1/6/11. There was no evidence of a comprehensive OT/PT evaluation following this event though progress notes indicated that he was seen by both OT and PT on or around 5/19/10. The facility reported that he was discharged in July 2010. • Individual #36: Per his Medical Summary and Treatment Plan dated 3/1/10, he had multiple risk factors related to osteoporosis, including Diabetes Mellitus, Type I, long term anti-epileptic therapy, non-ambulatory status, and history of a hip fracture (right femur in 1988). He also had chronic hip dislocations with degenerative changes. He sustained a fracture of his left femur discovered 11/1/10 and listed as related to lifting or transfer on the list of fractures submitted. An orthopedic consult on 11/16/10 made reference to a "probable osteopenic" angulated fracture of his left femur. The PSP addendum on 11/18/10 documented that the orthopedist had described Individual #36's bones as "paper thin." There was no evidence of a comprehensive OT/PT assessment related to this change in status in his personal record, though per a PSP addendum it was reported that a comprehensive OT/PT Evaluation had been completed on 11/23/10. His previous annual update was completed on 2/25/10. PNMPs had been requested for the last 12 months and only two were submitted (1/19/10 and 2/1/11 only). There were no special precautions related to his risk of injury noted in these plans and there was no evidence that his plan had been reviewed or revised to address this sentinel event in November 2010. <u>Falls</u> There were at least 72 individuals who experienced falls from 1/1/10 to 12/31/10. At least 20 individuals had three or more falls during that period and 19 of these falls resulted in serious injuries for 15 individuals. Individual #211, Individual #146, Individual #71 and Individual #39 each experienced two serious injuries related to falls. Individual #211, Individual #7, Individual #122, Individual #261, Individual #344, Individual #106, Individual #318 and Individual #39 each had four falls. Individual #209 had five falls and Individual #146, Individual #302 and Individual #254 each had six falls. Individual #4 experienced at least nine falls in a 10-month period. There were 13 individuals who sustained an injury resulting in a fracture, with nine of these related to a due to a slip, trip, or fall or were related to a lift or transfer.	

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		There were approximately 22 individuals considered at HIGH risk for injury who were also listed with falls in the last year. Of the 20 individuals with three or more falls, only six were currently considered at HIGH risk of injury and included Individual #211, Individual #7, Individual #261, Individual #277, Individual #71 and Individual #39. Conversely, Individual #146 had six falls in a four-month period, two of which were serious (both in June 2010). He was rated at HIGH risk until 9/16/10 when his risk rating for injury was reduced to MEDIUM on 9/16/10 and remained so at the time of this onsite review. Three individuals had experienced multiple falls in the last year including Individual #254 (six), Individual #318 (four), and Individual #4 (nine, seven of which had occurred in just over a three month period) each of whom were considered to be only at MEDIUM risk of injury. There were nine individuals who had three or more falls in the last year but were considered at LOW risk for injury. Of these: • Individual #302 had six falls in eight months, one of which was resulted in a serious injury. • Individual #232 had three falls in just over seven months, one of which resulted in a serious injury. • Individual #106 had four falls in a nine-month period. • Individual #344 experienced four falls in a four-month period, also one of which resulted in a serious injury. • Individual #209 experienced five falls in just over a three-month period. Of those considered to be at HIGH risk for injury and had experienced falls in the last year only four had participated in PT intervention, including Individual #211, Individual #39, Individual #93 and Individual #336. <u>Aspiration/Aspiration Pneumonia</u> Per the new At Risk Individuals policy, any individual who had aspiration pneumonia since May 2009, any individual who was enterally nourished, and anyone who was deemed to be at HIGH risk for aspiration via the PST risk assessment process was to be evaluated using the Aspiration Pneumonia/Enteral Nutrition Evaluation prior to 3/31/11. Evaluations completed since 1/1/11 (done with annual PSPs and Addendums) were requested by the monitoring team for 24 individuals designated to receive this assessment, per Patricia Delgado, RN. The new Integrated Risk Rating Form, PST signature sheet and Aspiration Pneumonia/Enteral Nutritional Evaluation were submitted for Individual #18 (2/2/11), Individual #311 (2/11/11), and Individual #263 (2/1/11). Dates for the other 22 individuals requested were scheduled for quarterly reviews or annual PSP meetings at which time this assessment was to be completed, as follows February 2011 (six), March 2011 (five), April 2011 (10). Clearly those conducted in April 2011 would miss the State imposed deadline of 3/31/11. Scheduled dates for Individual	

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		#81 and Individual #212 were not provided. There was a note on the schedule submitted that Individual #228 did not receive enteral nutrition per the diet list, though her PNMP stated that she used a feeding pump though there were also instructions for oral intake. The three Aspiration Pneumonia/Enteral Nutrition Evaluations submitted were reviewed. • Individual #18 had numerous PNM-related diagnoses and received all of his nutrition, hydration, and medication via PEG tube via continuous drip over 23 hours. It was noted that he had remained pneumonia-free since July 2009. There was no clear statement that enteral nutrition via PEG tube continued to be medically necessary, though that would be presumed given that data presented. Outcomes listed were not stated in measurable terms, but indicated that he would remain free of pneumonia and complications, as well as improved oral hygiene. There was no specific action plan outlined, but rather only reference to a dental hygiene service objective. He was listed as MEDIUM risk for aspiration and respiratory compromise. • The evaluation for Individual #263 appeared marginally completed. He did not receive enteral nutrition and, as such, the PST appeared to view this as an exercise related to that issue only. Individual #263 was hospitalized for an episode of community-acquired left lower lobe pneumonia on 2/22/10. It had been determined that this was an isolated illness and he was considered to be at LOW risk for aspiration. He had poor oral hygiene and was considered at HIGH risk for dental concerns. His BMI was noted to be 32.4 in the obese range and he was considered HIGH risk for weight issues. He was also at HIGH risk for polypharmacy. The PST determined that no action plan was needed, though it was not clear how these concerns were being addressed. • The evaluation for Individual #311 had many sections left incomplete. There were only 11 individuals identified at high risk of aspiration and another 44 individuals considered to be a medium risk of aspiration, per the All Risk Ratings (1/1/10 –Present) spreadsheet submitted. Two others who experienced pneumonia in the last year included Individual #312 and Individual #323, found to be rated at HIGH risk and MEDIUM risk, respectively, in other documentation submitted. There were 15 individuals with 20 episodes of pneumonia from 1/1/10 to 12/31/10 (type not differentiated). The hospital discharge diagnosis for seven of these episodes was aspiration pneumonia and nine were designated as pneumonia. At least three were listed as bacterial. There were an additional 11 episodes listed for 10 individuals with some type of pneumonia or possible pneumonia per the hospital admission list but none of these cases was included on the list submitted Individuals with Pneumonia Incident Past 12 Months (1/1/10 - 12/31/10) and included Individual #40 (admitted on 12/26/09, discharged on 1/22/10), Individual #323 (7/12/10), Individual #239 (8/13/10), Individual #226 (11/24/10),	

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		Individual #312 (7/4/10), Individual #217 (11/23/10), Individual #91 (11/12/10), Individual #66 (4/4/10 and 5/15/10), Individual #54 (11/25/10), and Individual #236 (1/9/10). At least two of these were classified as aspiration and one was bacterial. The others were listed as pneumonia or possible pneumonia. There were an additional four cases listed in the hospitalization list for Individual #227 (admitted on 12/24/10), Individual #143 (11/29/10), Individual #135 (11/25/10), and Individual #157 (11/17/10). At least two of these were listed as aspiration pneumonia. There were an additional 10 individuals listed with aspiration pneumonia/pneumonia in December 2010 and at least three of these were classified as aspiration pneumonia.	

In total for 2010, there were approximately 32 individuals with pneumonia, one or more times in the past year for a total of 44 cases. This was a significant increase in incidence over the totals listed for 2009, when there were 20 cases of pneumonia for 20 individuals. Another list submitted identified an additional five individuals with pneumonia that were not included on the other lists submitted and this list did not include a number of individuals listed in the other documents. Classifications for both years were as follows and included those individuals not identified on the lists submitted.

Year	Aspiration	Other	Bacterial	Viral	Total
2009	2	13	4	1	20
2010	15	18	11	0	44

Two of the individuals with aspiration pneumonia in 2010 were deceased as of 8/22/10 and 12/23/10, respectively. A third was deceased as of 2/25/10 with cause of death listed as pneumonia, but this episode was not included on the list of pneumonia cases submitted. Individuals who had experienced multiple episodes of pneumonia over this two year period included Individual #311 (3), Individual #54 (2), Individual #66 (2), Individual #91 (3), Individual #217 (2), Individual #239 (3), Individual #19 (2), Individual #40 (2), Individual #277, Individual #301 (3), Individual #20 (2), Individual #126 (3), Individual #197 (4), Individual #309, and Individual #157 (2). One other individual was deceased as of 7/1/10 with cause of death listed as refractory (relapsing) aspiration pneumonia.

Of those with aspiration pneumonia and/or multiple episodes of pneumonia over the last two years, HST risk ratings were as follows:

- High = 5
- Medium = 7
- Low = 8

Interestingly, there were only eight individuals listed with dysphagia, of whom none were

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		considered to be at HIGH risk of aspiration and only three were considered to be at MEDIUM risk (Individual #300, Individual #295 and Individual #317). Five others were considered to be at LOW risk of aspiration (Individual #331, Individual #194, Individual #80, Individual #260 and Individual #236). Of these eight individuals, only two were on a modified diet and/or thickened liquids (Individual #194 and Individual #80). There were 187 others listed with thickened liquids and/or modified diets, each of which is typically associated with some level of dysphagia. There were 50 individuals listed who received enteral nutrition all via gastrostomy tube. Twelve received continuous tube feedings while three others received bolus feedings and 31 received feedings intermittently throughout the day. Method of enteral intake was not listed for four individuals. It was known to the monitoring team that Individual #311 had recently begun enteral nutrition, but was not included on this list as it was likely prepared prior to his tube placement on 1/27/11. Nine of these individuals were identified at HIGH risk for aspiration, 20 were identified at MEDIUM risk, and 22 were identified at LOW risk. There were at least 20 individuals who had experienced one or more incidents of pneumonia in the last two years, 13 of whom had aspiration pneumonia. Of these, only six of these individuals were considered at HIGH risk of aspiration/aspiration pneumonia (Individual #335, Individual #239, Individual #227, Individual #91, Individual #197, Individual #40 and Individual #157). Seven others were identified at MEDIUM risk (Individual #126 and Individual #311) and LOW risk (Individual #226, Individual #243, Individual #217, Individual #259 and Individual #19). Clearly SASSLC did not track or trend the incidence of pneumonia in a consistent and accurate manner nor did the existing system of risk assessment assign the risk of aspiration and aspiration pneumonia in a way that accurately reflected actual incidence and frequency of occurrence. Poor oral hygiene is a well-documented risk factor related to the incidence of pneumonia. There were 135 individuals, or 48%, of the current census who were listed with poor oral hygiene. Another 39 individuals had oral hygiene status that was "unknown" per the untitled list submitted. Approximately, 50% of the individuals who had experienced pneumonia in the last two years were also listed with poor or unknown oral hygiene status (approximately 21 individuals). <u>Weight Loss/Gain</u> As of 1/10/11, there were 31 individuals listed with BMIs at 30 or greater, placing them in the category of obese. Six of these had BMIs of over 40 (Individual #209, Individual #308, Individual #218, Individual #89, Individual #4 and Individual #85). Thirteen of the individuals with a BMI over 30 were considered to be at HIGH risk for weight issues, 14	

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		were at MEDIUM risk, and two were considered to be LOW risk (Individual #93 and Individual #272). All of the individuals with a BMI calculated to be over 40 were appropriately identified at HIGH risk with the exception of Individual #89 who was not included on the All Risk Ratings (1/1/10- Present) submitted, so his HST risk level was unknown related to his BMI of 40.3. There were 18 individuals with a BMI under 20, at least seven of who were in the underweight category with a BMI of less than 18.5. Six individuals received enteral nutrition and included (Individual #335, Individual #343, Individual #239, Individual #227, Individual #151 and Individual #317), half of who were considered underweight. Five of 20 were considered to be at HIGH risk for weight and included Individual #122 (BMI=16), Individual #343 (BMI=17.8), Individual #344 (BMI=17.8), Individual #227 (BMI=16.3), and Individual #340 (BMI=19.5). Individual #317 and Individual #216 were considered underweight with a BMI of 18.4 and 17.7 respectively, but Individual #317 was considered to be at LOW risk only and Individual #216 was MEDIUM risk. Only Individual #185 had a documented unplanned weight loss of 10% or more in six months. His HST risk rating was LOW related to weight, however. There were approximately 21 individuals overall that were considered to be at HIGH risk for weight. <u>Pressure Ulcers</u> There were eight individuals considered to be at HIGH risk for skin integrity concerns and approximately 68 at MEDIUM risk. At least nine individuals who had one or more occurrences of pressure ulcers were included on the list People with Skin Breakdown During the Last 12 Months. All were listed as healed, with the exception pressure ulcers for Individual #49 (Stage II, sacrum) and Individual #152 (Stage II, left thigh) as of 12/31/10. There was a notation that the wound for Individual #152 was not considered to be a pressure ulcer per OT/PT, though he was at HIGH risk for skin integrity issues. Five others were at MEDIUM risk (Individual #253, Individual #236, Individual #334, Individual #197, and Individual #151) and one was at LOW risk (Individual #199). Seven of the individuals who had issues of skin integrity in the last year were seated in a wheelchair as their primary mean of mobility, though mobility status for Individual #49 and Individual #323 was unknown. <u>Medical Concerns</u> The hospitalization list with discharge diagnosis submitted was for the year 2010. There were approximately 185 hospitalizations for 87 individuals. There were 23 individuals who had been hospitalized three or more times in the last year. Many of these were the same individuals identified above who had one or more PNM concerns. Some examples included: Individual #311, Individual #164, Individual #108, Individual #227, Individual	

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		#143, Individual #36, Individual #312 Individual #126, Individual #197, Individual #226, Individual #236, and Individual #40. The process for risk assessment and the role of the PNMT had been recently implemented and further review will be necessary as these two systems evolve during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team hopes that these issues will be resolved as the new systems are implemented in the near future.	
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 252 individuals identified with PNM needs and all (100%) had PNMPs. The provision of PNMPs, however, was not necessarily based on risk. PNMPs were submitted for 20 of 27 individuals who had no PNM needs. Only one PNMP was submitted for Home 766 for Individual #218. She had not been included on the list of those with PNM needs or on the list of those without PNM needs. The clinicians had reported that all individuals living at SASSLC were provided a PNMP. The PNMP contained information related to the focus, assistive equipment, communication, PNM risks, mobility, transfers, and positioning, as well as mealtime instructions and precautions. Most of the plans were dated though in some cases there was a date of initiation, date of revision and/or date of review without consistency from plan to plan. A box and/or yellow highlighting alerted staff to changes in the plan from the previous version. Most of the plans reviewed were current within the last 12 months, with the following exceptions: Individual #1 (6/25/08), Individual #196 (1/25/10), Individual #73 (1/27/10), Individual #98 (1/7/10), Individual #132 (2/2/10), and Individual #99 (6/22/09). The monitoring team considered some or all of the following criteria in choosing 25 individuals for a record sample: • Emergency Room visits • Hospitalizations • NMT Committee meeting documentation • PNMT documentation • Individuals with active pressure ulcer within the last six 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	Noncompliance

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		• 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 administration, tooth brushing, personal care and functional communication The individuals selected included Individual #311, Individual #306, Individual #122, Individual #108, Individual #164, Individual #335, Individual #239, Individual #259, Individual #126, Individual #197, Individual #243, Individual #309, Individual #19, Individual #40, Individual #211, Individual #146, Individual #54, Individual #95, Individual #208, Individual #135, Individual #127, Individual #93, Individual #227, Individual #234, and Individual #36. It appeared that the PNMPs were generally of a standardized format, though content and detail was inconsistent from plan to plan, not only related to individual differences. The PNMPs submitted for each of the 25 individuals for whom personal records were submitted were reviewed with findings as follows: • PNMPs were submitted for 25 of 25 individuals included in the sample. The sample size for PNMPs was considered to be 25 for the purposes of this review. • PNMPs for 25 of 25 individuals in the sample (100%) were current within the last 12 months. • In 25 of 25 of PNMPs reviewed (100%), mobility was addressed, though detail varied greatly from plan to plan. • In seven of the 15 PNMPs reviewed (46%) for individuals who used a wheelchair as their primary mobility, general wheelchair positioning instructions for the wheelchair were provided, though most of these were very limited. • In 24 of 25 PNMPs reviewed (96%), the type of transfer was included or there was a statement indicating that the individual was able to transfer without assistance. • In six of 25 PNMPs reviewed (24%), the PNMP listed bathing instructions beyond the number of staff required. Eleven only had instructions as to the number of staff needed for bathing or hygiene activities with no other specific strategies listed. Bathing strategies were not addressed for four individuals who had	

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		specialized bathing equipment. There were four individuals who were described as independent with mobility and transfers. • In eight of 18 PNMPs reviewed (45%), for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. The majority of instructions for the others were related to bed positioning or other instructions for head elevation but no specifically related to specific handling techniques. • In 25 of 25 PNMPs reviewed (100%), instructions related to mealtime were included, though there were 13 who received their nutrition via gastrostomy tube and as such oral intake instructions were not indicated. The plans varied with regard to specificity of instructions particularly related to bite size, pace or other staff assistance techniques. • In 23 of 25 PNMPs reviewed (92%), dining position for meals or enteral nutrition was provided. Most merely indicated that the individual was to be upright during and after meals. • In 25 of 25 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally with statements related to enteral nutrition and instructions for nothing by mouth for those with non-oral intake. • In four of 12 PNMPs for individuals who received liquids orally (33%), the liquid consistency was included. Regular liquids were specified in three of those plans. Liquid consistency was not specified for the other eight individuals. It may have been in those cases that they received regular thin liquids, but this was not specified consistently in each plan. • In 12 of the 12 PNMPs for individuals who ate orally (100%), dining equipment was clearly specified, even when the individual used regular dinner ware and utensils. • In 15 of 25 PNMPs reviewed (60%), strategies for medication administration were included. Instructions were limited to the position only, with no description of head alignment, for example. The assessments did not reflect observation of this activity and specific strategies were not included in the plans. The plan for Individual #239 stated that he should be in the most upright position for oral hygiene and medication administration under the positioning/handling section, while the other plans had a separate section for this information. • In 15 of 25 PNMPs reviewed (60%), strategies for oral hygiene were included. As stated above, instructions were limited to the position only, with no description of head alignment, for example. The assessments did not reflect observation of this activity and specific strategies were not included in the plans. The plan for Individual #239 stated that he should be in the most upright position for oral hygiene and medication administration under the positioning/handling section, while the other plans had a separate section for this information.	

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		• 25 of 25 PNMPs (100%) reviewed included a heading related to communication, though the information included was very inconsistent in content and detail. In the case that an AAC system was listed, it was referenced. Information related to vision and hearing was included in some plans. There were inconsistent balance of instructions related to expressive and receptive communication or strategies that staff could use to interact with the individual. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Recommendations from discipline specific assessments were included in the assessment portion of the PSP, including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. In most of the PSPs reviewed, there was also a section under the General Discussion Record that addressed review of the PNMP that specified changes that were indicated. The action plan also listed service objectives that included the PNMP focus, and access to the equipment listed in the plan. Unfortunately, there was no Habilitation Therapies representation as evidenced by the absence of signatures on the sign in sheet by OT, PT, or SLP for nine PSP meetings of the 25 records reviewed. Occupational therapy attended 13 meetings, speech attended six of the meetings, and PT only attended two meetings. Integration of the plan would be difficult without these clinical specialists present for the discussion. While there was language in the PSP related to the PNMP, there was no clear evidence that the PST understood and considered the interrelationship between the risk issues the individual had or the effectiveness of the supports the plan provided in mitigating risks to an individual's health and safety. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Individuals who had received PNM supports were reviewed prior to the annual PSP meeting to complete assessments/updates and to address changes needed in the PNMP. These findings were documented in the OT/PT and SLP assessment reports. Unfortunately, therapy representation at the PSP meetings was not consistent and, as such, would impact the collaborative development of the PNMP. There was evidence of PST discussion of the elements of the plan and this was observed in two PSP meetings for Individual #311 and Individual #302. The PSP process had been revised and implementation was evolving at the time of this review. It was noted that the PSTs were struggling with integration of the new PSP process and the new HST risk assessment process at that time. Further assessment of this element will be required during the next review when these two systems are more familiar to the staff and well established.	

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		Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed. There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed and recommendations for changes were made at that time as indicated. In addition, most individuals had multiple revisions throughout the year. In the General Discussion Record of the PSP, there was generally a section that included a PNMP heading. In some cases, the elements of the PNMP were outlined there, but there was no statement that the plan was accurate or effective and it did not consistently connect the elements of the plan with the identified health risks. Changes were usually listed in this section. Again as stated above, without consistent attendance by the therapy staff at the PSP meetings, comprehensive discussion and review of the plans in relation to the risk elements identified by the PST at that time would not be effective.	
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.** PNMPs and Dining Plans were developed by the therapy clinicians. Generally, the PNMP was located in a notebook in the back of an individual's wheelchair if he or she had one, or nearby otherwise. In Home 674, however, the notebooks were locked up in the Medical Records room and staff had to get them if they wanted to refer to the plan. This was done so they would not get lost, according to one direct support staff. In most cases, pictures were not available with the PNMPs though pictures were included in each Dining Plan for mealtime position and adaptive equipment. Wheelchair positioning instructions were generally not specific in the PNMPs. 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, but not specified in the PNMPs. Dining Plans were the only true point of service plans and these were readily available in the Dining Areas. Staff were observed to read the plan to a co-worker when the tray of food was delivered to the table for each individual one by one. The intent was to ensure staff read the plan, but some staff did not appear to process what they were reading. The reading of the plan tended to be more of an exercise because some staff were noted to still make some errors in implementation of the plan as written. Based on observations of individuals during meals across a variety of homes, a number of errors were noted in staff implementation of interventions and recommendations	Noncompliance

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		outlined in the mealtime plan portion of the PNMP. Some examples are presented below: • Individual #234: The Dining Plan in use was dated 12/31/09. It stated that staff should encourage her to eat independently. Staff were not able to produce the most current plan when asked. They were also to encourage fluids throughout the meal, but she had not been served any. • Individual #337: Her Dining Plan stated that staff should only fill her glass one quarter full of liquid, yet it had been filled full. She was also supposed to put her spoon down between bites but when she did not, staff did not prompt her to do this. Per her PNMP, she was to use a single message device to request more food during the meal, but this was not provided. • Individual #144: Her Dining Plan indicated that she ate and drank independently using her left hand. She was observed to eat using her right hand and drink using her left hand. • Individual #180: Her Dining Plan indicated that she was to take a drink after every third bite, but this was not done. • Individual #185: Staff did not read the instructions on his Dining Plan before beginning his meal. • Individual #255: Staff were to hold his cup to offer a sip of fluids after every one or two bites. He was noted to cough two times during the meal after three to four presentations of ground beef without the sips of fluid. Staff did not offer fluids until prompted when the monitoring team asked why that strategy was necessary. The staff tentatively stated, “aspiration.” Then when staff did begin to offer fluids, they did not wait until he had swallowed before offering a drink. • Individual #343: The Dining Plan in use was dated 1/6/09. Staff did not wait until her she had swallowed and cleared her mouth before offering another bite. The diet card also was not current within the last 12 months. • Individual #38: Her diet card was not current with the last 12 months, dated 11/25/08. • Individual #228: Staff was standing to assist her and holding her head back in hyperextension as she presented bites and sips. Presentation of food and fluid was at too fast a pace, the bites were large, and there was significant food loss. Staff commented that she knew she was supposed to sit but that she stated, “I do better standing up.” Staff had not thickened the thinner pureed foods as indicated in the Dining Plan. When asked about this, staff requested thickener. Staff also sat down on the stool after being prompted to. • Individual #212: He had a gastrostomy tube placed on 2/3/11. His diet card was dated in September 2010, but did not reflect this significant change in his nutritional status. This outdated card stated that he should receive an oral supplement if he ate less than 50% of his meal. Per the nurse, physician orders now indicated that he should get a supplement via G-tube if he ate less than 50%	

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		of his meal orally. • Individual #309: He was served a full glass of milk with graham crackers broken up into it. Staff stated they did this because he liked it that way. Her Dining Plan indicated that her glass should only be filled half full and she was on a ground diet. • Individual #267: His Dining Plan indicated that he should have an inner lip plate to assist with scooping, yet he was offered applesauce in a light weight plastic tray cup that was difficult to stabilize for scooping. • Individual #54: He used a regular spoon, with his forearm and hand rotated into pronation, holding the spoon handle with his fingertips, suggesting perhaps he would benefit from assessment for an adapted utensil. He did not use the plate guard provided as he scooped away from it. A bent straw was pictured on his Dining Plan, but was he provided a straight one that made it difficult for him to manage. When staff were asked about this, they reported that they were out of bent straws. • Individual #181: He was provided repeated verbal prompts to take smaller bites, but this was ineffective and he continued to take large bites throughout the meal. • Individual #257: He was offered honey-thickened liquid from a bowl by spoon. The liquid was prepared using the gel thickener as staff reported they were out of the pre-thickened liquids. It was not clear why these were not replaced when the inventory was noted to be low. His Dining Plan indicated that he should have a plastisol spoon to protect his teeth and gums. This spoon was used to present food, but staff used a regular metal teaspoon to present the liquids. • Individual #106: The Dining Plan in use was dated 1/28/10 (i.e., not current in the last 12 months). His Dining Plan instructed that staff were to thin down thick foods to a nectar-thin consistency. He was served thick sticky pureed foods that had not been thinned. His liquid was also to be presented from a plastisol youth spoon, but staff were using a regular metal teaspoon. • Individual #11: His diet card stated he should receive chocolate milk for his evening meal. This was not provided to him as staff reported that they were out of chocolate milk. He was also to receive Benecal as a supplement and, per staff, they were also out of this item. • Individual #204: She was observed taking very large bites. There were no precautions in her Dining Plan and staff did not prompt her or intervene. • Individual #304: Staff were observed to hold her plate under her chin while presenting food. When asked why that was done, staff responded that she got mad when she got food on her clothes and that she refused to wear a clothing protector. • Individual #347: She was observed to be leaning to the right against the arm rest during the meal. Her right arm was hanging down to the side, unsupported. Her	

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		pelvis was not back in the seat of her wheelchair and her feet were not on the foot rest. She was noted to cough throughout the meal. When staff was asked for the PNMP, she reached into the bag on the back of the wheelchair and provided the PNMP there. It was dated 8/16/10. When asked about her Individual Book, staff reported that it was in the Medical Records room. Staff placed the old plan back in the bag. Follow-up revealed that the most current PNMP was dated 1/12/11. By report, Individual #347 had an aspiration trigger sheet to be completed by staff but there were no precautions related to aspiration risk on her Dining Plan dated 1/26/11. • Individual #10: She was observed to eat at a rapid pace and to drink over four ounces of fluid in one gulp with no staff intervention. There were no precautions in her Dining Plan. • When the issue about depleted inventory of some essential items including thickened milk, honey-thickened liquids and Benecal was brought to the attention of the home manager, she reported that these items were in the store room but staff did not go there to obtain them. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Dining plans were generally out on the tables during the meals. A few staff were able to verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident. For example, when questions were asked about the rationale for certain strategies in the Dining Plans, staff responded, "Aspiration?" As described above, there were a number of errors in implementation suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served.	
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.** Per the documentation submitted, staff training for New Employee Orientation related to PNM included body mechanics, lifting and transfers (stand pivot, two person, mechanical lift), osteoporosis, pressure ulcers, gait belt use, bath chair use, bed rail use, wheelchair use, food textures, and how to read use the PNMP and Dining Plan. There were skills-based checklists for these. Per the facility response related to competency-based training for direct support staff related to foundational PNM, only .025% had been completed at the time of this review. **Standard: Competency-based training focuses on the acquisition of skills or**	Noncompliance

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		knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable. Competency-based training checklists used for NEO staff training were submitted for stand pivot transfers, two person manual lift transfers, mechanical lift transfer lifts, bathing chair use, PNMP review, and Dining Plan review. By report, inservice training for direct support staff required verbal and/or return demonstration. Further review of progress in this area will occur in subsequent onsite reviews by the monitoring team. **Standard: All foundational trainings are updated annually.** Lifting and transfer, mealtime, and communication training were updated annually after initial NEO training. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Initial staff training was conducted by Habilitation Therapies for available staff and PNMPCs. Subsequent training was conducted by PNMPCs and home managers. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. A request for completed competency based training for Dining Plans submitted (10% of individuals for each risk category related to PNM used by the state. This should have resulted in a submission of a significant number of plans. Only six plans were submitted (Individual #157, Individual #243, Individual #230, Individual #335, Individual #297 and Individual #45). Completed competency-based training sheets for each of these plans in the last 12 months were also requested. Seven completed Meal Observation Forms were submitted for only two of the seven individuals including Individual #45 (5) and Individual #157 (2). Only two of these identified the staff who had been trained. These actually appeared to be related to monitoring of the plans rather than competency-based training. **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 level of training for implementation of PNMPs for those at high risk, it was not generally performance-based, and did not require successful performance of clearly established	

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		competencies. Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. Another example was the system of aspiration trigger sheets for identified individuals recently implemented, per the new statewide At Risk Individuals policy. Specific individuals had a trigger sheet that staff were to complete, indicating if the individual experienced any signs or symptoms of aspiration. If this occurred, the direct support staff were to notify the nurse and mark the data sheet. If, at the end of the shift there had been no symptoms, then they would mark the sheet at that time. The nurse was to review the documentation and initial it. • In home 671, three of three staff who were asked about the trigger sheets knew nothing about them. • In one home, the sheets were located in the meal intake book in the Dining Room and, in another home, the sheets were located in the book where staff documented bowel movements. • In Home 671, there was no evidence that the nurses had reviewed the documentation by staff. • In Home 670, one direct support staff had documented prior to 12:30 on 1/10/11 that Individual #61 had no signs and symptoms of aspiration for the day when the end of the shift was not until 2:00. There was no evidence that this staff had been trained per the training sheets submitted. • Initialing of the sheets by nursing was inconsistently done. • One float staff very confidently explained the use of the sheet to me and named a number of individuals who had a trigger sheet. Unfortunately, as it turned out, these individuals were in her regularly assigned home, not the home where she was working on this day. In this home, she could not name anyone in the current home who had a trigger sheet. The lack of staff awareness and competency in implementing this process was of significant concern. This system designed to closely monitor those at greatest risk for aspiration was ineffective and as such these individuals continued to be at risk of harm. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** A list of competency-based training was submitted related to the following topics in Homes 665, 668, 670, 671, 672, 673, 674, and 766: • Use of gel thickener • PNMP Review Quiz • Hygiene in bed/hygiene table	

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		• Mechanical lift • Two person manual lift • Stand pivot transfer • Gait belt use • Assisting individuals in and out of vans • Dining Plan reviews • Transporting individuals who were lethargic in a wheelchair • Preparing thickened liquids in pitchers and single serve containers • Thickening Ensure • Reading Meal Plans • Dining Plan competency • PNMP competency • Dining room texture and protocols • Transferring from bed to shower trolley • Correct position for gait belts • Demonstrate correct honey liquid consistency • Competency for bathing using a shower chair • How to inflate a ROHO cushion These trainings were general training on the topic, but were not individual-specific. There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals or for pulled/float staff. Training for changes to plans were conducted by therapists, PNMPCs, and in some cases, by home managers.	
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 related to the process of PNM 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, specialized equipment use and condition, transfers, and positioning in the homes. Bathing equipment was monitored, but it was not clear that bathing was actually observed. No monitoring was completed related to medication administration or oral hygiene. 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,	Noncompliance

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		documentation, or follow-up and communication of findings. The monitoring sheets submitted were completed by the therapists only rather than the PNMPCs so it was not clear as to the frequency or consistency of the process for these staff. **Standard: All members of the PNM team conduct monitoring.** The PNMT was only recently implemented and the primary method of monitoring was limited to follow-up meetings rather than actual observation by team members. There was evidence of formal monitoring by OTs, PTs, and SLPs though it was not clear that there was a schedule based on risk level or those individuals targeted for review by the PNMP. There was no evidence that the dietitian or RN team member conducted monitoring of the PNMP. PNMP monitoring addressed implementation of the plan only. There was no system of routine review (as determined based on risk or the acute nature of health concerns) by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. **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.** This system had only recently been implemented and follow-up occurred during PNMT meetings. It did not appear that they consistently used monitoring findings in their assessments to date. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when an individual was determined to be at risk of harm. There was a check-off at the bottom of the observation forms to record observer actions. It was noted, however, that this was not used consistently and was often left blank. Based on observations by the monitoring team, there were a number of issues identified throughout this report that suggested the PNMPCs were insufficiently trained to consistently identify concerns that required attention by the therapists.	
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	**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 new health risk assessment process and the new PNMT process were only recently implemented and further review during the next onsite visit will be necessary to determine the effectiveness of these systems.	Noncompliance

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	with physical or nutritional management difficulties, and revise interventions as appropriate.	**Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Individuals with PNMPs were reviewed on an annual basis with changes in the interim generally, as indicated, loosely based on risk level. In the case that an individual participated in direct therapy, a monthly progress note was written though very few individuals received this. PNMP and Dining Plan monitoring was conducted by the therapy staff and provided an opportunity for them to consider the effectiveness of these plans. The schedule was not necessarily based on risk or need, however. PNMP monitoring was also completed by PNMPCs and, as such, these paraprofessionals would not be able to make judgments as to efficacy of the plans and to determine if there was a positive outcome related to PNM risks. Currently, there was no other system of monitoring of PNMP effectiveness for those at highest risk.	
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.** There were 50 individuals listed as receiving nutrition and hydration enterally. There was a new system as an aspect of the At Risk Individuals policy that provided a format for the annual review of those who received enteral nutrition by the PST using the Aspiration Pneumonia/Enteral Nutrition Evaluation, to be completed by 3/31/11. Evaluations completed since 1/1/11 with PSPs and Addendums were requested by the monitoring team for 24 individuals designated to receive this assessment. The new Integrated Risk Rating Form, PST signature sheet, and Aspiration Pneumonia/Enteral Nutritional Evaluation were submitted for Individual #18 (2/2/11) and Individual #311 (2/11/11). • Individual #18 had numerous PNM-related diagnoses and received all of his nutrition, hydration and medication via PEG tube via continuous drip over 23 hours. It was noted that he had remained pneumonia-free since July 2009. There was no clear statement that enteral nutrition via PEG tube continued to be medically necessary though that would be presumed given that data presented. Outcomes listed were not stated in measurable terms but indicated that he would remain free of pneumonia and complications, as well as improved oral hygiene. There was no specific action plan outlined, but rather only reference to a dental hygiene service objective. He was listed as MEDIUM risk for aspiration and respiratory compromise. • The evaluation for Individual #311 had many sections left incomplete including	Noncompliance

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		his risk level and rationale, analysis of findings, recommendations, measureable outcomes and the action plan. As this process had just recently been implemented, further review will be conducted by the monitoring team in the future. **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 that included the same elements described above. Based on a review of 25 PSPs in the individual record sample, there were 13 who received their nutrition via gastrostomy tube and nothing by mouth. 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.** There was no protocol outlined for this process, however, as all individuals were provided a PNMP and Dining Plan, these elements would likely also be provided to an individual who transitioned back to oral intake. However, competency-based training was limited so staff training may likely be limited. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** One aspect of the new At Risk Individuals policy implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times or within the last year as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nursing case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST. Only three of these assessments had been completed at the time of this review, so further assessment will be necessary by the monitoring team in the future. **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	

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		to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. PNMT assessment and review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to reason for referral, specific risk indicators and timeframes for achievement. Interventions should support achievement of identified outcomes. The PNMT should continue to monitor until the individual attains and maintains at the goal level. Assessments should be new evaluations of the individuals referred that are collaborative and integrated with all PNMT members, not merely a review of previous discipline-specific assessments. This will be more difficult as the same staff clinicians also serve as the experts on the PNMT. It will be critical to view these individuals in a new manner in order to yield new information and new intervention plans for individuals who have been referred.

2. Identify a consistent RN member of the PNMT. Nursing case managers could continue as adjunct members depending on who is reviewed.

3. It will be absolutely necessary that each team member is prepared with all of the information on each case reviewed. The PNMT should also view this process as an assessment and not merely a meeting. The initial meeting should involve the development of an action plan so that additional information may be gathered or that additional testing, trials or assessment can occur. When the PNMT reconvenes they would outline a plan to address the individual needs. Outcomes must be related to the issues that brought the individual to the attention of the team in the first place.

4. Develop a policy or at least comprehensive written guidelines related to the monitoring system.

5. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor.

6. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. While it is important that the clinicians review findings from the validation monitors with the PNMPCs, it is critical to establish a mechanism to review the overall trends and findings to drive staff training in the homes and other settings in which the PNMP is implemented. This review is an important quality improvement element.

7. Consider retaining data for deceased individuals for tracking purposes to get a true and accurate picture of risk and incidence of pneumonia, choking, etc.

8. Consider a significant increase in nutritional staff. One dietitian is insufficient to adequately meet the needs of all individuals with PNM concerns.

9. Integrate instructions for staff related to medication administration and oral hygiene in the PNMP for all individuals. If no special instructions are needed, indicate that on the plan rather than omit the section or leaving it blank.

10. Ensure that appropriate photos are a part of the PNMP to illustrate equipment and proper alignment and support. The pictures should be of sufficient size to ensure clarity of detail for staff reference.

11. Immediate attention should be given to competency-based training for implementation of the aspiration trigger sheets. Careful monitoring of this process will be necessary to track actual incidence of signs and symptoms as well as accuracy and consistency of the observations and documentation by staff.

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 Clinical Staff list and PNMT members o State license verification for clinical staff o Continuing education documentation for clinical staff o List of individuals receiving direct PT services o List of individuals with wheelchairs as primary mobility o List of individuals with transport wheelchairs o List of individuals with assistive ambulation devices o List of individuals with orthotics and/or braces o List of individuals with decubitus/pressure ulcers during the past year o List of individuals who experienced a falling incident during the last three months o List of individuals with and without PNM needs o OT/PT Assessment template o Physical Nutritional Management Wheelchair Clinic Progress Notes submitted o PNM maintenance log (1/7/11) o Habilitation Therapy Adaptive Equipment (1/5/11) o PNMPs submitted o List of individuals with direct PT o Annual assessments, PSPs, consult reports, data collection sheets and monthly progress notes for the following individuals: • Individual #146, Individual #65, Individual #268, Individual #324, Individual #331, Individual #250, Individual #323, Individual #344, Individual #93, Individual #208, Individual #255, Individual #143, Individual #300, Individual #292, Individual #39, Individual #293, Individual #189, Individual #185, Individual #268, Individual #199, Individual #72 and Individual #336. o PSPs and OT/PT Annual Evaluations for each OT and PT clinician including: • Individual #7, Individual #229, Individual #81, Individual #41, Individual #253, Individual #105, Individual #254, Individual #60, Individual #58, Individual #163 and Individual #325. o Personal Records for Sample of individuals including Sensory Skills Update, PSP and Addendums, PSP Reviews, Annual Physician Summary Evaluation, Active Medical list, hospital summaries, Health Risk Assessment, ENT consults, gastroenterology consults, orthopedic consults, integrated progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, documents in Habilitation Therapies tab, documents in Nutrition tab, documents in PNM tab, 12 month of PNMPs, 12 months of Dining Plans, three months of PNMP Observation forms and three months of Mealtime

	Observation forms for each of the following individuals: • Individual #311, Individual #306, Individual #122, Individual #108, Individual #164, Individual #335, Individual #239, Individual #259, Individual #126, Individual #197, Individual #243, Individual #309, Individual #19, Individual #40, Individual #211, Individual #146, Individual #54, Individual #95, Individual #208, Individual #135, Individual #127, Individual #93, Individual #227, Individual #234 **and** Individual #36. Interviews and Meetings Held: o Patricia Hajny, OTR, o Kelly Patrick, OTR o Retha Skinner, MS, OTR, MOT/OTR o Edward Harris, PT, DPT o Raelynn Stolowsky, PT o Various Supervisors and Direct Support Staff o PSP meetings for Roberto Gomez and Michael Benton Observations Conducted: o Living areas o Dining rooms o Day Programs o Work areas
	Facility Self-Assessment: SASSLC's self-assessment identified noncompliance for all items of this provision. This self-assessment was consistent with the monitoring team's assessment of noncompliance. The plan submitted was very limited and will not serve as an effective guide to ensure completion of action steps for compliance.
	Summary of Monitor's Assessment: Changes in leadership and key staff on extended medical leave presented significant challenges for this department over the last six-month period. They should be commended for their hard work and dedication during that time. OT caseload size was 93.67 and PT caseload size was 140.50, which was excessive to ensure appropriate attention to assessments and to provide adequate supports and services to address chronic concerns, acute issues, and to promote skill acquisition. There were approximately 90% of these individuals presented with identified PNM needs. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMPs, and responding to any additional needs as they came up for each individual on their caseload. Annual assessments/updates were completed by OT and PT collaboratively. These caseloads were too high to permit adequate coverage to sufficiently

	identify needs and meet them appropriately. Generally, health and safety issues were addressed, but little to no interventions to address potentials for skill acquisition had been developed. A plan to provide a comprehensive assessment every three years with an update in the interim years for those who received supports and services was in place. The clinicians reported that they were "catching up" on evaluations that had not been completed for a while. The assessment format had been revised in the last one or two months to incorporate health risk assessments and to address supports required to address these. The clinicians were developing measurable health risk goals in the assessments, but had not yet consistently focused on skill acquisition outcomes for those who would benefit. Movement skills were included and level of independence was usually addressed. Descriptions, however, were often more generic than specific. Specific information would offer more useful information to the clinicians and other team members, such as day program staff, for training or active treatment purposes. The description of fine motor skills was usually much more limited. There was generally a review of health and medical status included in the health status section of the OT/PT assessment and a thorough review of relevant consults and diagnostic testing that had occurred in the past, particularly in the last year. Efforts to identify the rationale for these supports were noted, though these were scattered throughout the report and there was no comprehensive analysis of findings that included both health and medical concerns, with functional skill abilities and potentials for the development of an integrated therapy intervention plan. There was a new PSP and risk assessment process that should result in changes in the way this is addressed in the clinical evaluations completed by OT and PT. There were very limited intervention plans developed beyond the PNMPs, however, when an action was identified as necessary to address a more acute issue, the plans that were implemented were appropriate and generally well documented. The scope of service, however, was limited to a handful of individuals only and the goals were not measurable as written. Justification for continued therapy or discharge was not well justified as a result. The plans were not integrated into the PSP via addendums and were not reviewed routinely by the PST. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. Other than the limited evidence of direct intervention for only a few individuals at the time of this review, the primary support provided was via the PNMPs. PNMPs included staff instructions or precautions in the areas of assistive equipment, mobility, transfers, movement techniques, and positioning for wheelchairs, positioning/handling in a wheelchair or bed and during bathing and mealtime. Medication administration and oral hygiene were addressed for only 98 of the approximately 280 PNMPs submitted for review. The instructions for these, however, were vague and addressed only that the individual should be upright for both. Pictures illustrating assistive equipment and how the individual should be aligned or supported in that equipment were not available for any of the PNMPs reviewed in the homes. The focus of the PNMP was listed, but did not clearly relate to the health risk system in place at the facility. There was a new system implemented as of 1/1/11 and this should drive the need to revise the plans to accurately reflect the identified risks for each individual. Though equipment generally was available, implementation by staff was not consistently performed as

	intended per the PNMP or per generally accepted practice. There were very few pictures with the written PNMPs to serve as visual guides for staff to improve compliance with implementation guidelines. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. In general, however, it appeared that there were improvements in staff attention to the details of proper positioning and compliance with the PNMPs compared to what was observed during the previous onsite review. Transfers observed were completed appropriately. A trend analysis of monitoring results had been conducted across the months of October 2010, November 2010, and December 2010 to examine compliance of positioning in general, positioning for enteral nutrition, protection of feet, lifting procedures, and availability of equipment. Compliance was listed as 100% in Home 672 and improvements were noted in Home 668 across all three months. Decreases in compliance with these basic elements were noted in Homes 670, 671, and facility wide from November 2010 to December 2010. There was no documentation of actions taken to address these findings. This was an excellent start, but better validation of the completion of the forms used for monitoring was indicated to ensure the integrity of the analysis conducted.

#	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.** OT and PT staffing levels remained essentially unchanged since the previous review by the monitoring team. OTs included Patricia Hajny, OTR, Kelly Patrick, OTR, and Retha Skinner, MS, OTR, MOT/OTR. These clinicians were full time state employees. PTs included Edward Harris, PT, DPT, and Raelynn Stolowsky, PT, as part-time contract staff. Ms. Stolowsky worked 20 to 24 hours a week and Mr. Harris generally worked 32 hours per week. There were no OT or PT assistants employed at SASSLC, though there was one unfilled PTA position by report. There was one therapy technician. The Director of Habilitation Therapies, Margaret Delgado-Gaitan, MS, CCC-SLP, retired from state employment in September 2010. Patricia Hajny, OTR, served as interim director at that time and so had dual responsibilities in that position and in her role as a staff OT. Ms. Delgado-Gaitan returned as Director in December 2010, but was out on leave as of 1/11/11, by report. Again, Ms. Hajny served as interim director at that time. Ms. Delgado-Gaitan had not yet been cleared to return to work full time, but was present for a couple of brief meetings during the week of this review. In addition, Kelly Patrick, OTR, was out on leave for 23 days in January 2011. These events presented significant challenges for this department over the last six month period. They should be commended for their hard work and dedication during that time. There were no OT or PT assistants employed at SASSLC. There was one therapy technician.	Noncompliance

#	Provision	Assessment of Status	Compliance

		No evidence of current licensure was submitted for any of the therapists. Online verification was obtained for three of the five clinicians. There was no evidence of a valid license for either Retha Skinner or Raelynn Stolowsky. A resume for Edward Harris, PT, was submitted, but not for the other therapy clinicians. Mr. Harris presented with appropriate credentials and a diverse 10 year background in physical therapy. He had obtained a clinical doctorate in August 2008. His experience with developmental disabilities appeared to be limited to SASSLC. It was not possible to adequately review credentials for the other clinicians at this time.
		
		A list of continuing education was submitted with participation as follows:
		• Retha Skinner, MS, OTR
		  o PNMT Introduction Wound Investigation (2.0 contact hours)
		• Patricia Hajny, OTR
		  o PNMT Introduction Wound Investigation (2.0 contact hours)
		  o 20th Annual Habilitation Therapies Conference (12.0 contact hours)
		• Kelly Patrick, OTR
		  o PNMT Introduction Wound Investigation (2.0 contact hours)
		  o 20th Annual Habilitation Therapies Conference (12.0 contact hours)
		• Edward Harris, PT
		  o PNMT Introduction Wound Investigation (.10 CEUs)
		  o 20th Annual Habilitation Therapies Conference (1.2 CEUs)
		• Raelynn Stolowsky, PT
		  o Texas Ethics and Professional Responsibility (2.0 CEUs)
		  o Ready Bodies, Learning Minds (1.1 CEUs)
		
		Fabrication of seating systems continued to occur 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. By report, there had only been one fabricator from September 2010 to January 2011. During that time, one technician addressed repairs and maintenance only. At the time of this review, there were two full time fabricators/technicians. There was no documentation submitted as evidence of training, experience, or other qualifications for the fabrication staff.
		
		There were seven Physical Nutritional Management Plan Coordinators (PNMPCs). There had been some interruption in service due to medical leave for some of these staff since the previous onsite review.
		
		While not all individuals who lived at SASSLC required direct therapy, every individual	

#	Provision	Assessment of Status	Compliance
		had a PNMP and, as such, annual assessments were provided to each as well. Essentially, this plan was provided to every individual at SASSLC even those who were fully independent for mobility, had no specialized adaptive equipment, and had no mealtime related concerns or other physical/nutritional management needs. Based on a list of PNM needs submitted, 252 individuals were identified. Another 27 individuals were listed without PNM needs. This total did not exactly coincide with the current census of 281, but approximately 90% of the individuals living at SASSLC presented with identified PNM needs. Based on the reported census, the OT caseload size was 93.67 and PT caseload size was 140.50 which was excessive to ensure appropriate attention to assessments and to provide adequate supports and services to address chronic concerns, acute issues, and to promote skill acquisition. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload. Annual assessments/updates were completed by OT and PT collaboratively. Based on review of the records submitted, there were at least 49 out of 55 (89%) individuals with identified needs related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. None of the individuals were listed with direct OT services. Twenty-two received direct PT services. Others received indirect services via the PNMP and the provision of assistive equipment and/or orthotics. **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** OT/PT assessments were completed as a more discrete measure of status rather than screenings for most individuals, though screenings were submitted dated 5/21/08 for Individual #208 and 12/1/09 for Individual #122 rather than a comprehensive evaluation or update. Generally, the assessment was a combined OT/PT Comprehensive Assessment and, in some cases (for at least seven individuals), the SLP also contributed to this assessment as well. Approximately 40 of the current assessments (within the last three years) submitted were identified as comprehensive, 12 were identified as updates, and one was identified as an addendum to her comprehensive evaluation dated11/11/10 (Individual #72). There were also two adaptive equipment reviews (Individual #309 and Individual #54, dated 8/11/09)) and one special needs update (Individual #93). There was no comprehensive evaluation or update submitted for Individual #309 or Individual #54, though a comprehensive evaluation was competed for Individual #54 on 7/29/10. The special needs update was dated 9/29/10 as a result of a hip fracture and was	

#	Provision	Assessment of Status	Compliance
		described as an update to an OT/PT evaluation previously completed on 6/8/10. This other evaluation was not submitted. Six individuals were listed as admitted since the previous review through 11/10/10. Records for these individuals were not requested. By report, all assessments were completed within 30 days of admission. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period. There was no formal system to track specific referrals generated by the PST or via PNMP monitoring through to resolution. Based on the sample of assessments reviewed, 55 out of 57 (96.5%) of individuals had a current OT/PT assessment. Additional discipline-specific assessments were completed on a referral or consult basis for specific issues. These were generally completed well within the 30-day timeframe and, most often, in only a few days after referral or identification of need. Some examples included: • Individual #40: Referral date was not documented, but there was reference to a hospital admission on 12/24/10 – 1/22/10 for pneumonia and again on 1/30/10 for respiratory distress. A PT consult was documented on 2/3/10 to evaluate transfers and functional mobility. • Individual #127: Referral date was not documented, but there was reference to limping following a fall. He was transported to the ER on 1/6/11 and diagnosed with a left knee contusion. A PT consult was documented on 1/20/11. By report, earlier assessment had not been possible due to Individual #127's non-compliance and agitated behavior. • Individual #146: Referral date was not documented, but there was reference to seizure activity with subsequent fall and laceration of his right elbow. A PT consult was documented on 10/18/10. A previous consult was dated 6/10/10 to evaluate the stability of his gait following another fall with injury requiring two staples. • Individual #208: Referral date was not documented, but there was reference to left leg limp with diagnosis of bursitis on 6/18/10. By report, he received direct PT at that time, though there was only one progress note in the integrated progress notes dated 6/28/10 and no other documentation in the Habilitation Therapies section of his record. A subsequent consult was dated 9/28/10 again for left leg limp.	

#	Provision	Assessment of Status	Compliance
		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. All individuals received an OT/PT assessment on an annual basis even if they had not required supports or services during the previous year. These were identified as either an OT/PT Comprehensive Assessment (37) or Habilitation Therapies OT/PT Update (5). The format of these was nearly identical and it was unclear why one was considered an update while another was considered to be a comprehensive evaluation. A plan to provide a comprehensive assessment every three years with an update in the interim years for those who received supports and services was in place. By report, the clinicians were "catching up" on evaluations that had not been completed for a while. • Individual #208 only had an OT/PT screening rather than evaluation, dated 5/21/08. He was reported to present with functional motor skills, though he required verbal and physical assistance with daily living activities. He was provided a PNMP to elevate the head of his bed and to address diet texture modifications and adaptive equipment. According to the census list, he had been recently admitted to SASSLC, so this appeared to be a new admission assessment and was not of the quality consistent with other assessments completed for other individuals. It was not clear why he had received only a screening at that time. Though he did not require direct therapy, he was provided a PNMP and Dining Plan with adaptive mealtime equipment. There was no evidence of a subsequent assessment, though there was a one-page addendum to an OT Comprehensive Evaluation, dated 4/20/10, which reflected review of his Dining Plan and adaptive equipment. This was inconsistent with the other annual updates provided to other individuals. A comprehensive evaluation was not submitted as present in his personal record. There was reference to an OT/PT evaluation in his PSP dated 5/26/10. The date of the evaluation was also listed as 5/26/10. After the onsite review, the facility reported that an updated evaluation after comprehensive was done on 7/1/10 and again on 9/29/10. • Individual #122 was also provided an OT/PT screening dated 12/1/09 following his admission to SASSLC. He also was reported to present with functional motor skills, but was provided a PNMP and Dining Plan to ensure his safety and independence while eating and drinking. The screening did not indicate that further evaluation was not indicated, yet there was no evidence of a subsequent evaluation in 2010 despite receiving indirect supports via these plans. • Individual #259 had received an Annual Evaluation dated 3/30/10 that was of a similar format to the Comprehensive Evaluation and Updates submitted for other individuals.	

#	Provision	Assessment of Status	Compliance

		The assessment format was revised in the last one or two months to incorporate health risk assessments and to address supports required to address these. The clinicians were developing measurable health risk goals in the assessments, but had not yet consistently focused on skill acquisition outcomes for those who would benefit. Each of the assessments had been completed prior to the PSP staffing date, generally two weeks to one month prior to the annual meeting.
		
		In one case, there was a Special Needs Update evaluation to an OT/PT evaluation completed on 6/8/10 related to a change in status, as Individual #93 had a hip fracture on 7/1/10. This was of the same format as the comprehensive evaluations. Per this report, Individual #93 was readmitted to SASSLC on 7/23/10 following hip surgery and an admission to Warm Springs Rehabilitation Hospital from 7/7/10 to 7/23/10. He also experienced skin breakdown on his buttocks documented 8/24/10. An orthopedic consult on 8/16/10 had cleared him for ambulation as tolerated, six weeks after his surgery. There were progress notes in the integrated progress notes section of his personal record on 7/7/10, 7/23/10, and 7/27/10. The latter entry referenced a PT evaluation, but it was not in his record. He was to begin direct PT at that time, three times a week, to improve the efficiency of his transfers. The next entry was on 8/9/10, when it was reported that PT would resume with consideration for his limitations. There was no documentation describing his progress related to these interventions or why therapy had been discontinued. Monthly progress notes for August 2010 to December 2010 were present in the Habilitation Therapies section of his record. The OT/PT Special Needs Update did not occur until 9/29/10 nearly three months after this serious injury.
		
		The most recent OT/PT Comprehensive Evaluations and Updates included the following sub-headings:
		• Diagnosis
		• Health Status
		• Health Risk Levels
		• Relevant Consults and Diagnostics
		• Medications
		• Communication
		• Behavioral Considerations
		• Nutritional Management
		  o Reflux Medications
		  o Current Weigh
		  o Monthly Weight
		  o Lab Work
		  o Diet
		• Oral Motor/Feeding	

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		- Dining Observation - Physical/Positioning Considerations - Oral/Developmental Abnormalities - Oral Control/Equipment - Feeding Techniques or Dining Precautions • Physical/Occupational Therapy - Reflexive/Orthopedic Abnormalities - Muscle Tone/Strength - Skin Integrity - Upper Extremity Range of Motion - Lower Extremity Range of Motion - Mobility/Locomotion - Summary of Physical Therapy Intervention - Foot Assessment - Transfers - Wheelchair - Hand Function - Sensorimotor Function - Activities of Daily Living • Physical management Plan (PNMP) - Focus • Assistive Equipment • Annual Recommendations Each of the assessments reviewed contained most of these same headings and, as such, addressed movement, mobility, range of motion, independence, and functional status. The clinicians did not consistently document functional examples of systems level findings, such as range of motion, strength, and muscle tone. Observation of activities outside of the clinic setting was not consistently documented. This limited the clinicians' ability to identify potential for skill acquisition and therapy consultation for program development in these areas. Observation of fine motor skills was generally limited and interventions or programs to address deficits in this area were not noted in any case reviewed. Observations during mealtimes, however, were generally conducted. The monitoring team requested that the five most current assessments completed by each therapist with the associated PSPs be submitted. OT/PT Comprehensive Assessments were submitted for the following individuals: • Individual #41 (11/18/10 and 11/29/10) • Individual #349 (11/23/10) • Individual #105 (12/14/10)	

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		• Individual #253 (12/9 and 12/13/10) • Individual #254 (12/21/10) • Individual #250 (11/23/10 and 11/30/10) • Individual #58 (1/4/10, date appeared to be incorrect based on PST date given) • Individual #81 (12/9/10) • Individual #325 (12/6/10) • Individual #163 (12/21/10) • Individual #7 (12/14/10) • Individual #229 (12/9/10) • Individual #60 (12/16/10) • Individual #72 (11/11/10) PSPs for these individuals were also requested. A number of the PST meetings had been held from 1/5/11 to 1/25/11 and were not yet available for this document request. All other PSP submitted were current as submitted. Individual records were also requested for a sample of 25 individuals and assessments were submitted as follows for: OT/PT Comprehensive Assessment • Individual #234 (12/7/87 and 11/16/10) • Individual #146 (8/26/10) • Individual #197 (9/28/10) • Individual #306 (4/19/95) • Individual #54 (7/29/10) • Individual #243 (7/7/10) • Individual #127 (8/19/10) • Individual #227 (10/5/10) • Individual #239 (10/21/10) • Individual #40 (11/10/99 and 11/2/10) • Individual #135 (1/24/11) • Individual #311 (1/12/10) • Individual #126 (7/14/10) • Individual #309 (7/28/10) • Individual #19 (5/25/99) • Individual #335 (9/23 – 9/27/10) OT/PT Annual Update • Individual #164 (5/4/10)	

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		• Individual #40 (11/3/09) • Individual #36 (2/25/10) • Individual #306 (1/12/10) • Individual #211 (7/22/10) • Individual #108 (5/4/10) • Individual #95 (9/27/10) • Individual #19 (7/28/09 and 7/19/10 and addendum to correct weights 7/19/10) Habilitation Therapies Special Needs Update • Individual #93 (9/29/10) OT/PT Annual Evaluation • Individual #259 (3/30/10) OT/PT Adaptive Equipment Review • Individual #54 (8/11/09) • Individual #127 (8/24/09) Adaptive Equipment Review • Individual #309 (7/8/09) Habilitation Therapy OT/PT Screen • Individual #208 (5/21/08) • Individual #122 (12/1/09) PT Evaluation • Individual #234 (12/31/87) • Individual #135 (3/11/85) OT Comprehensive Evaluation • Individual #135 (3/11/85 and 3/26/85) Sensory Integration Evaluation • Individual #306 (4/8/99) Addendum to OT Comprehensive Evaluation • Individual #306 (2/28/05) • Individual #227 (10/14/07) • Individual #135 (4/6/04 and 4/12/05)	

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		• Individual #208 (4/20/10) Addendum to OT Adaptive Equipment Evaluation • Individual #306 (2/2/06) • Individual #135 (2/17/06) Addendum to OT/PT Comprehensive Evaluation • Individual #40 (11/15/01) Current annual PSPs were submitted for 25 out of 25 individuals, with addendums also submitted in some cases as present in the personal records. Documentation for those who received direct PT (22) was requested by the monitoring team. No one was listed as receiving OT services at the time of this review, though information was submitted for two individuals as an aspect of their individual record for Individual #243 and Individual #239, each monthly progress notes from OT interventions through 12/3/10. Assessments were submitted as follows: • Individual #292 (11/30/10) • Individual #323 (8/30/10) • Individual #72 (11/11/10) • Individual #331 (6/2/10) • Individual #199 (3/9/10) • Individual #255(7/1/10 to 7/26/10) • Individual #236 (11/2/10) • Individual #293 (7/9/10) • Individual #65 (6/9/10) • Individual #39 (3/12/10) • Individual #344 (7/26/10) • Individual #146 (8/26/10) Habilitation Therapies Annual Update • Individual #268 (1/26/10) • Individual #189 (4/23/10) • Individual #324 (3/19/10) • Individual #143 (4/20/10) • Individual #300 (3/9/10) • Individual #336 (9/16/10) Approximately 49 out of 55 (89%) assessments reviewed described individuals with	

#	Provision	Assessment of Status	Compliance
		significant movement disorders and limitations in self-care and/or functional skills. The following comments and concerns were also noted based on the documents submitted that would likely require supports and interventions by OT and/or PT. There were: • 252 (90%) individuals identified with PNM needs per the list submitted. • 158 (56%) individuals identified as non-ambulatory or requiring assistance for ambulation. • 122 (43%) individuals who used a wheelchair as a primary means of mobility. • 36 (13%) individuals who used assistive equipment for ambulation. • 29 (10%) individuals who used transport wheelchairs as needed. • 15 (5%) individuals with upper or lower extremity orthotics and/or braces. • At least 72 individuals who experienced falls from 1/1/10 to 12/31/10. At least 20 individuals had three or more falls during that period and 19 of these falls resulted in serious injuries for 15 individuals. Individual #211, Individual #146, Individual #71, and Individual #39 each experienced two serious injuries related to falls. Individual #211, Individual #7, Individual #122, Individual #261, Individual #344, Individual #106, Individual #318, and Individual #39 each had four falls. Individual #209 had five falls and Individual #146, Individual #302, and Individual #254 each had six falls. Individual #4 experienced at least nine falls in a 10-month period. Individual #93 sustained a hip fracture secondary to a fall that was not listed with the others. • 13 individuals who sustained an injury resulting in a fracture with nine of these related to a due to a slip, trip or fall or were related to a transfer. • 79 individuals considered at high or moderate risk of skin integrity issues; eight individuals had one or more incidences of pressure ulcers/skin breakdown in the last year. • 16 individuals listed with contractures. • 33 individuals considered to be at high or moderate risk for GI concerns, and 36 were at risk for choking. Appropriate alignment and support would be important for each of these individuals. • 29 individuals considered to be at high or moderate risk of osteoporosis. It was noted that only 22 individuals had received direct PT services and only two had received direct OT services, including Individual #243 and Individual #239. The PT interventions related to gait training, walker training, range of motion, and progressive exercise training. OT services for two individuals focused on passive range of motion and skin hygiene related to contractures in the hands or elbow. Justification for why other individuals did not require some level of intervention beyond the PNMP, particularly to address skill acquisition, was not clearly justified in the assessments in most cases. Many received only indirect supports via annual assessments, PNMPs, or dining plans.	

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		In general, an initial OT/PT Comprehensive Evaluation was completed for each individual upon admission, though in two cases only a screening was completed as identified above for Individual #208 on 5/21/08 and Individual #122 on 12/1/09. After admission to SASSLC, a subsequent annual assessment for each individual was to be completed and was referred to as an update. While the assessments were improved from the previous onsite review, there continued to be some issues related to these. For example: • There was a significant amount of health data reported in the assessments, but no evidence of a comparative analysis of health and functional status from the previous year. • There was little to no discussion of potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • There was no analysis of findings that was based on the data reported compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. For example, in the case of Individual #250, it was reported in his Comprehensive Evaluation, dated 11/23 and 11/30/10, that he was able to ambulate 205 feet with maximum assistance of one or two staff. There was no indication as to whether this was a change from the previous year. He was reported to participate in active PT during the last three months and had made progress related to improved strength and gait deviations, but was not generally cooperative. There were no statements related to his goals or objectives, or his specific progress toward achievement of these. The progress notes submitted for him identified PT goals as the following: • Will walk independently and safe with or without an assistive device on even surfaces. • Will be able to transfer independently and safe. These were not measurable in the sense that there were no clearly stated criteria identified unless the outcome was intended that he would complete these tasks one time only. The progress note for December 2010 stated that he had not made any progress toward his goals and was refusing to participate. It was not clear why the assessment stated that he had made progress, but the note stated he had not, and there was no mechanism for progress to have measured increments of change. Direct PT was discontinued at that time, however, he was still included on the schedule for active PT services submitted with the document request. Both a new PSP process and Health Risk Assessment process were in development and would likely further impact the OT/PT assessments over the next year.	

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		Per the Health Care Guidelines, the comprehensive assessment should address the following: • **Movement;** • **Mobility;** • **Range of motion;** • **Independence; and** • **Functional Status across each of these areas (Health Care Guidelines, VIII.B.2)** Range of motion was generally addressed and specific range of motion measurements were provided with a comparison across evaluations in previous years. Descriptions of the individual's posture in a variety of positions was usually very limited and most often described in sitting or, in some cases, standing. Movement skills were included and level of independence was usually addressed, however, descriptions were often more generic than specific. Specific information would offer more useful information to the clinicians and other team members for training or active treatment purposes. The description of fine motor skills was usually much more limited. For example, in the case of Individual #250, it was stated only that he had all mature grasps and pinches. There was no discussion of reach, functional manipulation, or release. It was reported that he required verbal prompts and some physical assistance for completion of daily living activities, so essentially, his actual level of participation was with specific tasks was not known. The evaluation for Individual #163 reported that she demonstrated all gross and fine motor grasps, had "good" in-hand manipulation, and "good" hand strength. No functional examples of this were reported. **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.** PT consults were consistently noted for a number of the individuals reviewed. The date of referral was not included in the consult reports, so it was not possible to assess the timeliness of these. In some cases, there was a reference to the consult in the integrated progress notes by the PT. Contacts were routinely documented there by PT and monthly progress notes related to direct intervention were written, but included in the Habilitation Therapies section of the personal record. These objectives were not included as SPOs in the PSP and, as such, documentation was not included there. A comprehensive evaluation was noted for only one individual, Individual #93, related to a change in status. As stated above, he had a hip fracture on 7/1/10. The OT/PT Special Needs Update did not occur until 9/29/10, nearly three months after this serious injury.	

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		Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment. In the case of Individual #58, it was stated under the lower extremity range of motion section of her Comprehensive OT/PT Evaluation, dated 1/4/10, that there were reports of increased difficulty with hygiene activities. There was no evidence of further assessment of this concern within this evaluation and there was no recommendation to further explore or to address this concern. Her PNMP stated that she had "very fragile bones." This was not identified as a concern in this comprehensive assessment and the plan did not outline specific strategies for staff. She was listed at LOW risk for osteoporosis per the HST health risk screening. The assessments consistently described the seating system components for individuals, though rarely was there a specific statement that the system was or was not meeting the individual's needs. For example in the case of Individual #325, his comprehensive evaluation, dated 12/6/10, stated that he had an HTR wheelchair frame with a high profile ROHO cushion and a custom contoured back with a lap belt for safety and positioning. By report, a head rest was added on 10/11/10 for support cited as important for mealtimes to keep his head upright. There was no statement in the report to reflect how well that was working for him. In most cases, individuals were seen multiple times throughout the year and issues related to their seating were addressed in PNMP clinics and documented in wheelchair clinic review notes. Recommendations for additional assessment were occasionally noted in the evaluations or updates submitted for review. Again in the case of Individual #58, however, her wheelchair was described as large and difficult to move and maneuver, yet the recommendation was only to evaluate her equipment as needed with no specific intent to address this identified concern. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** There was generally a review of health and medical status included in the health status section of the OT/PT assessment and a thorough review of relevant consults and diagnostic testing that had occurred in the past, particularly in the last year. Efforts to identify the rationale for these supports were noted, though these were scattered throughout the report and there was no comprehensive analysis of findings that included both health and medical concerns with functional skill abilities and potentials for the development of an integrated therapy intervention plan and to provide a foundation for non-clinical supports and programs. There was a new PSP and risk assessment process	

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		that should result in changes in the way this is addressed in the clinical evaluations completed by OT and PT. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together, though issue specific consults were generally discipline-specific. In some cases, the SLPs participated in the assessments to address communication and oral motor and dysphagia issues. They appeared to work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized 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.** Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and was updated as needed due to a change in status. Eight of the plans submitted were not current within the previous 12 months including Individual #345 (2/5/10), Individual #73 (1/27/10), Individual #132 (2/2/10), Individual #99 (6/22/09), Individual #218 (1/7/10), Individual #196 (1/25/10), and Individual #1 (6/25/08). One plan did not have an individual's name, but rather only the case number 139 and was dated 6/22/09. Changes were identified by a symbol and/or highlighted text on the plan to alert staff to a change from the previous version. **Standard: Within 30 days of development of the plan, it was implemented.** As there were very limited intervention plans developed beyond the PNMPs, this element was not in compliance. Generally, however, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30 day period. These did not involve a PSP addendum, though documentation by the clinicians was consistent in most cases and documentation was in the form of monthly progress notes and not a part of the PSP monthly or quarterly reviews. For example: • Individual #208's PST met on 6/11/10, 6/15/10, and 6/16/10 to discuss a limp and swelling in his knee. He had x-rays that ruled out fracture, though the limping and swelling were reported to be worsening. On 6/16/10, the physician ordered a PT evaluation, Motrin for pain, and a wheelchair as needed. A PT consult was provided, five days later. It was reported at that time that he had been diagnosed with bursitis on 6/18/10. There were no further PSP addendums to address the recommendation for PT two times weekly or to further review his	Noncompliance

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		status. There was a subsequent PT consult on 9/28/10 for Individual #208. There was no PSP addendum related to this to address the recommendation for treatment for a limp and bursitis in his left leg. A Monthly Progress Note was written by the PT for interventions provided in October 2010, November 2010, and December 2010. PT was to monitor his gait for one additional month prior to discharge. The note for January 2011 was not available when the document request was prepared for submission. • A PT consult was provided to Individual #146 on 6/10/10 at which time direct PT was not indicated, but the PT was to monitor his gait for two weeks to ensure his safety. There was no evidence that this had occurred in monthly progress notes or in the integrated progress notes in his personal record. On 10/18/10, a second consult was completed to evaluate and treat after a fall resulting in a laceration of his left elbow. It was recommended that he begin active PT treatment at that time. There were progress notes written for November 2010 and December 2010 related to this intervention. The intervention began on 10/18/10, though there was no progress note submitted for October 2010. As of 1/5/11, it was reported that he had met his goals and that PT was to be discontinued at that time. • There was a monthly progress note dated 9/8/10 which indicated that Individual #93 had participated in PT for at least 30 days. There was no consult report or other documentation to justify why this had been initiated and when. Direct therapy intervention continued through 1/5/11 at which time PT was discontinued. It was reported at that time that he had participated in therapy for six months, had reached a plateau, and was no longer making progress. Intervention was to continue with the therapy technicians two times weekly for sit to stand transfers and ambulation. The Special Needs Update dated 9/29/10 reflected that a PT evaluation post hip fracture and subsequent surgery had been completed on 7/27/10 at which time direct PT was recommended three times weekly to improve mobility and transfers. There were no progress notes submitted for August 2010. On 7/16/10, there was a PSP addendum meeting to determine his Medical High Risk classification. The only condition identified was seizure activity and it was reported that he was medically stable at that time despite a fall with serious injury on 7/1/10, hip surgery on 7/3/10, and admission to a rehabilitation hospital on 7/7/10. Though his PSP was dated 7/22/10, three weeks after this fall, there was no mention of this incident or subsequent significant medical concerns in his PSP. It was not until 8/3/10 that there was mention of the injury during another medical high risk meeting at which time conditions of seizure activity and injury were identified. Subsequent PST meetings were held on 8/4/10 that stated he was receiving daily PT, but the training objectives related to therapy were not stated. There were plans for him	

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		to return to his original home in 668 the following week. Other than the medical high risk meetings held on 9/14/10 and 10/14/10, there were no additional PST meetings to discuss his progress relative to PT until 10/19/10 at which time it was reported that he continued with daily PT and that he was finally to return to his home that day. There was no evidence that PT had attended any of these PST meetings. There was no evidence of further PST meetings after 10/19/10. • Individual #127 had a PT consult on 2/23/10 following hospitalization from 1/21/10 to 2/9/10. He was status post colostomy. Active PT was recommended eight times a month to increase his strength and endurance. The service objective was "to restore Individual #127's ability to be a safe and functional ambulator." He was to gain strength, stability, and endurance to resume his prior level of independent function, though what that entailed was not outlined in the consult report. There was no monthly progress note to reflect when intervention began or to document his progress. The first note was dated 4/2/10 reflecting interventions provided in March 2010 with subsequent monthly progress notes through 6/30/10 at which time he was discharged from PT. He independently ambulated 1000 feet at that time and was deemed to be safe. The goal on that date was stated to "be able to ambulate independently and safe at home and at work." There had been no measurable goal established at the onset of this intervention, but rather the clinician arbitrarily determined that 1000 feet was adequate and he was discharged. There was no evidence that Individual #127 had been observed in both his home and work environment as would be indicated by the stated goal. A subsequent PT consult was noted on 1/20/11 and PT was to resume after a fall resulting in a left knee contusion. PT intervention was to be provided two times a week to increase his strength and endurance with gait. Stated goals included (1) transfer from sit to stand independently and safe and (2) walk independently and safe on even surfaces. Again, these goals were not measurable because they were missing the details of performance criteria. No monthly notes were completed at the time of this onsite review. His PSP dated 9/23/10 stated that he walked short distances independently, but with standby assist as needed. He used a wheelchair for long distances. **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.** As stated above, there were 22 individuals listed as participating in direct PT at the time of this onsite review. A review of the documents submitted, however, suggested that at least 14 of these had been discharged, so that only four individuals received active PT	

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		intervention and two were on what was referred to as maintenance programs. Others received indirect services via the PNMP and the provision of assistive equipment and/or orthotics. Goals/objectives were identified related to skill acquisition with each of the interventions, but they were all written in a manner, such that the described skill was only required to be demonstrated one time for achievement. There were no other criteria to establish the frequency or consistency of performance expected. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. PT interventions were limited to the four individuals identified, OT intervention for two individuals, and maintenance programs for two others. PT treatment was generally designed to address gait, ambulation, and transfers with some for range of motion. The OT intervention was designed to promote skin hygiene for hands and elbow crease due to contractures and range of motion. Those plans that were implemented were appropriate and generally well documented, however, the scope of service was limited to a handful of individuals only, and the goals were not measurable as written. Justification for continued therapy or discharge was not well justified as a result. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. As stated above, it was reported in her comprehensive assessment that there had been increased difficulty with hygiene activities for Individual #58. There was no evidence of further assessment of this concern within this evaluation and there was no recommendation to further explore or to address this concern. Her PNMP stated that she had "very fragile bones." This was not identified as a concern in this comprehensive assessment and the plan did not outline specific strategies for staff. She was listed at LOW risk for osteoporosis per the HST health risk screening. PNMPs included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and positioning for wheelchairs, positioning/handling in a wheelchair or bed, and during bathing. Medication administration and oral hygiene were addressed for 98 of the approximately 280 PNMPs submitted for review. The instructions for these, however, were vague and addressed only that the individual should be upright for both. In some cases, in Home 673 and 674, level of upright was specified such as upright in wheelchair to 45 degrees or 30 degrees or as upright as possible. These instructions, however, did not address head alignment or support in any case. There were	

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		mealtime instructions and adaptive mealtime equipment listed consistently with precautions as indicated. In many cases, this was left blank rather than clearly stating that the individual did not have any special precautions. There was a very brief communication section. A list of assistive equipment was consistently provided in the plan. The focus of the PNMP was listed but did not clearly relate to the health risk system in place at the facility. There was a new system implemented as of 1/1/11 and this should drive the need to revise the plans to accurately reflect the identified risks for each individual. **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 assessments generally provided a brief rationale for the equipment recommended for use. Pictures were rarely provided for staff reference as to details for alignment and support. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans, though these were generally well documented with a consult, daily data collection sheets and monthly progress notes. Goals were identified for each intervention, but as stated above, these were not generally measurable with performance criteria clearly outlined. Monthly documentation described progress, but without a clear baseline and/or specific measurable goal this was well justified. As a result, the decision to continue therapy or discharge was not well supported. **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 person's status, transition (change in setting), or as dictated by monitoring results.** In the case that an individual received direct therapy, monthly progress notes were written and a daily data collection sheet was maintained. Routine reviews of the PNMP were conducted on an as needed basis upon referral or based on the findings of scheduled or requested monitoring. There was evidence that some plans were reviewed quarterly by the licensed clinicians but this was not clearly documented in the personal records.	
P3	Commencing within six months of the Effective Date hereof and with	**Standard: Staff implements recommendations identified by OT/PT.**	Noncompliance

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	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.	Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standard of care. There were very few pictures with the written PNMPs to serve as visual guides for staff to improve compliance with implementation guidelines. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair. Some additional examples included the following: • There were numerous instances where staff did not remove or loosen a gait belt when the individual was seated. These belts remained tight around the trunk or, in some cases, the belt was loose enough for comfort in a seated position, but staff did not tighten the belt for assisted ambulation. A few examples included Individual #71, Individual #267 and Individual #294. • Individual #144 was seated in a wheelchair that was to remain at the Developmental Center and was intended for home use, though her wheelchair was being repaired. • Individual #238, Individual #30, and Individual #35 were seated in wheelchairs that did not appear to be appropriately customized for them. • Individual #126 was not positioned back into his wheelchair properly and there was a very loose strap across his lower legs that did not appear to serve any apparent purpose. • Individual #248 was seated in a significant posterior tilt and his head was positioned well below his head rest. • Individual #243 was seated in her wheelchair and her head was positioned well below her head rest. • An individual in Home 674 was seated in his wheelchair. His hips were in extension and he was not well supported in the seat. • Individual #22's legs were elevated, but were not adequately supported. There were no pictures with the PNMP to guide staff how to provide this support. • In home 674, the first PNMPs reviewed (five out of five) did not have PNMPs with pictures for staff reference. • The wheelchair for Individual #200 was very dirty. • Individual #328 was observed with her head on her wheelchair tray during day program. The staff reported that she was always in that position. • Individual #347 was observed during a meal with her feet not supported on the foot rests and she was not positioned back in her wheelchair. She was leaning to the right against the armrest and her right arm was hanging unsupported on the side. Staff did not assist to reposition her. • In the sensory room at the Developmental Center, most of the individuals were transferred to a recliner for their day program activities. For many, this did not	

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		appear to provide optimal alignment or support for functional activities. This impacted freedom of movement, trunk alignment, and ability to visually attend. There was no evidence that assessments had been conducted to determine a positioning schedule to correspond with the activities presented in the day program area. There also was no evidence that the clinicians had included observations in these areas as an aspect of their evaluations to determine potential for skill acquisition related to movement. In general, however, it appeared that there were improvements in staff attention to the details of proper positioning and compliance with the PNMPs compared to what was observed during the previous onsite review. Transfers observed were completed appropriately. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** Transfers and lifting training offered in New Employee Orientation (NEO) was competency-based. Competencies were clearly outlined for bathing using a shower chair, mechanical lift transfer, two person lift, stand pivot transfer, and gait belt use. Lifting was the only PNM-related area for which retraining was provided at the time of this review. Staff were required to take this retraining every two years. Per the POI, in the case that direct OT or PT interventions were transferred to Habilitation Therapy technicians or direct support staff, inservice training was conducted and competency-based training was provided as indicated. Individual-specific training was reported to be competency-based. Therapy staff provided inservice to available direct support staff and home managers or supervisors who in turn provided training for additional staff. None of this was submitted with the therapy intervention documentation or was included in the personal records for anyone reviewed. As described above there was no mechanism to ensure the only staff who were competency-trained were assigned to work with individuals at highest risk. Pictures illustrating assistive equipment and how the individual should be aligned or supported in that equipment were not available for any of the PNMPs reviewed in the homes. Pictures in the PNMPs should be large and clear enough to highlight detail for staff because this serves as a cue or reminder for staff of the critical components of the prescribed supports. **Standard: Staff verbalizes rationale for interventions.**	

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		In the examples above, staff were not consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was also not consistently included in the PNMP related to specific strategies. This is an important aspect of staff training as well as monitoring and coaching. The focus of the PNMP highlighted the overall risk issue for the individual as a rationale for the plan, but detail as to why a specific strategy was used was not consistently indicated on the PNMP.	
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 system for monitoring was revised and implemented beginning on 10/6/10. The forms used were revised to clearly outline availability of the PNMP and whether the individual was supported and aligned as intended as well as the condition of the equipment. A section related to observer actions noted that the concern was corrected, that on the spot training occurred, the home manager was informed, that equipment was taken for repair or adjustment, or that further training was scheduled as indicated. A trend analysis had been conducted across the months of October 2010, November 2010, and December 2010 to examine compliance of positioning in general, positioning for enteral nutrition, protection of feet, lifting procedures, and availability of equipment. Compliance was listed as 100% in Home 672 and improvements were noted in Home 668 across all three months. Decreases in compliance with these basic elements were noted in Homes 670, 671, and facility wide from November 2010 to December 2010. There was no documentation of actions taken to address these findings. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** Since the majority of monitoring was conducted by PNMPCs, it was primarily limited to availability and condition of equipment as well as staff implementation, rather than efficacy of the interventions in the PNMPs. The frequency of monitoring was not driven by level of risk, though this will continue to be modified as the new risk assessment process is implemented. The licensed clinicians conducted monitoring for individuals to also assess for efficacy of supports via the PNMP. Monitoring sheets for the month of December 2010 were submitted for review. It was noted that there were 33 completed forms submitted for 26 people during that month by OTs and PTs. In 10 cases, there was no action required and in 12 instances the monitor did not indicate whether action was taken or required. In 12 cases, the clinician corrected	Noncompliance

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		the issue, provided on the spot training, notified the home manager, took the equipment to the wheelchair shop, or other actions as needed. The forms identified where observation took place, such as the bedroom or dining room, but did not document which home. The time was recorded and the activity observed, but not the name of the staff working with the individual. • In the case of Individual #8, it was reported that her shoes were too big and on the wrong feet. There was no action documented to address this concern. • Individual #92's lap belt was too loose, but no action was documented. • Individual #152's lap tray was missing, but there was no action documented by the monitor to address this. • Individual #311's head of bed was not elevated sufficiently. It was stated that he had three episodes of pneumonia since May 2010. The OT corrected the bed position, however, this was not marked as an observer action and, as such, would not have showed up in a data system if there was one in use. **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 were no policies or guidelines to address the monitoring process. Procedures were communicated to staff via inservice training. There was no formal method to validate PNMPCs to ensure consistency. There was no formal analysis of findings to identify and track trends or to drive staff training. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored as an aspect of the individual specific monitoring conducted by PNMPCs. There was no tracking however to determine if this covered all staff who were responsible for implementation of PNMPs. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** As described above, however, these were not well integrated with the PSP process. Documentation was maintained in the Habilitation Therapy section and did not generally occur in the integrated progress notes and status of these plans was not included in the quarterly QMRP reviews submitted or included in the PSPs or addendums. **Standard: For individuals at increased risk, staff responsible for positioning and**	

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		transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff . There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. Specific examples were described in section O above. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no standardized method to document action on findings from the PNMP monitoring through to problem resolution. The new physical management observation form did provide a place for the monitor to check actions taken but no means to review if those were effective was in place as yet. **Standard: Data collection method is validated by the program's author(s).** Only direct treatment plans were implemented and the data was reported in a daily progress note and monthly summary. As more programs are developed for implementation by direct support staff, a system of data collections sheets with review and analysis by the therapy clinicians will be necessary to track progress on a routine basis. Validation of the accuracy of data collection should be a critical aspect of this review. This should be well-integrated into the PSP process. Further assessment in this area will be needed during future onsite reviews by the monitoring team.	

Recommendations:

1. Ensure more in-depth consideration of the POI in the future in order to ensure that it will serve as an effective guide for completion of actions steps toward compliance.

2. Integrate new risk assessment process into the OT/PT assessment, in the development of intervention/support plans, as well as to guide monitoring and staff training needs. Risk indicators should be considered in a more integrated manner throughout the report. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations.

3. Address skill acquisition in the OT/PT assessment. More discreet task analysis and observation generally will yield greater specificity, laying a better foundation for potentials for learning and the design of implementation programs and plans.

4. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports. All PNM-related risk issues must be considered when assigning needed frequency of PNMP and mealtime monitoring.

5. Integrate direct and indirect supports into the PSP through the development of SPOs that included measurable goals with performance criteria.

6. Medication administration and oral hygiene should be a standard category on each PNMP. Greater detail than only a statement that the individual should be upright would be indicated in many cases. It would be necessary for the clinicians to observe these activities in order to discern other details that would be important to include in the PNMP. When there are no special instructions in any area there should be some indication that it was not applicable rather than merely omitted or left blank.

7. 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. These same steps could be applied to training techniques and skills as well.

8. Consider use of therapy assistants and more therapy technicians to ensure that supports and services are readily available to those who require it.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ DADS Policy #15: Dental Services, dated 8/17/10 ○ SASSLC Dental Operating and Procedure Manual ○ SASSLC Health Services - Dental/Medical Sedation and Restraint, 9/15/10 ○ SASSLC Policy Dental Desensitization and Restraint ○ Facility census containing the date of last annual dental exam ○ SASSLC Dental Data (September 2010–January 2011) • Refused dental services • Tooth extractions • Dental emergencies • Preventive dental care • Restorative dental care • Annual dental exam • Initial/Comprehensive exam • Sedation ○ Dental records for the individuals listed in Section L ○ List of pretreatment sedations, dosages, route and plans ○ List of sedation consents and status ○ List of interventions for persons with missed appointments ○ Specific Program Objectives – Dental Interviews and Meetings Held: ○ James P. Fancher, DDS, PhD, Dental Director ○ Amy Jo Weimer, RDH ○ Leroy Quintanilla, RDH ○ Carmen Mascarenhas, MD, Medical Director ○ Daisy Ellison, MA, Psychology Services Coordinator Observations Conducted: ○ Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated noncompliance with both provision items. Observations of clinics, interviews with the staff, and reviews of many documents indicated that progress has been made in both of these provision items.

	Significant problems were noted regarding the use of pretreatment sedation and a lack of desensitization plans. Suction toothbrushes were limited to those individuals with tracheostomies. The monitoring team must currently agree with the facility's self-assessment of noncompliance.
	Summary of Monitor's Assessment: The dental clinic opened in September 2010 in a limited space with one operatory. Basic dental services were provided and all individuals had been to clinic to attempt an initial and/or annual exam. Failed appointments were problematic and this was truly significant given the large percentage of individuals with poor hygiene ratings. The dental director had carefully drafted and implemented desensitization strategies and those were ongoing. Many individuals who had failed strategies were in need of assessments for formal desensitization plans. No desensitization plans had been developed because no formal functional assessments had been completed. Special supports for those at high risk for aspiration were needed. At the time of the onsite visit, suction toothbrushes were being utilized only for those individuals with tracheostomies. There were others who would likely benefit from this support.

#	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 dental department staff was overseen by a fill time dental director who was appointed in April 2010. The other department staff included a full time dental hygienist and a part time (.8 FTE) hygienist. Dental services were provided by the San Antonio State Hospital until the end of August 2010. The facility's "bridge" clinic was opened on 9/1/10 to allow for provision of dental services until a definitive location could be identified and renovated. The bridge clinic was a single room located within cottage 637. This space provided room for one operatory, essential equipment, and a charting area for the hygienists. The atmosphere of the clinic was closed and a meeting of the monitoring team and dental staff within the space was difficult. In spite of the challenge of the physical plant, clinic staff managed to see individuals and provide dental services. All individuals at the facility had been seen for an initial/annual assessments in dental clinic, although several individuals had not completed these assessments. The clinic provided routine, preventive, and restorative services. Restorative services were limited to routine fillings. The dental director reported that emergency consultation services were available on a 24-hour basis. After normal business hours, the primary care physician was responsible to evaluate the individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		and consult with the dentist as needed. Individuals who required immediate treatment were referred to the local emergency department. According to the Dental Services Policy, "the dental department performs basic/primary dental services as needed and may provide elective services in certain situations." The policy stated that the scope of care provided was divided into two general classifications of dental treatment: primary dental services and elective dental services. Primary services included dental examination and diagnostics, radiographic examination, prevention, emergency care, acute disease management, periodontal treatment, extractions, restorative treatment, endodontic treatment, and biopsies. Elective treatment included complex tooth replacement, complex endodontic, dentures, crowns, treatment for aesthetical reasons, and orthognathic surgery. The number and types of services provided in the SASSLC dental clinic are provided in the table below.	

SASSLC Dental Clinic September 2010 – December 2010	
	No. of Individuals n=279
Annual Exams	236 (84.5%)
Incomplete Annual Exams	42 (15%)
Overdue Annual Exam	1 (.35%)
Procedure	No. of Individuals
Extractions	3
Dental Emergencies	8
Preventive Dental Care	124
Restorative Dental Care	4

The data presented are inclusive of all procedures started since the clinic opening in September 2010. The number of extractions was essentially the same as the number of fillings. The restorative treatments (four) were all fillings, indicating a limited amount of basic restorative services, and no complex restorative services were provided. When questioned by the monitoring team about the number and types of services provided, the dental director indicated that the physical space alone prohibited performing some procedures and that it would not be possible to use anesthesia equipment in the current location.

#	Provision	Assessment of Status	Compliance
		In June 2010, the dental department implemented the use of suction toothbrushes for individuals with tracheostomies. The monitoring team inquired about the use of suction toothbrushes for other high-risk individuals, such as those with complete enteral nutrition or other risk for aspiration. The dental director reported that (a) there was no good evidence in the literature to support the value of suction toothbrushes and (b) the facility had difficulty identifying who was actually at risk for aspiration. The facility had not clearly identified criteria for use of the suction toothbrushes. During a follow-up discussion with the medical director, she reported that the facility clearly identified those at risk for aspiration and that information was forwarded to the dental clinic.	

The following data were submitted during the onsite review for facility oral hygiene ratings:

Facility Hygiene Ratings (%) N=279		
	December 2010	February 2011
Good	5	7
Fair	24	29
Poor	48	44
Unknown	13	10
Edentulous	10	10

During discussions wit the dental director and dental clinic staff, the dental director expressed the opinion that oral hygiene was a "universal problem" at SASSLC. He believed this was due to several factors, but primarily due to a lack of oral care in the homes. Although employees received instruction during orientation and residential supervisors were updated, it was his opinion that the direct care professionals lacked knowledge related to oral hygiene and were fearful about using supports for positioning to achieve proper hygiene.

He also reported that many appointments were incomplete due to the inability to obtain consent for procedures. The consent process was labeled as "broken" due to a lack of a consistent HRC chair and problems with a QMRP lead. He reported that consent was still needed for some individuals who were identified as needing treatment back in September 2010 and October 2010. The medical director was aware of these issues and he believed that she was doing all that she could to achieve resolution.

#	Provision	Assessment of Status	Compliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	Dental Policies and Procedures The facility implemented a comprehensive set of dental policies and procedures, including dental staff regulations and bylaws, dental services, informed consent, dental restraints and desensitization, infection control, and conscious sedation. Failed Appointments Failed appointments included refusals, no shows and other episodes where the individual did not complete keep a scheduled appointment. Data related to failed appointments, provided during the onsite review, are summarized below:	Noncompliance

Summary of Onsite Document Request Failed Dental Appointments				
	October	November	December	January
Refused		6	1	6
No Show		13	8	9
Ill		0	2	2
Outing		2	0	0
Work		1	1	0
No Staff		0	3	0
Off Campus		0	0	1
Total Failed Appointments	20	22	15	18

Dental schedules were sent to all homes, supervisors, QMRPs, and team leaders by the Thursday of the week prior to the scheduled appointment. The dental clinic contacted the nursing stations of each home by 7:30 am as a reminder of scheduled dental appointments. The dental director stated that reports of missed appointments were sent monthly to home supervisors and QMRPs. Two emails dated 11/2/10 and 2/8/11 were provided to the monitoring team as evidence of communication with the PST.

- In one response from a PST member from home 670, the responder acknowledged that the record was not available due to the responder's failure to sign out the integrated record.
- Another appointment was missed due to a lack of staff.
- The responder also indicted that direct care professionals in the home 670 had all been re-in serviced on the importance of getting individuals to dental clinic regardless of staffing issues.
- The responder also mentioned that Individual #174 would not be able to attend dental clinic the next day due to problems obtaining consent for treatment.

#	Provision	Assessment of Status	Compliance
		<u>Dental Restraints</u> The facility reported that five individuals received pretreatment sedation for a total of six episodes in December 2010. The facility temporarily halted all chemical and physical restraints on 8/1/10. The Restraint Reduction Committee Meeting held on 10/15/10 documented that the this was done to: • Allow time to establish procedures and policies for use • Allow all patients being seen to evaluate status and ability to be treated with or without restraints and • Establish a baseline to work from The policy "Dental Desensitization and Restraint" detailed the continuum of behavioral supports, physical restraints, and chemical restraints. It provided progressive steps that could be employed to successfully manage individuals who displayed oral aversions, behavioral management problems, or physical problems that limited the ability to have routine dental care. The policy specifically stated that all individuals should be considered for participation in a desensitization program whenever behavior management was required and no one was ever considered permanently unable to benefit from the desensitization program. Several examples of specific program objectives to achieve adequate oral care were reviewed. In spite of well-written policy and procedure and attempts at strategies to minimize failed appointments, there were still some 50 to 70 individuals that needed sedation to complete treatment due to failed dental strategies. These were the individuals who needed assessment for appropriateness of desensitization plans. The director of psychological services reported that there were no formal desensitization plans in place during the onsite visit nor had anyone undergone the assessments to determine the appropriateness of desensitization plans.	

Recommendations:

1. The facility must accelerate the plans to open a dental clinic. The current physical space is not adequate and more than one operatory is needed in the clinic in order to provide the services.

2. Additional staff is needed in the clinic. The current flow of data and information requires personnel for better information management.

3. The facility must address the problem of oral care provided in the homes. Consideration should be given to providing training updates directly to all direct care staff. Improving oral are in the homes may result in a diminished need for frequent visits to the dental clinic.

4. The facility should develop a home oral hygiene program. The facility currently has dental hygienist 1.8 FTE and one operatory in clinic.

Consideration should be given to using the .8 FTE hygienist for teaching and training about oral care and oral hygiene in the homes.

5. The facility must address the issue of failed appointments. This will need to be a collaborative effort between the dental clinic, the PSTs and residential services. The dental clinic should address failed appointments. The clinic should submit in writing a letter which states the appointment missed. The QMRP along with the PST should provide a reason for the missed appointment as well as strategies to complete the appointment. A timeframe for return of this document to dental clinic should be specified. This process should be codified into operational procedure.

6. Consideration should be given to expanding the use of the suction toothbrushes and chlorhexadine to other individuals who are at high risk for aspiration pneumonia such as those individuals who receive total enteral nutrition.

7. The facility should ensure that the procedures implemented related to desensitization plans are implemented.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **<u>Documents Reviewed</u>:** o Clinical Staff list and PNMT members o CVs for Margaret Gaitan, MA, CCC-SLP, Allison Block-Trammell, MA, CCC-SLP and Roland Hoffmann, MS, CCC-SLP o State License verification for clinical staff o Continuing Education documentation for clinical staff o SASSLC POI o Communication Tracking Sheet (1/6/11) o Communication Audit- New (1/4/11) o List of Individuals Receiving Direct Speech Services o AAC Evaluation Priority Screen o Comprehensive Communication Evaluation template o Communication Devices list (1/6/11) o Communication Dictionaries submitted o Five PSPs and Communication Evaluations for each speech clinician including: • Individual #89, Individual #234, Individual #265, Individual #43, Individual #239, Individual #228, Individual #7, Individual #257, Individual #282, Individual #190 o Annual communication assessments, program objective plans and documentation for individuals participating in direct speech therapy including: • Individual #31, Individual #112, Individual #255, Individual #335 o Personal Records for Sample of individuals including Sensory Skills Update, PSP and Addendums, PSP Reviews, Annual Physician Summary Evaluation, Active Medical list, hospital summaries, Health Risk Assessment, ENT consults, gastroenterology consults, orthopedic consults, integrated progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, documents in Habilitation Therapies tab, documents in Nutrition tab, documents in PNM tab, 12 month of PNMPs, 12 months of Dining Plans, 3 months of PNMP Observation forms and 3 months of Mealtime Observation forms for each of the following individuals: • Individual #311, Individual #306, Individual #122, Individual #108, Individual #164, Individual #335, Individual #239, Individual #259, Individual #126, Individual #197, Individual #243, Individual #309, Individual #19, Individual #40, Individual #211, Individual #146, Individual #54, Individual #95, Individual #208, Individual #135, Individual #127, Individual #93, Individual #227, Individual #234, Individual #36 <u>Interviews and Meetings Held</u>: o Allison Block-Trammell, MA, CCC-SLP o Roland Hoffmann, III, MS, CCC-SLP o Melissa Garcia, MA, CCC-SLP

	o Various supervisors and direct support staff o PSP meetings for Individual #302 and Individual #311 Observations Conducted: o Living areas o Dining rooms o Day Programs o Work areas
	Facility Self-Assessment: SASSLC's self-assessment identified noncompliance for all items of this provision. This self-assessment was consistent with the monitoring team's assessment of noncompliance.
	Summary of Monitor's Assessment: During a group interview with the monitoring team, the speech staff reported that not all individuals who needed AAC and other communication supports and services received them at the time of this review. Overall, there were at least 160 individuals living at SASSLC who were identified as nonverbal or minimally verbal and were not considered to be functional communicators in a variety of contexts and environments (Priority 1 and 2). They would generally be considered to have significant communication limitations with likely potential to benefit from AAC supports and services. A comprehensive assessment had been provided to all of those individuals identified as Priority 1 (100%), as well as 39% of those identified as Priority 2, 52% of those identified as Priority 3, and 30% of those identified as Priority 4. There were a number of individuals who had not received a communication assessment in up to 21 years. Overall there were approximately 62 individuals that appeared to have no current communication assessment and another 57 who had not received a communication assessment in five or more years. At the time of this onsite review, it was reported that not all individuals with a need for an AAC system had been identified to date. Per the Communication Tracking Sheet there were approximately 43% of individuals who were identified with potential to benefit from AAC, who actually had some type of AAC system. There was generally very limited focus on expansion of communication skills or new skill acquisition. There were only a few home-based SPOs recommended and SPOs for only four individuals who participated in direct speech services though these were not integrated into the PSP. The majority of the AAC systems were portable and intended to be functional in a variety of settings. There continued to be a number of these, however, that were specific to a particular setting, such as work or the dining room. A number of devices had to be mounted as many of the initial devices were previously lost. It will be critical that all staff take on responsibility for taking care of the AAC systems issued to individuals to ensure substantial compliance with this critical element of the Settlement Agreement. During observations there were only a few devices that were observed in use.

	Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. They presented pictures and cards to individuals while they described them verbally. The staff were to be commended for their diligent efforts, but many of these activities lacked real meaning or function. The time spent would have been better if the focus had been on activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**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 review, SLP staffing was as follows: • Allison Block-Trammell, MA, CCC-SLP • Roland Hoffmann, III, MS, CCC-SLP • Melissa Garcia, SLP Ms. Block-Trammell and Mr. Hoffmann were full time state employees and the other clinician was part-time contract since 2/1/11. Her contract allowed for a maximum of 33 hours weekly. The audiology position had not been filled, so was shifted to a position for an additional SLP. A potential candidate had previously committed to the position, but had developed health issues and subsequently declined. There was a contract audiologist one day a month. No speech assistants were employed at the time of this review and there were no established positions for assistants at SASSLC. The therapy aide was also the administrative assistant for the OT, PT, and speech departments. Margaret Delgado-Gaitan, MA, CCC-SLP, was the Director of Habilitation Therapies, but did not carry an active communication services caseload. No evidence of current licenses (0/4) was submitted for any of the speech clinicians. Resumes for Ms. Block-Trammel, Mr. Hoffman, and Ms. Delgado-Gaitan were submitted. The resume reviewed for Ms. Block-Trammel did not reflect her employment at SASSLC, but rather indicated that she currently worked at for the Karnes City Independent School District in Falls City, TX. Participation in a 14 hour course, titled “Issues in Evaluation and Treatment of Individuals with Developmental Disabilities” in September 2010 was documented for	Noncompliance

#	Provision	Assessment of Status	Compliance
		both Mr. Hoffmann and Ms. Block-Trammell. It was unclear, however, if this was related to communication. While participation in additional continuing education was listed for both, these courses were related to physical/nutritional management rather than communication or AAC. Each of these clinicians had also attended the Texas Assistive Technology Network Statewide Conference in June 2010 for a total of 15 hours each as reported in the previous monitoring report for August 2010. There were two full-time clinicians and one part time clinician (approximately .83 FTEs) responsible for the communication and mealtime needs of the 281 individuals living at SASSLC. This was an increase in staffing since the previous review, however, adequate and appropriate communication services were not provided for the individuals who presented with significant communication deficits at SASSLC as outlined below. **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.** 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 During a group interview with the monitoring team, the speech staff reported that not all individuals who needed AAC and other communication supports and services received them at the time of this review. A spreadsheet dated 1/6/11 was submitted and included 280 individuals of whom 46 were listed as Priority 1, that is, those who were nonverbal and/or had behavioral concerns (at least 17% of the individuals listed on the spreadsheet). This was consistent with the numbers reported during the previous review in August 2010. The clinicians had projected at that time that they would be able to complete the remaining Priority 1 evaluations by the end of the calendar year 2010. During this review, they reported that this had actually been accomplished only as of 2/1/11 because one of the clinicians had been on leave for an extended period during that time. By report, 47 individuals classified as Priority 1 had been assessed. The new contract SLP had just begun working at SASSLC on 2/1/11 and had not been available to assist with this. There were nine individuals who had received a communication assessment in	

#	Provision	Assessment of Status	Compliance
		2008 and were then due for re-evaluation in 2011, per the Master Plan. There were at least 24 of these individuals currently listed with an AAC system. Individual #287 and Individual #24 also had environmental control devices for a TV or radio. One had a community-use AAC device available to them in a common area. Two others had environmental control devices only. Further, it was reported that there were 113 individuals identified as Priority 2 (112 were listed on the spreadsheet submitted) or approximately 40% of the individuals living at SASSLC. There were 44 assessments completed for these individuals in the last three years (39% of the total needed). Four of these individuals had received a communication assessment in 2008 and were then due for re-evaluation in 2011, per the Master Plan. There were at least 35 individuals listed with no previous communication assessment and nine others with previous assessments as many as 21 years ago including Individual #30 (2001), Individual #136 (1999), Individual #116 (1989), Individual #167 (2005), Individual #62 (1997), Individual #342 (2007), Individual #77 (1996), Individual #86 (2006), and Individual #334 (2003). Per the spreadsheet submitted, 21 individuals currently had some type of AAC and Individual #141 also had an environmental control device (radio and switch on his wheelchair). Three others had access to a community-use AAC device in a common area of their home. There were nine individuals with environmental control only. There were approximately 35 individuals identified as Priority 3, 18 of who had received communication assessments in the last three years (52% of the total needed). There were four individuals who had received a communication assessment in 2008 and were then due for re-evaluation in 2011, per the Master Plan. One was past due in 2010 (Individual #95). Nine individuals had no previous communication assessments. There were seven individuals with previous assessments as many as 19 years ago including Individual #313 (1996), Individual #220 (2004), Individual #298 (1997), Individual #99 (2001), Individual #206 (1992), Individual #194 (1991), and Individual #193 (2000). Sixteen of the individuals listed as Priority 3 currently had some type of AAC system and included Individual #31, Individual #119, Individual #205, Individual #269, Individual #191, Individual #199, Individual #333, Individual #178, Individual #204, Individual #122, Individual #144, Individual #95, Individual #224, Individual #211. One had an environmental control device only (Individual #310). There were approximately 84 individuals listed as Priority 4, 25 or 30% of who had received communication assessments in the last three years. Three individuals had received a communication assessment in 2007 and per the Master Plan had been due for re-evaluation in 2010. There were 41 individuals with previous assessments from five to 18 years ago. There were 19 individuals who had yet to receive an assessment at all.	

#	Provision	Assessment of Status	Compliance
		Only Individual #22 and Individual #275 were listed with AAC. Overall there were approximately 62 individuals that appeared to have no communication assessment and another 57 who had not received a communication assessment in five or more years. Records of 25 individuals were reviewed as well as communication-related assessments for another 10 individuals. This included individual records requested: Individual #311, Individual #306, Individual #122, Individual #108, Individual #164, Individual #335, Individual #239, Individual #259, Individual #126, Individual #197, Individual #243, Individual #309, Individual #19, Individual #40, Individual #211, Individual #146, Individual #54, Individual #95, Individual #208, Individual #135, Individual #127, Individual #93, Individual #227, Individual #234, and Individual #36. Also assessments requested for individuals who received direct speech services included Individual #31, Individual #112, Individual #255 and Individual #335. A sample of communication assessments was requested from each clinician: Individual #7, Individual #89, Individual #43, Individual #282, Individual #257, Individual #265, Individual #190, Individual #239, Individual #228, and Individual #234. There was no evidence of a communication assessment in the individual records submitted for six individuals (Individual #197, Individual #54, Individual #335, Individual #164, Individual #259 and Individual #309). In the case of Individual #335, an assessment was submitted related to the request for those who received direct speech services and as such was available for review by the monitoring team. Assessments submitted for another seven individuals were not current and included the following Individual #243 (8/12/94 and 4/16/97), Individual #227 (8/23/00 and 2/27/95, these were also incomplete as submitted), Individual #126 (8/3/94), Individual #127 (2/20/92), and Individual #146 (9/21/05). Most of the assessments reviewed indicated that the individuals presented with significant communication deficits. Eight individuals were reported to be at least partially verbal with some level of expressive and/or receptive communication skills, though most of these were minimally functional in a variety of contexts and environments per their assessments. Three others presented with some level of functional AAC use to communicate expressively (Individual #31, Individual #112 and Individual #335). Individual #211 appeared to use sign language as a functional means of receptive and expressive communication. Per their assessments or the Communication Tracking Sheet, 78% of the individuals reviewed (27/35) were identified as nonverbal or minimally verbal with significant expressive and/or receptive language deficits. The other eight individuals were	

#	Provision	Assessment of Status	Compliance
		identified as verbal, though in some cases, this appeared to also be minimal as in the case of Individual #282, Individual #31, and Individual #255. The assessments for most of these individuals also identified concerns related to functional communication across contexts and environments (Individual #282, Individual #89, and Individual #40), communication-related behavior concerns (Individual #255 and Individual #122), limitations related to intelligibility (Individual #31, Individual #19, Individual #311, and Individual #255) and/or discrepancies between receptive and expressive language (Individual #255 and Individual #89). It appeared that 18 of the 25 (72%) individuals for whom current assessments were submitted were recommended for specific communication supports and services designed to improve or augment existing language and communication skills. Direct speech services were recommended for only two individuals (Individual #335 and Individual #112) in the 25 current assessments submitted and reviewed. Home-based training objectives were recommended for Individual #239, Individual #190, Individual #228, and Individual #265. There was no evidence, however, that SPOs designed and monitored by SLPs with implementation by technicians, day program staff, or direct support professionals were in place to expand or enhance existing communication skills for any of the individuals reviewed. Training objectives were also recommended for Individual #255 and Individual #31, though it was not specified in the assessment as to whether these would be provided through direct services by a SLP or would be also home-based. These two individuals, however, were identified as receiving direct speech therapy on the list submitted. Environmental control was recommended for Individual #239 and Individual #40. It was of concern that only 1% (4/281) of the individuals living at SASSLC received direct communication services (only 2.5% of those who were considered to be nonverbal or minimally verbal). General recommendations for exposure to communication folders and/or voice output devices were recommended for several others. Supports related to sign language were recommended for Individual #122 and Individual #211. Individual #89 was verbal and bilingual and it was recommended that staff who were also bilingual be assigned to work with him. Only Individual #7 had no recommendations for communication supports other than the identification of her Communication Dictionary that described nonverbal ways she expressed how she felt, what she wanted, and what she liked or disliked. There was nothing to enhance or support expressive communication via AAC. As stated above, there were five individuals for whom no communication assessment was submitted. No AAC was listed as provided to Individual #54, Individual #309, Individual #197, Individual #259, or Individual #164 on the Communication Tracking Sheet.	

#	Provision	Assessment of Status	Compliance
		Overall, there were at least 160 individuals living at SASSLC who were identified as nonverbal or minimally verbal and were not considered to be functional communicators in a variety of contexts and environments (Priority 1 and 2). They would generally be considered to have significant communication limitations with likely potential to benefit from AAC supports and services. Per the Communication Tracking Sheet, there were approximately 69, or only 43% of individuals who had potential to benefit from AAC who had some type of AAC system. Eighteen of these individuals were listed as Priority 3 and 4. Assessment had ruled out AAC for a number of individuals, but in some cases, the rationale for this was inadequate because the assessment did not reflect a comprehensive review of alternatives or sound clinical reasoning and, furthermore, most did not recommend training objectives to promote or enhance communication skill acquisition. There were at least 69 individuals who were considered Priority 2 who had yet to receive an assessment to determine their AAC needs. The types of AAC systems included the following: • Voice Output devices (10), object boards (2), object rings (4), picture boards (4), picture communication books (10), communication folders (6), picture rings (1), picture schedules (1), picture schedule rings (1), picture sign language boards (1), sign language books (2), picture sign folders (2), picture sign books (1), Say It Play It devices (2), communication wallets (6), communication posters (4), four button output devices (2), three button output devices (1), Twin Talk devices (1), Big Talk devices (3), Cheap Talk 4 devices (2), Cheap Talk 8 devices (2), 32 message communicator devices (1), communication dictionaries (1), GUS laptop computer devices with head switch (1), lap tray communication boards (2), Small Talk devices (3), and tactile activity boards (1). These systems were widely varied, included both low and higher tech systems, and appeared to be individualized. Many were designed to be available to individuals across environments. In some cases, two or three systems were available in specific environments. For example: • Individual #177 had a communication wallet, with a communication picture board available at work and a poster in the activity room of his home. • Individual #174 had a communication book, a picture folder related to reflux precautions and a 32-message communicator device. • Individual #240 had a voice output device available in his home and another in his work environment. • Individual #95 had a picture schedule ring and a picture schedule in her bedroom. A number of others had systems that were limited to a specific environment only. For	

#	Provision	Assessment of Status	Compliance
		example: • Individual #252 had a poster mounted in the activity room of his home. • Individual #257 and Individual #280 had devices available to them only in the dining rooms of their homes. Others only had community use devices available to them and included Individual #91, Individual #256, Individual #268 and Individual #149. Eight homes had community use devices available and included 674, 665, 670, 672, 671, 668, 766 and 673.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Standard: All individuals in need of AAC were identified as being in need of AAC.** The five most current SLP assessments with the related PSPs were requested by the monitoring team. Assessments were submitted as follows: • Ron Hoffmann, MS, CCC/SLP o Individual #7 (12/22/10) o Individual #89 (11/29/10) o Individual #43 (12/7/10) o Individual #282 (12/27/10) o Individual #257 (11/30/10) • Allison Block Trammell, MA, CCC/SLP o Individual #265 (9/7/10) o Individual #190 (10/13/10) o Individual #239 (11/8/10) o Individual #228 (9/9/10) o Individual #234 (11/30/10) PSPs were submitted for only seven of these individuals: Individual #234 (12/2/10), Individual #265 (9/9/10), Individual #43 (12/16/10), Individual #257 12/2/10), Individual #239 (11/9/10), Individual #228 (10/12/100 and Individual #89 (12/8/10). No PSPs were submitted for Individual #7, Individual #282, or Individual #190. There were additional assessments submitted as part of the sample records request and included the following: • Individual #311 (2/9/09) • Individual #306 (4/15/95) • Individual #122 (12/6/10) • Individual #108 (6/5/09 and 6/2/10) • Individual #164 (no assessment submitted)	Noncompliance

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		• Individual #335 (no assessment submitted) • Individual #239 (11/8/10) • Individual #259 (no assessment submitted) • Individual #126 (8/3/94) • Individual #197 (no assessment submitted) • Individual #243 (8/12/94 and 4/16/97) • Individual #309 (no assessment submitted) • Individual #19 (7/7/89) • Individual #40 (11/30/99 and 11/25/09) • Individual #211 (7/24/09) • Individual #146 (9/21/05) • Individual #54 (no assessment submitted) • Individual #95 (9/25/09) • Individual #208 (5/16/08) • Individual #135 (4/6/90, 1/29/09 and 2/19/09) • Individual #127 (2/20/92) • Individual #93 (7/21/09 and 7/15/10) • Individual #227 (partial assessments dated 2/27/95 and 8/23/00) • Individual #234 (11/29/89, 12/5/00, 11/19/09 and 11/30/10) • Individual #36 (3/26/92, 3/8/97, 2/27/09 and 3/8/10) Also assessments for those who received direct speech services were also requested and submitted as follows: • Individual #31 (2/12/10) • Individual #112 (9/2/10) • Individual #255 (7/29/10) • Individual #335 (10/11/10) Assessments were not submitted for six of the individuals and there were seven submitted that were not current within the last three years. The types of current assessments varied and included the following each dated in 2008 or 2009: • Augmentative Communication Review (2), Speech Language Evaluation (2), Speech-Language Evaluation Update (6) and Speech and Language Evaluation Addendum (1). Others, each dated in 2010 included the following: Interim Communication Update (6), Comprehensive Communication Evaluation (12), and Addendum to Comprehensive Communication Evaluation (1). The most current Comprehensive Communication Evaluation generally included the following subheadings:	

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		1. General Information 2. Communication History 3. Current Assessment Information 4. Receptive Language Skills 5. Expressive Language Skills 6. Articulation 7. Voice and Fluency 8. Augmentative Communication and Environmental Access 9. Clinical Impressions 10. Communicative Strengths 11. Recommendations 12. Specific Communication Strategies The most current Interim Communication Update generally included the following subheadings: 1. General Information 2. Communication History 3. Description of Augmentative Communication 4. Description of Environmental Control Devices 5. Findings 6. Recommendations 7. Specific Communication Strategies These headings varied slightly between the two clinicians. There was a general reference to a previous assessment in each of the updates and in some cases in the comprehensive assessments also. Some were not consistent with the date listed in the Communication Tracking Sheet (Individual #31) or two different assessments were listed as most recent in the update (Individual #93). By report, the Master Plan was designed to provide a comprehensive communication assessment every three years for each individual with a stated intention to provide interim updates annually for those who received some type of service or support from the SLP. This was not included in a departmental policy and was not clearly stated in any of the assessments or on the tracking sheet submitted. For example, Individual #255, Individual #31, Individual #112, and Individual #335 each received direct speech therapy. Individual #112 had received a comprehensive assessment on 9/2/10 and was scheduled to receive a subsequent evaluation in 2013 per the Communication Tracking Sheet. There was no reference to when her next evaluation was due in her assessment, however. Individual #255 had transferred to SASSLC and received a comprehensive assessment on 7/29/10. He was scheduled for a subsequent assessment in 2013. There was no reference to when his next evaluation was due in his assessment. Two individuals received Augmentative Communication	

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		Reviews (Individual #234 and Individual #95). It was not clear as to the purpose of these relative to the other types of assessments or updates provided. As described above, a comprehensive assessment was reported to have been provided to all of those individuals identified as Priority 1 (100%), as well as 39% of those identified as Priority 2, 52% of those identified as Priority 3, and 30% of those identified as Priority 4. Also as noted above, there were a number of individuals who had not received a communication assessment in up to 21 years. Overall, there were approximately 62 individuals that appeared to have no current communication assessment and another 57 who had not received a communication assessment in five or more years. There were significant inconsistencies related to the current schedule of assessments and updates. The following findings were based on the evaluations and updates reviewed: • Individual #211: He did not respond to auditory stimuli and had a profound hearing loss per his audiological examination on 7/11/09. He generally used sign language for functional communication (a repertoire of approximately 90 signs) and was also believed to likely benefit from a picture/sign language communication book. Though direct services were not recommended, inservice training for direct support staff was to be provided in July 2010 and ongoing as needed "when scheduling permits." He had a speech-language evaluation on 7/24/09 at the time of his admission to SASSLC. He was listed in the Communication Tracking sheet with a sign language binder, a communication wallet, a communication poster, and a four-button voice output device, however, there was no evidence that he had received an interim update at any time during 2010. He was identified as Priority 3 and was not scheduled for a subsequent evaluation until 2012. • Individual #208: He had received a speech-language evaluation on 5/16/08 and was described as nonverbal. Findings related to AAC were based on the clinician's judgment that because he did not maintain visual focus on a stimulus, did not gain information from spoken language, did not observe hand movements, and did not imitate signs presented, the use of an object or picture communication system or sign language was not justified. There was a recommendation that the use of a picture folder or a simple speech generating communication device should be evaluated for use in choice making activities and was to be provided to his home. There was no evidence of interim updates since 2008. He was listed as a Priority 2 and a subsequent evaluation was scheduled for 2011. No AAC supports were listed in the Communication Tracking Sheet for Individual #208 and there was no evidence that the recommendation had been explored. • Individual #36: He had received a speech and language evaluation on 3/26/92, a speech-language addendum on 3/8/97, and more recently a speech and	

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		language update on 2/27/09. The update in 1992 stated that further updates were not required unless requested by the interdisciplinary team. It was unclear why after 17 years an update rather than a comprehensive communication assessment was completed in 2009. At that time, a large button switch was recommended that played a message and activate external devices. These were to be mounted on his wheelchair lap tray. A radio and voice output switch was listed as environmental control on the communication tracking sheet. There was no evidence of an interim update at any time in 2010. He was identified as Priority 2 and was not scheduled for a subsequent evaluation until 2012. • Individual #227: He had received a speech and language evaluation on 2/27/95 (the copy was incomplete as submitted). By report, he had been seen two times weekly over a four month period since his transfer to SASSLC. AAC or environmental controls were not recommended though re-evaluation was recommended prior to his annual meeting in 1996 or 1997. There was no evidence that his had occurred. A subsequent speech and language update was provided on 8/23/00 though again the copy was incomplete as submitted. It was recommended that a home training objective be discontinued because he did not have the necessary skills to use a picture communication board. No alternative was identified nor were supports to address the identified need to be able to communicate his wants and needs to others more effectively. There was no evidence of further updates or evaluations since 2000 submitted with his individual record, though the Communication Tracking Sheet listed his last evaluation in 2010 with a subsequent evaluation due in 2013. He was identified as Priority 2 and was listed with a voice output device mounted on the end of his bed. • Individual #127: He received a speech and language evaluation on 2/20/92. It was identified at that time that sign language was an appropriate method of AAC. Participation in the Language Stimulation Program was recommended for a 30-60 day period. A subsequent update was recommended in 1993. There was no evidence that this was provided. There was no date listed in the Communication Tracking Sheet for his previous evaluation and the next evaluation was required "asap." He was identified as Priority 2 with no AAC or environmental control devices provided. • Individual #135: She received a speech and language evaluation on 4/6/90. There was no evidence of a subsequent assessment until 1/29/09 when an update was provided. It was unclear why after 19 years an update rather than a comprehensive communication assessment was completed in 2009. It was recommended that she have a two message voice output device to request a massage or lotion. This was revised via an addendum dated 2/19/09 which included a communication dictionary and a one message voice output device	

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		(Big Mack). There was no evidence of a subsequent update or comprehensive assessment in 2010. She was identified as Priority 2 and a subsequent assessment was not scheduled until 2012. A Big Talk switch to request lotion was listed in the Communication Tracking sheet for Individual #135. • Individual #146: He had received a speech-language evaluation on 9/21/05. He had a moderate to severe hearing loss in the left ear per his audiological examination in 2004. He was reported to be primarily verbal and his primary language was Spanish. The only recommendation was to ensure that staff addressed him in Spanish for optimal comprehension. There was no evidence of subsequent updates or evaluations since 2005. Per the Communication Tracking Sheet, he was identified as Priority 4 and it indicated that his next evaluation was due "asap." No AAC or environmental control devices were listed for Individual #146. • Individual #40: She received a speech and language evaluation on 11/30/99 with a speech and language update on 11/25/09. It was unclear why after 10 years an update rather than a comprehensive communication assessment was completed in 2009. AAC was not deemed to be appropriate, but rather a switch to activate a personal radio was recommended in addition to a communication dictionary. There was no evidence that the environmental control device and radio had been provided per the Communication Tracking Sheet submitted. She was identified as Priority 2 and her next evaluation was not scheduled until 2012. • Individual #19: He received a speech and language evaluation on 7/7/89. There was no evidence of a subsequent update or other assessment since that time. He was identified as Priority 2 with a due date for his next evaluation "asap." • Individual #306: She appeared to have received a speech and language evaluation on 4/15/95. There was no evidence of subsequent updates or assessments since 1995. She was described as nonverbal at that time and she displayed self-abusive behaviors. Per the Communication Tracking Sheet she was currently identified as Priority 2 with her next evaluation due "asap." There were no AAC or environmental control devices listed for Individual #306. • Individual #243: She had received a speech and language update on 8/12/94. There was no evidence of subsequent updates or assessments since 1994. She was described as nonverbal at that time. Per the Communication Tracking Sheet, she was currently identified as Priority 2 with her next evaluation due "asap." There were no AAC or environmental control devices listed for Individual #243. • Individual #126: He received a speech and language update to his previous formal assessment in 1989 on 8/3/94. There was no evidence of any subsequent update or assessment since that time. He was listed as Priority 2	

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		and the due date for his next evaluation was "asap." • Individual #93: He received a speech and language update to the previous evaluation provided in 1999 on 7/2/09. It was unclear why after 10 years, an update rather than a comprehensive communication assessment was completed in 2009. It was recommended that he have access to a simple message voice output device in order to gain attention from others. He was listed with a two message Say It Play It device for use during meals. There was no evidence of an interim update at any time during 2010 despite the provision of AAC. He was identified as Priority 2 with his next evaluation not scheduled until 2012. • Individual #311: He received a speech-language evaluation update to his previous assessment in December 1989. It was unclear why after 20 years, an update rather than a comprehensive communication assessment was completed in 2009. The clinician identified that AAC was not indicated because Individual #311 did not show cognitive skills to maintain focus on a stimulus, did not appear to gain information from spoken language, did not look at hand movements, did not imitate signs modeled for him, and did not appear to understand that a voice output device could assist him in communicating with others. He resisted physical prompts to activate the device, by report. There were no recommendations other than to direct staff to encourage him to reach out for simple voice output devices in his home. Specific strategies were outlined to promote his participation, but there was no recommendation for a learning objective to address this. Interestingly, he was identified as Priority 1 (nonverbal with good potential to benefit from AAC), though no AAC system was listed on the Communication Tracking Sheet for Individual #311. There were no further updates provided in 2010. He was not scheduled for a subsequent evaluation until 2012. • Individual #108: He received a speech and language update to his previous assessment in 1998 on 6/5/09. It was unclear why after 11 years, an update rather than a comprehensive communication assessment was completed in 2009. A communication dictionary and pictures of a radio and headphones for his lap tray were recommended. He was identified as Priority 1 (nonverbal with good potential to benefit from AAC), though no AAC system was listed on the Communication Tracking Sheet for Individual #108. There were no further updates provided in 2010. He was not scheduled for a subsequent evaluation until 2012. • Individual #234: She received an interim communication update on 11/30/10 subsequent to a previous formal assessment in 2008. She had a picture ring that was determined to meet her needs. The clinician reported that Individual #234's use of spoken words may have decreased and that a comprehensive assessment be provided in 2011. This was also indicated in the Communication	

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		Tracking Sheet. She had received an Augmentative Communication Review on 11/19/09, though the copy was incomplete as submitted. The facility noted that updates titled Augmentative Communication Reviews were now called Interim Communication Updates. • Individual #31: He received an interim communication update on 2/12/10 subsequent to a previous formal assessment in 2007. He used a Mighty Mo device mounted to his wheelchair and a Zygo Macaw device as a backup device to the Mighty Mo. He had participated in training objectives during the year with mastery of some objectives (4/8 SPOs) and progress with others. Six training objectives were outlined, but it was not clarified that these were related to direct speech therapy, though Individual #31 was listed as participating in direct therapy in the documents submitted. He was identified as Priority 3. Based on the three year schedule reported, Individual #31 was due for another comprehensive assessment in 2010 rather than an update. It was not clear that additional updates had been provided since 2007 because these were not submitted with his individual record information. The Communication Tracking Sheet listed his previous evaluation as 2008 and as such he would not receive another comprehensive assessment until 2011. • Individual #335: He received an interim communication update on 10/11/10 subsequent to a formal assessment provided in 2009. He had a lap tray communication board and a Tech/Scan 32 Plus voice output device. This voice output device was not listed for him on the Communication Tracking Sheet. He was recommended to participate in direct speech therapy. Specific SPOs were not outlined in this update. He was identified as a Priority 1 and was due for another assessment in 2011. The comprehensive assessments were generally comprehensive in nature, though the AAC sections were typically an assessment of existing systems only, with no additional assessment of other alternatives and, in a number of cases, AAC was summarily ruled out based on the lack of object recognition skills, lack of regard for pictures, and the inability to imitate sign language (e.g., Individual #43 and Individual #282). There was little to no regard for the impact that context played on the user's perception of need for communication or for the potential for learning or skill acquisition. Essentially, the individual needed to demonstrate an immediate understanding of the usefulness of a system or it was eliminated as an option. For instance, AAC was ruled out for Individual #239 because he presented with increased muscle tone and "almost no" active range of motion in his upper and lower extremities. He was described as blinking with a downward head movement two of two times to indicate an intentional "yes" response to a yes/no question, however. There was no assessment as to whether using his head to activate a switch was a viable option. There was no evidence of collaboration with	

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		occupational or physical therapy in cases like this. At the time of this onsite review, it was reported that not all individuals with a need for an AAC device had been identified to date. There was generally very limited focus on expansion of communication skills or new skill acquisition. There were only a few home-based SPOs recommended and SPOs for only four individuals who participated in direct speech services though these were not integrated into the PSP. For example, in the case of Individual #335, there were no action steps or SPOs related to direct speech services in his PSP. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** Per the list submitted, there had been six admissions to SASSLC in the previous six months. Individual #89 was included in the sample reviewed. He had received a comprehensive communication evaluation well within the 30 day timeframe. Recommendations were related to ensuring that bilingual staff were assigned to work with him. There was no evidence, however, that the PST had considered this in the Living Options section of his PSP. There was no other evidence of this as a need anywhere in his PSP dated 12/8/10. There was no indication that individuals were re-evaluated related to communication upon change in status. In the case of Individual #234, her interim update (1/30/10) reported that she had a decreased use of spoken words yet it was recommended that she receive a comprehensive assessment in 2011 rather than at that time. This was already indicated per the Master Plan as her previous assessment had been completed in 2008. It was also reported that she communicated using self-injurious behavior. She had a PBSP. In addition, it was also reported that she used words and short phrases to make requests or to report that she was in pain secondary to degenerative joint disease. There was no discussion to determine if there was any interrelatedness to these issues and it was of concern that a comprehensive assessment was deferred for a full year. **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.**	

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		Each of the comprehensive assessments reviewed generally addressed both verbal and nonverbal skills and expressive and receptive language skills. This was less consistent in the interim updates. In some cases, 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 recommended whether direct therapy was indicated in only 12/23 assessments or updates. In four other assessments, there was a recommendation for an SPO, but it was clarified that it would be home-based for Individual #228, Individual #265, and Individual #190 only. The evaluation for Individual #255 did not indicate if the recommended training objective was to be implemented by the SLP or direct support staff. He was identified as participating in direct therapy, however, in the list provided. Each of the assessments or updates included a section of Specific Communication Strategies that tended to focus predominately on what staff could do to ensure that their communications were more readily understood by the individual and did not generally address expansion or development of expressive communication skills. There was very limited evidence of more specific interventions intended to specifically increase communication skills through structured clinician-designed programs and interventions. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** Individuals were to be provided an assessment based on the Master Plan per the prioritized schedule. The intended plan was to provide re-evaluation every three years for each individual with interim updates on an annual basis for those who received supports and services. The intent of the interim update was to review the individual's status and the relevance and appropriateness of the supports provided. As described above, there were a number of individuals who had received communication supports, but an annual update had not been completed for them. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** Per the POI, SLPs participated in discussions with the PST related to the development of training objectives. There was no evidence, however, of any SPOs in the PSPs reviewed related to communication that were implemented with measurable goals or objectives for skill acquisition as recommended by the SLPs in the sample reviewed. Some action	

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		steps were related to the availability of an AAC system rather than skill acquisition. The SPOs implemented in direct therapy by the SLPs each had measurable objectives outlined with documentation. The focus for these individuals was to improve their communication skills, yet these were not integrated into the PSP. **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.** There was no policy or assessment/screening to identify those who received behavioral supports and interventions, such as a PBSP, and would benefit from AAC or other communication-related interventions. Per the POI dated 1/27/11, individuals requiring behavioral supports had an increased priority for assessment and other supports. There were 19 individuals included in the sample for review who were listed with a PBSP. There was reference to these plans in the communication evaluations for 12 of the 19 individuals including: Individual #228, Individual #255, Individual #93, Individual #135, Individual #40, Individual #234, Individual #108, Individual #211, Individual #282, Individual #257, Individual #7 and Individual #89. This could not be determined for the others as the assessments submitted were not current. There was little to no analysis of the relationship of communication to these behavioral concerns and there was no evidence of collaboration with psychology in the communication assessments. **Standard: Communication programs were integrated into the BSP as indicated.** In the assessments reviewed for individuals with PBSPs, 12/19 identified the target behaviors of the plans, but as stated above did not provide any discussion as to the relationship of behavior and communication skills. There was little evidence that there had been actual collaboration between psychology and the SLPs in the development of PBSPs or in the development of skill acquisition plans to address individual needs as they related to communication. For example: • Individual #234: The PSP dated 12/2/10 identified that one of her top priorities was communication. Interests and preferences were related to being understood more easily, be with staff she knows and likes, dress warmly throughout the year, time out of her wheelchair listening to music, and singing. Under supports and services needed, a communication dictionary was listed as the only support related to speech and audiology. In the behavior support needs section, it was stated that her functional assessment indicated Individual #234	

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		engaged in tantrums and aggression. The PBSP was designed to increase her ability to communicate appropriately to staff when she had an unmet need or want without engaging in inappropriate behaviors. It was reported that she did not speak clearly with limited abilities to express herself through vocalizations, one or two word phrases, and gestures that allowed others to understand her wants and needs. A training objective to be implemented by psychology and direct support staff was that she would ask for staff assistance in an appropriate manner with verbal prompts. Other training objectives related to communication were developed by the home supervisor included pressing a communication device to indicate that she wanted to take her medication at the nurses' station and another was that she would select a picture on her picture ring to indicate that she was cold. The communication update by the SLP identified that she became frustrated when others did not understand her and that she had difficulty adapting to change. The SLP recommended only that the pictures on her ring be reduced from 13 to six to eight pictures only with no other evidence of collaboration regarding the programs developed by psychology and the home supervisor as described above. There was sufficient need established that Individual #234 needed additional skills to effectively make her needs known to others without the use of maladaptive behaviors. There was no clear link across or between the efforts by the psychologist, SLP, and home manager to ensure coordinated programming and communication methods. The SLP should be intimately involved in the process of assessment, program development, implementation, and monitoring to ensure effectiveness. The POI reported that the SLPs attended Behavior Therapy committee meetings in order to integrate communication and behavioral supports. There was no evidence of integration of communication programs into the PBSP likely because there were very few communication programs in place. **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 Master Plan incorporated the Communication Tracking Sheet that guided the schedule of assessments. The plan was intended to prioritize those individuals who would most benefit from AAC devices or equipment. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or that established specific staff responsibilities.	

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R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The information contained in the PSPs related to communication was extremely inconsistent across the plans reviewed. Several were of the new format and the potential for improved descriptions was noted, but were not well implemented at this time. The communication-related training objectives identified for individuals were inconsistent with assessments and recommendations **Standard: AAC devices were portable and functional in a variety of settings.** The majority of the AAC systems recommended were portable and intended to be functional in a variety of settings. There continued to be a number of these, however, that were specific to a particular setting such as work or the dining room. By report, a number of devices had to be mounted because many of the initial devices were previously lost. It will be critical that all staff take on responsibility for taking care of the AAC systems issued to individuals to ensure substantial compliance with this critical element of the Settlement Agreement. In only one case (Individual #93) was an instructional plan submitted. It was dated 7/21/09 and as such was not considered to be current. During observations, there were only a few devices that were observed in use. Some examples included three-message devices for Individual #31 and Individual #335 at work and a single message switch outside the bathroom in Home 674 that Individual #335 used to let staff know that he needed to use the bathroom. Staff responded appropriately and in a timely manner to his request for assistance. Several others were noted in the dining rooms, but were not used at that time. In many cases, it was unclear as for whom the devices were intended to be used. There were a number of picture boards that were intended for community use which obviously were not portable and, as such, would not necessarily be functional for a number of users. **Standard: Communication programs and AAC devices were individualized and meaningful to the individual.** There was limited discussion of the settings observed or timeframes and methods used to assess individuals in the evaluations or updates. In many cases, the selection of a system was not well supported by the rationale in the assessment or ruling out a system was not clinically well-justified. The absence of individualized formal training regarding communication and language continued to be a serious problem at SASSLC. Similar	Noncompliance

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		comments regarding this are also included in sections F, S, and T of this report. **Standard: Staff were trained in the use of the AAC.** Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. There were few if any formal communication programs. There was no evidence that staff received individual-specific training related to the Specific Communication Strategies identified in the assessments or competency-based training related to AAC or environmental control devices issued to individuals. There was only one instructional plan for AAC use submitted in the sample records reviewed and it was not current within the last 12 months. The Communication section of the PNMPs provided more specific information about how the individuals communicated in some cases. There continued to be very limited instruction as to how staff could support or enhance both expressive and receptive language. **Standard: Communication strategies/devices were implemented and used.** There were few AAC systems observed being used throughout this onsite visit. In a number of cases, the system was available on the table in the dining room, for example, but staff did not encourage use by the individual at any time during the meal. Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful, such as during a meal. Many of the language stimulation groups that were directed by direct support staff were not appropriate to the individuals observed and the communication methods used were awkward at best, with likely limitations in meaning and function to the individual. For example, several individuals who received enteral nutrition were introduced to a drawing of cream cheese. The staff spent an extended time discussing cream cheese though this likely had limited value or meaning for those particular individuals. The monitoring team acknowledges the efforts of the direct care staff and understands the challenges in engaging these individuals in meaningful activities. The time, however, would have been better spent if the focus had been on something that was meaningful to them with more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology. This will only be possible when the clinicians are sufficiently available to model, train and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. **Standard: General AAC devices were available in common areas.**	

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		A number of community use devices were available in the homes. These non-portable devices may be useful as a backup or extra system for individuals, but should not be used as a primary augmentative or alternative means of communication for an individual. Very few of these were observed in use during the onsite review by the monitoring team.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**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.** There were no policies related to a monitoring system for AAC. A communication audit was conducted monthly to address availability and use, condition, and need for replacement or repair of communication and environmental control devices. This audit was completed for approximately 81 individuals and in eight homes. Audits had been conducted since February 2010 through December 2010, per the spreadsheet submitted. There were some instances that the device was marked unavailable and described as missing or broken for approximately 22 individuals on one or more occasion. There were 13 individuals who had missing or broken equipment on three or more occasions. These included Individual #310 (3), Individual #149 (5), Individual #250 (5), Individual #223 (3), Individual #50 (7), Individual #158 (3), Individual #177 (5), Individual #178 (4), Individual #132 (3), Individual #86 (5), Individual #252 (4), Individual #112 (3), and Individual #334 (3). Generally, the device was also marked as replaced, though it was not always possible to discern how long this took. • In the case of Individual #310 there was no evidence that her device was replaced in November 2010 or December 2010. • In the case of Individual #50, his device was listed as missing from September 2010 through December 2010. • There was no evidence that Individual #178's device was replaced in November 2010 or December 2010. • Individual #112's communication device was marked as broken from May 2010 through July 2010 with replacement in August 2010. A progress note for direct therapy services indicated that the device was pending administrative approval of parts. • There were repeated replacements of community use devices in Home 672 (5) due to missing equipment. In addition, the majority of devices were marked as available per the audit but this did not appear to reflect actual use by individuals and the staff. No analysis of monitoring results was submitted as requested.	Noncompliance

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		The SLPs should have routine and frequent responsibilities to monitor communication programs beyond the annual assessment or requests and referrals to assess actual use of the devices issued as well as the effectiveness for the individual. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Monitoring of AAC appeared to be generally conducted 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 validation check provided for monitors at the time of this review. Further assessment of this element will be necessary in future reviews.	

Recommendations:

1. SASSLC may want to consider the use of Speech Assistants to assist with the implementation of communication programs (SPOs) and for staff training and monitoring.

2. Assessments must provide a clearly stated and thorough rationale as to why or why not AAC is determined to be appropriate for an individual. Actual trials of certain systems may be needed to more thoroughly explore this. Greater specificity is needed to describe the clinical reasoning process used by the therapist to select a particular device. These are key elements to a comprehensive assessment that meet generally accepted professional standards of care.

3. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted. Ensure all of these are integrated into the PSP process.

4. There is a significant need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs.

5. Consider expanding the NEO training to address AAC, and also to teach staff to understand how to be an effective communication partner. As AAC is developed, it then becomes a method much like speech, rather than a unique entity in which the functional purpose becomes lost on staff. When that happens, it loses meaning for them as well. It becomes a "task" and is not integrated into the individual's daily routine.

6. Many recommendations appeared to be left to the PST for the development and implementation of plans, even in the absence of sufficient staff training. 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, as well as training, modeling, and coaching for staff. 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.

7. Routine monitoring needs to include a review by professional staff as to the effectiveness of AAC systems, as well as formal and informal programming rather than only availability and condition of existing systems.

8. Clarification of expectations for monitors related to the indicators on the PNMP Monitoring Sheet must be provided. Each element must be well defined. This is reinforced through competency-based training and validation.

9. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Personal Support Plans (PSPs) for: • Individual #150, Individual #140, Individual #298, Individual #229, Individual #304, Individual #278, Individual #23, Individual #218, Individual #333, Individual #185, Individual #104, Individual #225, Individual #349, Individual #86, Individual #72, Individual #43, Individual #252, Individual #113, Individual #327, Individual #244, Individual #250 o Specific Program Objectives (SPOs) for: • Individual #304, Individual #333, Individual #276, Individual #81, Individual #25, Individual #204, Individual #150, Individual #264, Individual #327, Individual #105, Individual #225, Individual #4, Individual #194, Individual #3, Individual #349, Individual #86, Individual #72, Individual #43, Individual #209, Individual #16, Individual #148, Individual #181, Individual #333 o Quarterly reviews of SPO progress for: • Individual #248, Individual #199, Individual #155, Individual #316, Individual #38, Individual #42, Individual #217 o SASSLC Plan of Improvement o Monthly Community Integration/Inclusion Tracking, dated July 2010, August 2010, September 2010, October 2010, November 2010, December 2010 o Skill Acquisition Observation Tool, undated o Engagement, Dignity, and Respect, and Group Management Observation Tool, undated o List of individuals under age 22 and the SAISD school that each attended o PSP, ARD/IEP, progress notes for: • Individual #113**,** Individual #252**,** Individual #122**,** Individual #15 o Assistant Ombudsman description of involvement in school-related discussions in November 2010 <u>Interviews and Meetings Held</u>: o Gina Dobberstein, Coordinator of Leisure and Recreational Activities o Charlotte Fisher, Associate Psychologist o Robert Rocha, Rehabilitation Therapy Technician IV o John Morales, Vocational Supervisor o Melissa Cordova, Active Treatment Coordinator o Dr. James Fancher, DDS, PhD o Gevona Hicks QMRP o Mark Boozer, Associate Psychologist and Andrea Blue, QMRP

	Observations Conducted: o Observations occurred in every day program and home 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: SASSLC's Plan of Improvement (POI) indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas.
	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. Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were several improvements since the last review. These include: • Development of an engagement monitoring tool • Introduction of a skill acquisition monitoring tool • Modification of skill acquisition plans (training instructions) • Improvement in the documentation of the rationale for SPO selection • Development of a data system to track and improve training of individuals in the community • Improved individual engagement scores The monitoring team believes that these improvements could result in a relatively fast and dramatic improvement in this provision if they are coupled with a reorganization and simplification of how skill acquisition programming is organized, implemented, and monitored at the facility.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at 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 this provision. Skill Acquisition Programming 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 qualified mental retardation professionals (QMRPs). SPOs were implemented by direct care professionals (DCPs). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. The facility has made some progress in this area since the last review. The SPO training instructions sheet for several individuals has begun to be modified to include the reason/rationale for the selection of each new skill. For example: • Individual #81's SPO of learning to release a maraca into a container included the following rationale: "One of (Individual #81's) preferred activities is to play a maraca… This task teaches him how to end the activity and to put the instrument in a specific location where he can find it next time he wants it." • Individual #25's SPO of activating a switch to turn on the radio included the statement, "This objective was chosen because it reflected a need to improve communication skills, and listening to music was a highly preferred activity." • Individual #204's SPO of increasing on-task work included the following rationale: "As discussed by the PST and indicated in the vocational assessment training, the decreasing of off task behaviors will prepare (Individual #204) to progress into more advanced work opportunities." The monitoring team was encouraged by this addition to the SPOs, and looks forward to evaluating more SPOs with clearly stated rationales during the next onsite review. Once identified, skill acquisition plans need to contain some minimal components to be	Noncompliance

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		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 This is another area where SASSLC had begun to make improvements since the last review. A modification of skill acquisition plans (training instructions) was recently made to ensure that the above components have been included. For example the new format SPO plans added specific teaching cues, instructions, consequences for correct response, consequences for incorrect response, and a plan for skill maintenance and generalization. The monitoring team encourages the facility to continue to expand the use of this new SPO format, and look forward to assessing the outcome of these changes in future reviews. The training methodology for SPOs reviewed consisted of variations of forward chaining (e.g., Individual #194) and backward chaining (Individual #4). Conversations with staff and observations of the implementation of SPOs, however, suggested that the correct use of these procedures may not be understood by all staff. The facility was investigating other training methods and was awaiting the development of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. <u>Desensitization skill acquisition</u> The dentistry department developed dental desensitization plans designed to teach individuals to tolerate dental procedures without sedating medication. These plans consisted of a series of visits to the dental clinic with gradually increasing intensity and time of dental procedures. If these general desensitization procedures did not successfully result in an individual allowing the necessary dental work without restrictive procedures, the dentist requested a more individualized desensitization program from the psychology department. Dr. Fancher, SASSLC's dentist, reported that	

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		the general desensitization protocol has resulted in a substantial reduction in sedation at the dental clinic (from 130 individuals requiring sedation or physical restraint last year, to 55 at the time of the onsite review). Those 55 individuals for whom the general desensitization protocol was not successful, however, require individualized desensitization plans. At the time of the onsite review the psychology department had not begun to write these plans. It is recommended that the psychology department begin to write dental desensitization plans for those individuals that the general protocol was not successful. Moreover, these plans should be included into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. 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. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with desensitization plans, will be reviewed in more detail during future onsite visits. Also see section J4 above. <u>Replacement behaviors from PBSPs as skill acquisition</u> SASSLC included replacement behaviors in each PBSP. There were descriptions of teaching conditions (see K5), however the format was not consistent and the quality and detail of the training varied greatly. It is recommended that replacement behavior training procedures be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed below. <u>Communication and language skill acquisition</u> The monitoring team found a few acquisition programs targeting the enhancement or establishment of communication and language skills (see example of Individual #25 communication objective below). It is recommended that the facility expand the number of communication SPOs for individuals with communication needs. <u>Service objective programming</u> Finally, 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 in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at SASSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and	

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		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 continues to be encouraged by the overall quality of the activities, and the generally positive and caring interactions between staff and individuals at SASSLC. As found in past reviews, the ability to maintain individual's attention and participation in the activities varied widely across staff and homes. For example in Home 672 West, the shift supervisor, the QMRP, and the unit psychologist were all actively involved with individuals. In home 671 the active treatment coordinator was assisting DCPs in implementing meaningful group activities. On the other hand, in other homes some staff 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 59%, a noteworthy improvement over the last review (i.e., 42%) and the baseline score (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 some room to improve. The facility developed an engagement tool just prior to the onsite review to collect engagement data in each setting, and establish specific engagement goals in each home and day program site. SASSLC did not have engagement data at the time of the review; however the monitoring team look forward to reviewing the facility's engagement data at the next review. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
Home 670	2/3	2:3
Home 668	2/9	2:9
Home 668	3/6	2:6

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Home 668	1/7	1:7
Home 670	3/10	3:10
Home 670	2/2	1:2
Home 670	3/4	1:4
Home 671	6/11	3:11
Home 671	8/11	5:11
Home 766	3/4	1:4
Home 766	4/5	1:5
Home 665	4/6	2:6
Home 665	3/4	1:4
Home 672	2/5	1:5
Home 672	1 /2	1:2
Home 672	1/1	1:1
Home 674	4/17	3:17
Home 674	5/5	4:5
Home 673	2/3	0:3
Home 673	2/2	1:2
Home 673	0/1	0:1
Home 673	1/2	0:2
Home 672	5/8	4:8
Home 672	3/3	2:3
Home 672	2/10	2:10
Home 672	5/13	3:13
Vocational Workshop	7/9	3:9
Vocational Workshop	10/10	4:10
Vocational Workshop	7/7	3:7
Vocational classroom	1/3	1:3
Vocational classroom	3/6	3:6
Vocational classroom	1/2	1:2
Vocational classroom	1/6	2:6

Educational Services
Fourteen individuals living at SASSLC received their educational services from the San Antonio Independent School District (SAISD). Andrea Blue, QMRP, and Mark Boozer, psychologist, were the primary liaisons between SASSLC and SAISD. Based upon a meeting with these two staff and a review of school-related documents, it appeared that the facility had maintained a positive working relationship with the SAISD that was beneficial to the individuals. Both the psychologist and the QMRP spent time each week devoted to school-related activities. In addition, the facility was responsive to the

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		recommendations made during the previous onsite review. There were a number of ways that SASSLC and SAISD appeared to work together: • The QMRP attended all ARD/IEP meetings. These were held off-campus at the public school buildings (e.g., high school, middle school). She reported that she was an active participant at the meetings and that her opinions and comments were valued and respected. ARD/IEP documents verified her attendance for all four of the individuals whose records were reviewed by the monitoring team. • There was also indication in the annual PSP of the school district's special education supervisor attendance at one of the four individual's annual PSP meeting at SASSLC. This was good to see. • School teachers developed behavior intervention plans for the individuals for when they were at school. The SASSLC psychologist provided inservices to school personnel to help them do this in a way that was consistent with the way the facility was approaching behavior problems. • SAISD made many efforts to have students attend full day and full time. • The QMRP reported that she held a PSPA meeting for the individual's PST at SASSLC following every ARD/IEP meeting so that facility staff would be updated and informed. • The QMRP and psychologist reported that school personnel kept the facility informed of any important medical or behavioral events that occurred at school. • Each individual's PSP included an action plan to "attend public school daily." Since the last onsite review, the QMRP and psychologist had taken some actions in response to the monitoring team's recommendation for the facility to explore whether summer educational programming (i.e., extended school year) was appropriate and needed for these individuals. As a result, they had both engaged ARD/IEP teams and the school district special education department in this matter. It was still being discussed at the time of this onsite review and the monitoring team recommends that the facility continue to examine whether extended school year services are appropriate for these individuals. Moreover, the facility's assistant independent ombudsman looked into this matter somewhat in November 2010, including attending a SAISD meeting. Even so, there are some areas for the facility to focus on regarding this portion of this provision item. These are listed below. • Have better daily communication with the classroom, such as a daily school note from the classroom to the home, and a daily note from the home to the classroom each morning. • Attempt to obtain sufficient information in the school's progress reports. The progress reports for three of the four individuals reviewed merely had a "W" for	

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		every objective. The "W" indicated "work in progress." The progress report for the fourth individual had an "M" for every objective indicating it was met. With no additional information, the validity and reliability of these ratings is highly questionable. • Consider engaging in activities to promote generalization and/or more fluent mastery of each objectives taught in school. Examples include adding action plans to PSPs to correspond with school objectives, obtaining homework assignments from classroom teachers, and applying what was taught at school in new situations at home and in the community. • Ensure that the QMRP and psychologists have enough time allotted in their schedules to properly attend to the many school-related activities in which they regularly need to engage and participate.	
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.	SASSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Because this process recently began and was not being implemented for all individuals at the time of the onsite review, this item is rated as being in noncompliance. 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. Finally, SASSLC had been using PALS for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS is in the process of evaluating several assessments as an alternative to PALS. The monitoring team is supportive of the identification of an alternative to PALS, and looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology, etc.) and individual preference, to identify meaningful individualized skill acquisition programs.	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		

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	shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Improvements are needed in the monitoring of SPO progress and outcomes before this item can be rated as being in substantial compliance. QMRPs at SASSLC summarized SPO data monthly and presented those data at quarterly meetings. The skill acquisition plans appeared practical and functional for some individuals (e.g., Individual #276 increasing the time she independently exercises, and Individual #25 learning how to independently turn on her radio), but other SPOs were very similar, and therefore appeared less individualized and functional. For example: • six of the 23 SPOs reviewed (26%) involved increasing time-on-task, and • five of the 23 SPOs reviewed (22%) involved purchasing items. The facility should ensure that SPOs are consistently practical and functional. The monitoring team was provided with several examples of individuals whose SPOs were producing meaningful behavior change (e.g., Individuals #230, Individual #155 on vocational goals). The monitoring team was encouraged by these examples of SPOs that were successful, and that new SPOs were developed as individuals achieved old ones. Subsequent reviews will focus on evaluating a sample of SPOs to determine if plans are modified based on individual behavior and if the SPOs are producing meaningful behavior change. 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. The monitoring team observed the implementation of SPOs during day programming and in the homes in the evening. For example: • The monitoring team observed a staff member implementing Individual #148's money management SPO. The staff member prompted Individual #148 to get his money, and he and the staff went to the vending machine located outside of another home. Once there, the staff prompted Individual #148 to make his selection. Then he asked Individual #148 how much money he needed to make the purchase. Individual #148 did not correctly respond, and the staff helped him select the correct coins to put in the machine by pointing to each appropriate coin. The activity appeared to be a very positive interaction, and Individual #148 appeared very pleased with his efforts and the result. As a skill acquisition program however, the activity was much less successful. Individual #148's money management SPO included listing the item (s) he wanted and	Noncompliance

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		writing them down. The SPO also stated that the training should occur at an off-campus store, not at a vending machine on campus. Finally the teaching techniques section of the SPO stated that the staff was to prompt Individual #148 through each of the five steps of the program using least-to-most prompting technique. o The staff missed, or modified, four of the steps, did not consistently use a least-to-most teaching technique, and conducted the training in the wrong location. • The monitoring team observed Individual #181 in a vocational class. His SPO was to complete six units of work. The SPO specified the teaching technique to be partial physical prompts. It appeared that the DCP was using physical prompts. When the monitoring team asked the DCP how partial physical prompt was different than a physical prompt he replied that they didn't know. These observations suggested that SPOs were not conducted with integrity at the facility. Although the QMRPs were charged with monitoring the implementation, all staff interviewed reported that they believed the QMRPs did not have the time to train and monitor DCPs in the implementation of SPOs. It is recommended that the facility ensure that DCPs are trained in conducting SPOs for the individuals assigned to them. Additionally, it is recommended that a supervisor regularly observe the implementation of SPOs, and collect SPO integrity data to ensure that SPOs are being implemented as intended. At the time of the onsite review the facility introduced a new skill acquisition monitoring tool to objectively assess if DCPs were implementing the SPO with integrity. The monitoring team is optimistic that the use of this tool and a reorganization of efforts will result in a substantial improvement in the implementation and outcomes of SPOs at the facility.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SASSLC enjoyed various recreational activities in the community. The facility had begun to make progress in providing and documenting the occurrence of training in the community that address specific needs for services or preference. This process had recently begun and could not be fully evaluated at the time of the onsite review, therefore, this item was rated as being in noncompliance. Since the last review, the facility has begun the community integration tracking report. This report attempted to capture recreational and training activities in the community for each individual. It not only documented community training, but it could be used to track progress in providing community training in the community, and was, therefore, potentially a very useful tool. In reviewing the version available at the onsite review, it	Noncompliance

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		appeared unclear when an activity was recreational or training. For example, one category was dining out. Individuals could be dining out as a leisure activity or as specific SPOs (e.g., purchasing). In order to better track trends, it is recommended that the report be modified to specifically indicate if an individual's community activity represented a recreational activity or a training activity. During the last review, four individuals worked in the community. Documentation provided to the monitoring team indicated that three individuals were employed in the community at the time of the onsite review. Additionally, the facility provided a list of eight individuals whose SPOs involved training in the community (e.g., purchasing items at community stores, using a menu at a community restaurant, utilizing public transportation). The monitoring team was encouraged by the facility's progress on this provision item and looks forward seeing continued progress at the next review.	

Recommendations:

1. The facility should ensure that SPOs are consistently practical and functional.

2. The facility should continue to explore additional training methodologies and systems.

3. 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 databased decisions concerning the continuation, discontinuation, or modification of the skill acquisition plan.

4. It is recommended that the psychology department begin to write dental desensitization plans for those individuals that the general protocol was not successful.

5. It is recommended that replacement behavior training procedures be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed below.

6. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs.

7. It is recommended that the facility ensure that DCPs are trained in conducting SPOs for the individuals assigned to them. Additionally it is recommended that a supervisor regularly observes the implementation of SPOs and collects SPO integrity data to ensure that SPOs are being implemented as intended.

8. The facility should ensure that each individual is provided with training in the community that appropriately addresses his or her needs and

preferences.

9. The community integration tracking report should be modified to specifically indicate if an individual's community activity represented a recreational activity or a training activity.

10. Continue to examine whether extended school year services are appropriate for the individuals who attend SAISD.

11. Improve the collaboration between SAISD and SASSLC in ways described in S1 above: (a) have better daily communication, (b) attempt to have SAISD progress reports contain adequate detail, (c) promote generalization and fluency of school learning, and (d) ensure QMRP and psychologist have enough time in their schedules for school-related activities and responsibilities.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 o DADS Obstacles Report for SSLCs, October 2010 o Organizational chart, July 2010 o SASSLC policy list, two pages, not dated o List of typical meetings that occurred at SASSLC o SASSLC POI, December 2010 o SASSLC Admission and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/7/11 o Weekly enrollment report, 1/7/11 through 1/28/11 (four) o Monthly enrollment report, January 2011 and February 2011 (draft) o Position description: Admissions/Placement Coordinator and Post-move monitor o List of individuals who were referred for placement and had been placed since 7/1/10, dated 12/31/10 (one individual) o List of individuals who were referred for placement and had not yet been placed, dated 12/31/10 (eight individuals) o PSPA notes describing why each of two individuals were not placed within the required 180 days o List of individuals who had requested placement themselves, but were not referred (nine individuals, two of whom were now on the referral list), dated 12/31/10 o List of individuals not referred solely due to LAR preference (three individuals) o Document stating that no individuals were discharged under alternate discharge procedures o Document stating that no individuals were under court-ordered evaluation status o Document stating that SASSLC was awaiting state office direction regarding assessing individuals for placement o List of individuals who had a CLDP completed (one individual), dated 12/31/10 o DADS review comments on completed CLDP (one), dated 1/30/11 o Documents stating that SASSLC was awaiting state office direction regarding data and analysis on obstacles to referral at the facility o Document stating the no individuals had returned to SASSLC after being placed in the community o Community Placement Report, dated 1/6/11 o Agenda and minutes from quarterly meetings with local MRA, October 2010 and January 2011 o Presentation materials and sign in sheets for CLDP training conducted by DADS central office o Presentation materials and sign in sheets for CLDP training conducted by SASSLC APC for

	members of PST of Individual #92 o Various documents regarding community tours, including a form indicating an overview of the entire tour, a summary listing of all individuals who went on tours on specific dates, and a detailed list of every site visited, dated 2/8/11 o SASSLC newsletter for employees and friends of SASSLC, The Bridge, 3/10, 6/10, 9/10 o DADS SASSLC family satisfaction survey online summary, 15 respondents o Proposed revised CLDP format (blank) o New post move monitoring form o PSPs for: • Individual #229, Individual #298, Individual #279, Individual #327, Individual #140, Individual #150, Individual #43, Individual #244, Individual #72, Individual #86, Individual #95, Individual #275, Individual #289, Individual #41, Individual #40, Individual #239, Individual #307, Individual #313, Individual #213, Individual #241, Individual #348, Individual #99, Individual #232, Individual #299, Individual #77, Individual #227, Individual #335, Individual #160, Individual #4, Individual #89, Individual #234 o PSPs for individuals who were referred for placement: • Individual #107, Individual #269, Individual #211, Individual #1, Individual #160, Individual #159, Individual #275, Individual #92 o Completed monitoring form of living options discussion section of annual PSP meeting for: • Individual #180 o CLDPs for: • Individual #192 o CLDPs in progress for: • Individual #1, Individual #92 o Set of PSPA meeting notes for Individual #1 regarding community placement o Post move monitoring checklists conducted since last onsite review for: • Individual #192: 7-day, 45-day • Individual #329: 45-day, 90-day • Individual #76: 90-day • Individual #102: 90-day Interviews and Meetings Held: o Carol Young, Admissions and Placement Coordinator o Anna Cruz, Post-Move Monitor o Ralph Henry, Facility Director o Gevona Hicks, Megan Lynch, QMRPs o Patrick Haas, Director, Vocational Services, SASSLC o Joshua Castro, QE department program auditor o Tyrone Peterson, CLOIP staff worker, ALA Services, local contracted MRA agency o Andrea Ayala, case manager, Crystal Rodriguez, house manager, D&S Residential Services

	○ Sherry Hartsfield, Advocate from Advocacy, Inc. ○ Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted: ○ PSP Meeting for: • Individual #180, Individual #201, Individual #311 ○ CLDP meeting for: • Individual #1 ○ Various meetings related to community placement for: • Individual #92, Individual #245, Individual #192 ○ Community group home visit for: • Individual #192 ○ Many residences and day programs at SASSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, was revised and simplified compared to the POI presented during the previous onsite review. This was an improvement and should provide the admissions and placement department with guidance and direction. The POI was dated December 2010, about six weeks before the onsite review. The monitoring team recommends that the department use the information provided in this section of the report to revise the content of this POI. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the APC to use this report to guide her in setting forth a set of actions to work towards achieving substantial compliance with this provision. The POI indicated a self-rating of substantial compliance with three provision items. The monitoring team was in agreement with these three self-ratings of substantial compliance, as well as with the self-ratings of noncompliance with all other provision items. The POI did not indicate that the facility looked at any of the PSPs, LODs, optimistic vision statements, CLDPs, or post-move monitoring forms to make a determination of their own substantial compliance or noncompliance. The facility will need to engage in specific activities to self-assess the status of its performance for this provision and all of its components. This will probably involve monitoring, sampling, and providing feedback to PSTs, post-move monitors, and facility management. The POI can certainly provide guidance. Furthermore, the post move monitor and APC were in the process of implementing a self-monitoring tool. The initial drafts looked like the tool will be helpful to them and to the facility in their ongoing efforts to self-assess the facility's progress towards substantial compliance. The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment. The APC's presentation book contained a lot of relevant information.

	Summary of Monitor's Assessment Overall, the facility had made progress in a number of areas related to meeting the requirements of this provision item (e.g., CLDP, post move monitoring), however, as noted below, more work needed to be done, especially in those areas where progress had not occurred (e.g., number of placements, professional determinations, adequate assessment of individual preferences). Referral and placement activities continued to be overseen by Carol Young, the Admissions and Placement Coordinator (APC). She was experienced, well organized, and knowledgeable about the placement process and many of the details of the personal lives of many, if not most, of the individuals at the facility. The number of individuals placed in the community had decreased over the past year. The number of individuals in the referral process at SASSLC had increased, though, overall, the numbers remained low, given the size of this facility Actions to encourage and assist individuals to move to the most integrated settings were required to be consistent with the determinations of professionals that community placement was appropriate. Opinions of the professionals on the PST did not appear to be adequately incorporated into discussion, documentation, and decision-making as required (this was also noted in the previous monitoring report). Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. The monitoring team was concerned about the way in which SASSLC supported individuals' decision-making regarding community referral and placement based upon a number of observations during the week of the onsite review, as well as based upon a review of PSP documents. For example, single questions during annual PSP meetings were not likely to get at an individual's preference for something as abstract and important as choosing a place to live. Preferences must be obtained in a valid way, that is, in a way that is similar to the aspects of obtaining informed consent, including that the individual must have the capacity to understand the options available and information being presented, be informed adequately and thoroughly, and be able to provide his or her preference freely. For many of the individuals at SASSLC, the validity of their preferences will have to be determined in multiple ways. SASSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. Family members and LARs were involved in the lives of most of the individuals who were on the active referral list. The monitoring team noted that a number of family members and LARs appeared to be willing to learn more about community placement, to go on tours, and/or to have their family member go on tours of community providers. Educational activities continued and the monitoring team continues to recommend that the facility identify the desired outcomes of these activities and assess whether or not those outcomes are occurring for the provider fair, the CLOIP, community tours, and so forth. Progress, however, had been made in the system

	of community tours, including an increase in participation by individuals and by staff, as well as an improvement in documentation. New policies were being developed for most integrated settings practices. These were not yet disseminated or implemented. New CLDP and post move monitoring forms were initiated very recently. Their impact, however, will need to reviewed during the next onsite review when the facility will have had experience with them. Of note, however, was that SASSLC was beginning to implement an important aspect of the new CLDP process. Specifically, the placement process was occurring in a more individualized manner, planning was beginning earlier in the process, and PST members were more involved. QMRPs will need more training and support to implement and lead the new style, more complicated annual PSP meetings. Discussions of most integrated setting will need to be thorough and skills chosen for formal teaching will need to be related to community living and to the specific obstacles to referral and placement that the PST has identified. These obstacles need to be identified and addressed on an individual basis. In addition, a comprehensive assessment of obstacles to placement for the entire facility was still needed. The facility did not maintain an important list, that is, of all individuals for whom LAR preference was the only reason for a referral not occurring, including both those individuals who expressed a desire to move, and those individuals who were not capable of expressing a preference. This information should be gathered and managed. The list of essential and nonessential supports in the CLDP was inadequate to meet the requirements of this provision item. This was noted in the previous review and continued to be a problem. First, the CLDP did not identify needed supports from a wide range of possible supports that would be appropriate for the individual (e.g., especially given the list of prioritized outcomes on page 26 of the one CLDP completed since the previous onsite review). Second, the supports, both essential and nonessential, were not described in adequate detail. The wording did not provide the facility, the receiving provider, or the post move monitor with adequate guidance regarding the development, implementation, and monitoring of supports for this individual. Supports need to be defined in measureable observable terms, ways of determining if the support is present need to be specified, and a criterion for the presence of each support must also be included. Post move monitoring was occurring within the required timelines. The new post move monitoring form was being initiated. Suggestions for improvement are provided in the report below. The post move monitor was a dedicated staff member committed to improving the process. The definitive identification of supports and their criteria will be required if post move monitoring is to be conducted adequately.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	SASSLC and the state engaged in some activities to encourage and assist individuals to move to the most integrated setting. These activities 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. Funding did not appear to be an obstacle to any individual's transition. There were no reported instances of a placement being delayed or prevented due to lack of funding and there were reported to be plenty of slots available to individuals at SASSLC. Overall, the facility had made progress in meeting this provision item, however, as noted below, more work needed to be done in order to achieve substantial compliance. The monitoring team learned about many changes that were in the works at both the facility and state levels regarding PSP processes, CLDP contents, determination of evaluation of essential and nonessential supports, and training of all facility staff and departments regarding the community referral and placement process. The new PSP process was observed in action during the onsite review, and a draft of a revised CLDP format was presented to the monitoring team for review. These two new processes are discussed below in this section of the report. Referral and placement activities were overseen by Carol Young, the Admissions and Placement Coordinator (APC). She was experienced, well organized, and knowledgeable about the placement process and many of the details of the personal lives of many, if not most, of the individuals at the facility. She led a number of meetings during the week of the onsite review. Her meeting leadership style solicited participation from all attendees, she was sensitive to the limited time available for each meeting, and she was specific in letting attendees know what was required of each of them as follow-up to the meeting. Ms. Young had been in this position for many years and was considering retirement sometime over the next year. The facility was fortunate to have an APC such as Ms. Young and should take advantage of this advanced notice and thoroughly plan for a transition to a new APC. The number of individuals placed in the community had decreased over the past year. The number of individuals in the referral process at SASSLC had increased, though, overall, the numbers remained low, given the size of this facility. • Only one community placement occurred since the last onsite review. This	Noncompliance

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		compared to three placements that had occurred during the previous onsite review six months ago, and five placements that had occurred at the time of the baseline review.
		• Eight individuals were on the active referral list and one was added during the week of the onsite review to make nine. A tenth was a possibility pending an upcoming PST meeting to follow-up to her annual PSP meeting. This was an increase from the previous onsite review during which four individuals were actively referred, and an increase from the baseline review when three individuals were actively referred.
		• Of these nine active referrals, four were new referrals since the last onsite review. Of the five that were the same, two had passed their 180 days (described elsewhere in this section), and three had been rescinded and then re-activated (one of these occurred during the onsite review).
		• Of the nine current referrals:
		  o Two had selected providers and were in various stages of CLDP planning activities (Individual #1, Individual #275).
		  o One was in the process of choosing between two providers (Individual #92).
		  o Two (Individual #107, Individual #269) were past the 180-day target for placement. This was due to a high level of involvement of the parents of the two individuals (i.e., an understandable reason). A provider had been chosen for one of the individuals. The second individual was in the process of visiting a number of possible providers.
		  o Three were experiencing difficulties since being referred. These difficulties were being addressed by their PSTs and were related to a need to obtain new communication equipment (Individual #211), psychiatric problems that resulted in medication adjustments (Individual #159), and having second thoughts about moving (Individual #160). Once resolved, possible providers were to be explored.
		  o One was a previously rescinded referral that was re-activated during the week of the onsite review (Individual #245). Exploration of possible providers was to begin within the next few weeks.
		• Since the last onsite review, three referrals had been rescinded and all three had been re-activated.
		• No individuals had returned to SASSLC after being placed in the community in the last six months. This was the same number as during the last onsite review.
		
		SASSLC reported that seven individuals had themselves requested referral, but were not referred. These seven individuals were not referred due to LAR preference (three),	

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		behavioral or psychiatric reasons (three), or the individual being in the process of exploring options by visiting community homes (this latter reason is often chosen by facilities so as to not begin the 180-day placement requirement). The monitoring team believes there are other individuals who have requested placement who are not on this list. For example, Individual #201 requested placement during her PSP meeting (and had done so many times before according to staff report), and Individual #279's PSP noted his preference for a group home. Moreover, this list contained 11 names at the time of the previous onsite review. Two of those 11 were now on the referral list. There was no indication why other names no longer appeared. SASSLC should be sure to include all individuals who themselves have requested referral on this list. Further, the facility did not maintain a list of all individuals for whom LAR preference was the only reason for a referral not occurring, including both those individuals who expressed a desire to move, and those individuals who were not capable of expressing a preference. This information should also be gathered and managed (also see below regarding determination of obstacles for each individual). Determinations of professionals This provision item also requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. It appeared to the monitoring team that the opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required (this was also noted in the previous monitoring report). This was based on a review of PSP documents that included little about the opinions of PST professionals. In most PSPs, a statement at the end of the PSP narrative attempted to present the PST's decision regarding most integrated setting and referral. These were typically one or two sentences that provided insufficient detail regarding the opinions of professionals, and led the monitoring team to assume that the professionals did not provide their opinion on this important matter. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Examples of what was found in SASSLC PSP documents are presented below. • In Individual #298's PSP, it stated that the "PST further agreed that Individual #298 would benefit from living in a group home as he would be exposed to his own bedroom, he could maintain his own personal space, and he can attend work daily." Immediately below this sentence, however, the PSP stated, "The PST determined the most integrated setting at the current time is Home 672 East at the San Antonio State Supported Living Center." The PSP did not indicate why	

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		the PST arrived at this conclusion. This was especially noteworthy given statement that preceded it. • Individual #99's brother was his LAR and said that he was aware of community options, but wanted his brother to remain at SASSLC. During the PSP meeting, the individual said, "… like it here" and his brother said that "It's safer here." The PSP stated that the "PST agrees with (brother)'s decision." The PSP, however, did not indicate why the PST arrived at this conclusion. • The aunt of Individual #313 reported on his history and his current needs. The PSP stated that "Based on this information and discussion PST agrees that Individual #313's living arrangement at SASSLC remains appropriate at this time." The PSP did not indicate why the PST arrived at this conclusion. • Individual #289 was reported to have had a failed previous experience living in the community. His family member reported that she would "love him to be in community," but did not want to risk another bad experience. The PST did not make a referral and PST members did not provide their opinions regarding community referral. • Individual #213's sister's preference was for her to remain at SASSLC, opining that she would not do well and would be a failure in a group home setting. The PST found her current residence to be most appropriate, but did not give a reason as to why. • Individual #43's PSP stated, "The optimistic living vision for Individual #43 is to live on 671 Sycamore." The PSP did not indicate why the PST arrived at this conclusion. • Individual #275's PSP stated, "The PST determined the most integrated setting is 766 Sycamore, SASSLC." The PSP did not indicate why the PST arrived at this conclusion. • Individual #86' PSP stated, "The PST determined the most integrated setting at the current time is SASSLC, home 672." The PSP did not indicate why the PST arrived at this conclusion. • Individual #244's PSP stated, "The PST has agreed that the most integrated setting for her at this time is 670 West Daisy Lane where she currently resides." The PSP did not indicate why the PST arrived at this conclusion. • The PSP for Individual #41 indicated that his PST agreed that his needs could be met in a community home." The PST, however, did not indicate why it did not make a referral. • Individual #229's PSP noted that her team would like her to explore community living options because they felt she would receive a better quality of life within the community. The PST, however, did not indicate why it did not make a referral.	

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		Perhaps the new style PSP will set the occasion for the incorporation of professional's determinations. The facility should ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. This provision item allows (and calls for) professional determination as separate from both the preference of the LAR and the opinion of the PST as a whole. <u>Preferences of individuals</u> SASSLC appeared to work hard to honor and support the preferences of individuals regarding community referral and placement. Nevertheless, the monitoring team was concerned about the way in which SASSLC determined individuals' preferences regarding community referral and placement based upon a number of observations during the week of the onsite review, as well as based upon a review of PSP documents (see examples below). Single questions during annual PSP meetings, for instance, are not likely to get at an individual's preference for something as abstract and important as choosing a place to live. Preferences must be obtained in a valid way. The individual must have the capacity to understand the options available and information being presented, be informed adequately and thoroughly, and be able to provide his or her preference freely. For many of the individuals at SASSLC, the validity of their preferences will have to be determined in multiple ways. The monitoring team recommends that SASSLC develop a way to ensure, in an individualized manner, that the preferences of each individual are individually and adequately determined regarding community placement. For many individuals, this activity will likely need to occur outside the context of a PST meeting. Illustrative examples observed or reviewed in documentation during the onsite review are provided below. • Individual #92 was to choose between two group homes during a meeting held with some members of his PST. The choice was presented to him by having the QMRP show him some photos of each home and giving him a foot pedal to use to answer yes/no questions. It appeared to the monitoring team that his answers were somewhat random and inconsistent. Further, the foot pedal involved pressing the left side for "yes" and the right side for "no." It was unclear as to whether the individual could reliably use this device. He seemed to answer questions differently than PST members (and his mother, who was on the speakerphone) expected, based upon previous discussions. Add to this the importance of the decision, the inequality of the photos of the two homes, and the presence of new people in the room (e.g., the monitoring team). Fortunately, the APC intervened and asked the individual and the PST to engage in more discussion and come back to making a decision in a few days. This was a good move by the PST. • In Individual #72's PSP document, it read,	

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		"The PST asked Individual #72 several times her preference. When asked with gestural prompts if she wanted to continue living at SASSLC, she smiled while making loud gestures. When asked with gestural prompts if she wanted to move away from SASSLC and live somewhere else she became quiet with no response. The PST restated the question in the above sequence two more times. She displayed the same response to continue living at SASSLC. Individual #72 continued to be quiet and eventually became teary eyed and sticking out her tongue at the PST members when mentioning the topic of moving away." Reading this made the monitoring team question whether this was truly a rejection of all community living options and whether this was an informed decision that met the types of criteria one would want to ensure were in place for a decision as important as this. • Similarly, the PSP for Individual #307 said that he "has expressed through his smiles and contentment that he is happy here at SASSLC." It was great to see that this individual, as well as Individual #72 as noted above, and many others appeared to be happy and doing well at SASSLC. Nevertheless, if an individual's preferences related to community referral are to be respected, those preferences must be assessed and determined in an adequate and valid manner. • In Individual #77's PSP, it noted that he was asked if he would like to continue living where he now lived. He answered, "Yes." Again, although it was great that he was perhaps happy at SASSLC, it was unclear whether a preference for community referral was determined in an informed way. • Individual #279's PSP stated that "Individual #279 would prefer to live in a small group home environment with 3 or 4 other individuals…" Other preferences for home characteristics were also listed. This individual, however, was not referred for placement and no indication was made as to why he was not referred, or why his preference was perhaps not an informed one. • Similarly, according to Individual #299's PSP, he had visited group homes and said he liked the community, but that SASSLC "is for him." Further, his father supported this decision. This may, or may not, be another example of where an adequate decision making process occurred. Either way, it was not explained adequately in the PSP. • Two individuals had almost identical PSP documents, including statements that each individual wanted to obtain a supported employment job in the community prior to being referred (Individual #140, Individual #150). If this was the case and if it was a good decision for these individuals, it was not indicated in the PSP and, further, neither individual had an action plan or objective for obtaining community employment. • A meeting for Individual #245 was held to discuss whether he wanted to be	

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		referred to a group home after a plan for him to live with his sister fell through. He said that he wanted to consider a group home. In this case, although it was not clear that he was making an informed decision during the PST meeting, members of the PST talked about a number of other discussions they had had with him about this new decision. Therefore, this appeared to be an adequate and appropriate decision for this individual. Thus, SASSLC should develop a methodology to reliably determine an individual's preference for community placement and referral, and then to clearly indicate in the PSP how that individual's preferences were determined. This activity of supported decision-making and is an area in which the facility needs to improve. <u>Preferences of LARs and family members</u> SASSLC also attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. Family members and LARs were involved in the lives of most of the individuals who were on the active referral list. The monitoring team noted that a number of family members and LARs appeared to be willing to learn more about community placement, to go on tours, and/or to have their family member go on tours of community providers (e.g., Individual #229, Individual #298, Individual #77, Individual #213, Individual #307, Individual #41). <u>Senior management</u> Recently, the APC developed a weekly and a monthly report for senior management. The weekly enrollment report was one page long and listed the current census and vacancies at each of the 13 homes on campus, scheduled community placements, admissions, transfers from or to another SSLC, and referrals and inquiries for admissions. It was a simple, easy to understand overview of the admissions, referral, and placement status at the facility. The monthly report was new as of January 2011. The report was presented at the QAQI Council and was to be a regular component of this monthly council meeting. The report contained space for detail about all of the information that was in the weekly report, however, much of this was still blank. Senior management will be especially interested in the status of individuals who were on the referral list and, therefore, more detailed narrative information should be included. In addition, the report should contain information about obstacles to referral, once that information is gathered in a more comprehensive manner. It is likely that information about obstacles will lead to discussion by senior management at the QAQI Council. Also, these data (i.e., the information in the monthly report) should be incorporated into	

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		the facility's QE 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 the need for improved practices as discussed in all of the following subsections of this provision T1b. Upcoming changes in the state and facility policies were reportedly being designed to improve current practices regarding most integrated setting practices so that they would be more likely to be in substantial compliance with this provision item. The state policy regarding most integrated setting practices was numbered 018.1 and was dated 3/31/10. All of the monitoring team's comments from the previous monitoring report remained the same for this review and are not repeated below. The APC reported that SASSLC had adopted the state policy and was working under the policy. The state policy was available at the facility and had been re-labeled as a facility policy. The monitoring team learned that 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. The APC was developing two facility-specific policy and procedures. One was to describe the specific processes at SASSLC that any staff involved in the referral and placement process would need to know, such as SASSLC paperwork, timelines, and expected outcomes. The second was to provide specific details around the CLDP process and document. Once developed, these policies should be reviewed and approved by the DADS central office. 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 changes.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety	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

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	and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The new statewide policies and procedures were being implemented at SASSLC regarding the PSP process. These policies and procedures were recently taught to the facility's QMRPs and the new procedures were put into place in mid-November 2010. All five of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. These were implemented under the new PSP format. In addition to attending these PSP meetings, 31 PSP documents were reviewed (listed in the Documents Reviewed list at the beginning of this section of the report). The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. This set of PSPs included those provided to the monitoring team based on a request for all new style PSPs conducted in December 2010 and January 2011, as well as a variety of PSPs conducted since October 2010 provided in response to the monitoring team's overall document request submitted to the facility prior to the onsite review. Of these 31, seven were incomplete, missing pages, or had blank sections related to most integrated setting practices. <u>Protections, Services, and Supports</u> The new-style PSP for each individual noted a variety of preferences, needs, required supports, and action plans (i.e., service and training 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 to be found in the section titled "Optimistic Living Vision." The discussion about the ideal optimistic vision should focus on 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, and skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The optimistic vision should not merely be a listing of the individual's preferred items. Nor should it merely be a listing of the supports currently provided to the individual. That being said, the SASSLC documents, the meetings that were observed, and conversations with some of the QMRPs indicated that the facility was eager to achieve this type of integrated discussion. The monitoring team expects that the QMRPs, with additional practice and experience, proper training, and ongoing support, should be able to accomplish this.	

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		Each written PSP began with a listing of the individual's preferences. This list came from a meeting held a couple of weeks prior to the annual PSP meeting called the PFM (Personal Focus Meeting). Below this listing was a short paragraph describing which of these preferences was most important. Following this was a heading "Optimistic Living Vision" followed, in most of the PSPs by a description of the individual's awareness of community options, preferences of individual and LAR, obstacles, needed supports, and a statement about the most integrated setting and the PST's determination as to the most appropriate setting for the individual. The PSPs ranged in length due, in part, to the transition from the old style to the new style, that is, some of the PSPs contained both the old and new style (e.g., Individual #140, Individual #150). These two PSPs were nearly identical in wording, action plans, and objectives. The facility should ensure that this was not an error and if not an error, that the PSP was individualized for these two individuals (it appeared that it was not individualized). Two minor changes are suggested to help the reader of the PSP have a better understanding of the individual: (a) add a short paragraph describing relevant history, and (b) when appropriate, refer to any relevant assessments without unnecessarily repeating what is already in each assessment. The PSP meetings observed by the monitoring teams were, as designed, free flowing and did not follow the order and format of the written PSP. Although this made sense to do, the written documents did not accurately reflect the breadth (or brevity) of the actual discussions. Although the written PSP needs to follow a structured format, the resulting document needs to reflect the level and intensity of discussion that occurred during the meeting. Of the set of PSPs submitted, Individual #229's appeared to have the most in-depth description of the meeting's discussions. The monitoring team also looked at the skills chosen by the PSTs to be taught in a formal structured manner using training objectives (called SPOs). Across the set of PSPs reviewed, the number of skill training objectives ranged from five to nine per individual. This was a relatively small number of training objectives per individual, considering that at least two of each individual's objectives were the state-required self-administration of medication and money management related objectives. Three additional comments regarding typical important community living skills are presented below. • Only two of the PSPs reviewed contained an SPO about a relevant community living skill that was to be taught in a community setting: Individual #298 had an SPO to make a purchase in the community, and Individual #244 had an SPO to order fast food at a restaurant. Perhaps these two examples are the beginning of	

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		a trend at SASSLC to include community-based SPOs for more individuals. • No individuals in the sample reviewed had an SPO related to employment. The closest approximations were SPOs for staying in the work area or staying on a work task for a short period of time. There were no SPOs related to any specific or generic job skills. Surprisingly, there were no employment related SPOs for Individual #140 or Individual #150 even though their PSPs specifically noted a request by each individual for a community job. • The PSPs of individuals who were referred for placement did not take the opportunity to specifically focus on more intensive skill training of relevant community-related skills. The inadequate list of skill acquisition objectives in SASSLC PSPs begged the question of the adequacy of the facility's skills assessment process in guiding the PST in choosing important objectives for formal (and even for informal) instruction for all individuals at SASSLC. To address this problem, DADS recently convened a statewide workgroup to look at this issue. As of the time of this onsite review, the workgroup had drafted a functional skills assessment that was a revision of the PALS, and was also looking at commercially available functional skills assessments in order to consider whether there might be any that are appropriate for use at the SSLCs. The monitoring team was pleased to learn that these activities were occurring. Please also see further discussion of training objectives in sections F1d, F2a1, and S of this report. Five annual PSP meetings occurred during the week of the onsite monitoring review. All five were observed by members of the monitoring team. Comments are provided below for two of these meetings. Overall, the observations indicated that more practice and support of QMRPs will be required for the QMRPs to accomplish all that they are expected to accomplish during the annual PSP meeting. • Individual #180: Attendance was good and included her QMRP, day program supervisor, OT, home supervisor, RN, SLP, and direct care staff. In addition, the new QMRP coordinator and staff from the facility's "at risk" program attended (see more discussion below and in section I of this report). This was only the third time the QMRP led a new style PSP and the monitoring team understands the difficulty in implementing this new type of PSP meeting, especially given the added observational staff (i.e., monitoring team, QE department program monitor, QMRP coordinator). Overall, she ran the meeting in the way that, with additional practice, should allow her to meet the goals of the new style PSP process. She began by asking everyone to put their cell phones on vibrate and saying "We want this to be integrated, please everyone, participate." She then	

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		talked about the individual's preferences as identified at her PFM meeting (family relationships, eating, retirement activities). The QMRP also noted that the individual's mother was highly involved (called twice each day and visited every weekend), but due to a medical injury could not attend this meeting. o The discussion for the next hour was about how to attend to these three areas of the individual's preferences. First, there was a discussion of how to help the individual visit her mother at her mother's home, including providing transportation, sending adaptive mealtime equipment along on visits to her mother's home, and the OT doing a visit to see what other environmental supports could be provided. The QMRP was able to improve participation by asking direct questions of attendees, such as "What do you think?" to the direct care staff member regarding types of items to send along with the individual on a home visit. The discussion then went on to helping the individual to walk as independently as possible. Throughout the meeting, participants addressed the individual directly and talked to her in a very pleasant, respectful, and adult manner. o There was some discussion of community referral. PST members noted that over the last year, Individual #180 refused to get out of the car on group home tours, but had no problem getting out of the car to go to restaurants, the park, or the zoo. The monitoring team understood that her refusal to get out of the car indicated her preference to not go into the home, but did not understand how this could be considered to be her expression of a desire to not be referred or an indication as to whether or not she could be successfully supported in a more integrated setting. Perhaps, for this individual, the PST needed to merely note that her preference for community referral was unknown and could not be determined. Please see the discussion above in T1a. The QMRP said that Individual #180's mother was not interested in her moving to a community group home. The QMRP, however, wondered aloud whether more education would be helpful and suggested talking with the mother about going on tours and attending the next provider fair. o The meeting then continued onto topics of her vision, her rapid eating, her enjoyment in eating, cooking class, her weight, exercise, and day program activities. This was a good discussion, the type intended by the designers of the new style PSP. Rights restrictions were reviewed and the meeting was about to come to a close when the "at risk program" nurse said that they hadn't discussed this yet. Then, each of the risk areas was reviewed (this process was modified during the week of the onsite review to be more integrated into the meeting as well as to not	

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		merely refer to the previous ratings by the old health status team system of assigning risk ratings). Overall, the meeting covered many important topics. More specificity during the meeting, however, will be needed around the discussion of optimal living, addressing all areas of support (not only related to her preferences), determining SPOs, and incorporating the at-risk component. • Individual #201: The meeting was led by an experienced QMRP who was very familiar with the individual. There was a large attendance at the meeting, a total of 14 attendees (not including the monitoring team). There was, however, very little participation by PST members. This may have been due to the monitoring team's attendance; the QMRP said, after the meeting, that she tried to get greater participation, but this was less participation than she typically gets. The recreation therapist and the individual's day program staff were two exceptions, they participated throughout the meeting. The meeting was quite long, almost three hours. Rather than summarizing the entire meeting, some highlights are presented below. o The QMRP went through Individual #201's preferences and this led to discussion about visiting her mother, drinking liquids, following a diet, and spending money. Possible training objectives were identified during these discussions. o The QMRP also talked about risk categories when those topics came up. Later in the meeting, she reviewed the entire list to cover those risk areas that had not yet been addressed during the meeting. This was a good way to ensure that all risk areas were addressed by the PST. o The majority of the meeting was about community referral and placement, the Optimal Living Vision section of the meeting. Individual #201 was very happy and excited about moving to a group home. She had a failed placement a few years ago and her team wanted to move towards a new referral cautiously. The PST had made great progress with Individual #201's family and they were supportive of whatever the PST determined would be in the individual's best interest and make her happy. After much discussion, the team decided to not do a referral and instead wanted to have her do additional home visits and to continue to address two important issues from the past year: being compliant with medical appointments and getting up and going to work every day. After the monitoring team commented that it appeared she'd made good progress on these two areas since last year, and after the CLOIP worker said that that she saw no reason why Individual #201 could not be referred, the QMRP said that the team would now make the referral. Unfortunately, the opinions of other team members (i.e., other	

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		professionals) were not offered or solicited. After the meeting, the monitoring team spoke to the QMRP to make it clear that she and the PST should not have made a referral based on any questions from the monitoring team, that is, that it still remained a team decision. After further discussion, including the APC, Individual #201's team was to meet again the next day and create a more specific and appropriate plan for her. That plan was to have her do two overnight visits within 45 days and then the team would immediately meet and make the referral, unless there was some reason, based on the two overnight visits, to not make the referral. This was a reasonable outcome and one that the team might have come to if there had been more participation and more contribution of the opinions of professionals. The QE department conducted occasional monitoring of the annual PSP meeting. The completed form for the above PSP meeting for Individual #180 was submitted. The form was four pages long, but did not easily correspond to the new style of the PSP meetings making it impossible to gain a sense of the content of the meeting from this monitoring tool. Further, there was no content related to the optimistic living vision, referral and placement, and obstacles to placement. Sections regarding the team's review of professional's recommendations were blank. Monitoring of the PSP meeting can be a very valuable activity, but the format of SASSLC's monitoring of the PSP meeting will need to be revised. This may best be accomplished with the collaborative efforts of the QE department, APC, and QMRP coordinator. A better form and process would make better use of the QE staff member's time and provide more useful information to the QMRP and to those at the DADS central office who are interested in these data. The facility might also consider having the post-move monitor participate in occasional observations and monitoring, especially regarding the discussion of living options. Based on observations during the onsite review, review of documents, and discussions with some of the QMRPs and with the new QMRP coordinator, the following comments are provided regarding the new PSP process at SASSLC. Positive comments: • The process was very new and will take some time for QMRPs to be comfortable and competent with it. • It was implemented fairly consistently across QMRPs. • Participation from PST members appeared to be greater than in the old style format (though not in Individual #201's meeting). • Time was not wasted on topics that were not relevant to the individual or for the bland reading of reports and assessments.	

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		• The initial discussion of preferences set the tone that this meeting was about the individual. • Active participation by team members, and competent facilitation by QMRPs can lead to other important topics (some examples were noted above). • The list of supports helped to ensure that none were forgotten. • Individuals had opportunity to participate. Comments requiring attention: • PSTs may fail to cover all of the important areas due to the more open and free flowing nature of the new format. The QMRPs may benefit from having some sort of checklist (in addition to the list of support/need areas). • The characteristics of an ideal successful most integrated setting (i.e., optimistic vision) need to be discussed. o QMRPs may benefit from having a list of the types of topics to touch upon during the LOD. • The written document failed to present the thoroughness and depth of some areas of discussion. • Obstacles to community placement should be identified. • A relevant set of training objectives should be identified. • QMRPs will need support and specific training on how to lead a meeting and to be an effective facilitator. The advantage of the new format also sets the occasion for PST discussions to become in depth, to stray from the important topics at hand, and to include disagreements. Therefore, QMRPs as facilitators (and leaders of these meetings) must be confident and skilled. The monitoring team believes the QMRPs would welcome this type of training. Moreover, the monitoring team was quite impressed with the vibrancy of the QMRPs' desire to implement this new style PSP in a competent and valuable manner. • A brief paragraph or two regarding the individual's history would be helpful to include in the written PSP. • Assessments were not repeated in the PSP document. This was a good thing and helped to not overly lengthen the document. The narrative in the PSP document should, however, reference the assessments when appropriate to do so, such as when referring to medical supports or to communication supports. Obstacles to Movement There continued to be no coordinated plan or approach to identify and address obstacles to movement to the most integrated setting across the facility (also see T1g below). Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. Further, obstacles to	

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		movement were not included in all PSPs in which an individual was not referred (e.g., Individual #232, Individual #95). In other cases, obstacles were listed that did not appear to be obstacles, though they certainly were topics that needed to be addressed by the facility. These included: • Individual #298: having a rigid routine due to his autism • Individual #234: difficulty with change • Individual #244: she had a difficult and traumatic group home placement prior to residing at SASSLC • Individual #313: LAR (but he did not have an appointed LAR) • Individual #275: anger In most every case, a plan to address the obstacle was not explicitly being addressed via an action plan as a service objective or training objective. This was particularly noteworthy in regards to community employment for Individual #140 and Individual #150, as noted above. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. It may be that use of this list will help PSTs at SASSLC to be more successful in identifying and addressing obstacles.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	SASSLC continued to engage in activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. 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, an annual provider fair had occurred during the previous onsite review. It was scheduled to occur again. In the previous monitoring report, the monitoring team made a number of suggestions for improving the provider fair. Various notes in the POI and in the minutes from the SSLC-MRA meeting indicated that some actions were being explored regarding the next provider fair. Second, the APC and PMM attended a quarterly meeting with the local MRA offices, Alamo Local Authority and Camino Real Community MHMR Center. Agenda and minutes from the October 2010 and January 2011 meetings were related to educational activities for SASSLC residents, family members and LARs, and PST members. Discussions were in references to training sessions, changes to the next provider fair, and status of the CLOIP visits.	Noncompliance

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		Documentation for trainings regarding the new CLDP process were also submitted to the monitoring team. One training was conducted by the DADS central office discipline head for community placement. It was a two and a half hour training attended by more than 50 managers and QMRPs. The APC conducted the same type of training for members of the PST of Individual #92 to assist the team in its referral and placement activities. This seemed to be a great idea to get all team members ready for using the new CLDP process. 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. The purpose of the CLOIP was to educate individuals and family members about community living options. The CLOIP process had been in place for a number of years. The monitoring team, therefore, recommends that the facility assess the effectiveness of the CLOIP process, that is, whether or not it achieved the outcomes the facility intended it to achieve. Interestingly, 11 responses from the new online family survey data , indicated the answer to the question "Information is provided regarding living option choices in the community" was 64% always; 27% usually, and 9% sometimes, that is, these respondents felt they were given information about community options. It was great to see that the facility was beginning to collect this type of information, however is impossible, at this point, to generalize these initial data to the larger population of family members and LARs. Fourth, the facility took individuals on visits to community providers. The facility had made a lot of progress in organizing its system of planning, documenting, and reporting. Many more individuals and facility staff visited community providers than during the time of the previous onsite review. The PMM had lead responsibility for organizing this information. Further actions should: • Ensure that all individuals have the opportunity to go on a tour, except for those individuals who state that they do not want to participate in tours (or whose LARs state they should not participate), and those individuals whose PSTs have provided a reason why the individual should not participate in community tours. • Ensure that PSTs know what information is needed by the coordinator of these tours to make the tour meaningful (e.g., type of home, location, mobility needs). • Summarize the comments from staff and individuals, if possible, about the individual's response to the tour (the new form asked for this information). • Incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QE data system, such as number of individuals who have gone on tours, number of providers visited, number of direct care staff who have gone on tour, and so forth (see section E above).	

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		Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work (including training and support of the QMRP facilitators) was needed to have these discussions be more comprehensive and meaningful, especially given the new PSP format. Finally, although not solely related to education about community placements and providers, the self-advocacy group at SASSLC provided an opportunity for another venue to educate individuals about community placement and the community placement process.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility reported that it was not assessing individuals for placement and was waiting for direction from the DADS central office. Indication that individuals were not assessed for placement was evidenced by the absence of a list of individuals whom the PST would refer if not for LAR preference, and the list of individuals who themselves had expressed an interest in wanting to explore a possible move to the community did not contain all of these individuals. The monitoring team understands the difficulty in determining a process for assessing an individual for placement, that is, what tools, questions, or criteria, if any, should be included. Therefore, as noted in the previous monitoring report, the facility will need guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. If the position of the facility is that the PST goes into the annual meeting with the concept that all individuals can be supported in the community (with very few exceptions), the PSP meeting and PSP document will need to clearly show discussion of the supports the individual needs wherever he or she will be living, obstacles to community placement, and methods to address these with action plans. It is possible that a combination of a document review (of PSP) and an observation review (of PST meetings) could show that the facility did an assessment of the individual for placement. Further, the PSP might include an explicit statement, such as "The PST assessed (the individual) for placement by doing the following:"	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form.	Noncompliance

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	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:	Many of the changes to the CLDP format were in response to discussions that monitoring team members had with facility and state staff during onsite monitoring reviews, as well as in response to findings noted in baseline monitoring reports. The monitoring team appreciates and acknowledges the facility and state's responsiveness. Some comments regarding the new CLDP form are presented below. Note that this new format CLDP had not been implemented at the time of the onsite monitoring review. Therefore, these comments are based solely upon a review of a blank form. • Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. • The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. It sets the occasion for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. • A list of standard items to be completed and in place prior to every individual's move now appeared on page 6 (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus upon identifying those essential and nonessential supports that were truly based upon individual needs and preferences. • The list of summaries and recommendations on page 9 was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or nonessential supports. • Psychiatry should be added to the list of summaries and assessments. • The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the monitoring team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the state's desire	

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		for transition to grow out of the PSP process. • It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or nonessential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. • The pre-move site review should also be sure to include the list of standard items on page 6. This could be added to the list on page 23. The monitoring team looks forward to reviewing the implementation of these new procedures.	
	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. As noted above, this policy, including the CLDP process, was being revised. The one completed CLDP reviewed in this section of the report (Individual #192) was implemented as per the current (i.e., old) CLDP policy and procedures. This CLDP and some associated documents (e.g., discharge assessment summaries, PSP) were submitted to the monitoring team and were reviewed. Two CLDPs that were in process (Individual #1, Individual #92) are also discussed in various places in this section of the report. One of these two (Individual #1) was being developed under the old CLDP process; the other (Individual #92) was being developed under the new CLDP process. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections V. and VI. and was standard in all CLDPs. The absence, however, of adequately defined tasks resulted in this provision item being rated as being in noncompliance. Further, as indicated in the facility's self-assessment, the new CLDP and the new policy for most integrated setting practices would provide more direction to the facility in meeting this provision item. The CLDP also included a list of essential and nonessential supports, each of which was assigned to a staff member at the provider agency or at the facility. Essential and nonessential supports and their implementation responsibilities are addressed in section T1e below.	Noncompliance

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		The CLDP submitted for Individual #192 was lengthy and detailed. It was 31 pages long, plus signature sheets, and an attached PSP, PBSP, medical summary, and psychiatric summary. Other updated assessment information was included within the 31 pages of the CLDP. The CLDP described a total of three meetings that occurred during the development of his CLDP. DADS central office reviewed this CLDP and submitted two pages of comments to the APC. This review appeared to contain useful and relevant feedback that directed the APC to make edits, clarify information, and add information. The document given to the monitoring team appeared to contain some, but not all, of these suggested edits. The monitoring team wondered why some, but not all edits were made. Further, it was unclear as the process for updating a CLDP based on feedback that occurred after the individual had moved. The feedback for this CLDP was dated 1/3/11, the CLDP was dated 12/6/10, and his move date was 12/21/10. Of note, however, was that SASSLC was beginning to implement an important aspect of the new CLDP process. Specifically, the placement process was occurring in a more individualized manner, planning was beginning earlier in the process, and PST members were more involved. Below are some examples: • A CLDP meeting was held for Individual #1 during the week of the onsite review. The monitoring team expected it to be a final meeting, prior to his upcoming move. Instead, and more appropriately, it was one of a series of meetings towards the development of the full CLDP. A series of PSPA notes showed the progression of his placement process and PST discussions since September 2010. • A special PST meeting was held for Individual #92 for him to choose between two providers. The APC noted that this was the next step of his CLDP. He had interviewed two agencies. The QMRP had brought photos of both homes and a foot pedal yes/no communication device. When asked if he wanted to move to the community, he answered "Yes, yes." Over the course of a number of subsequent questions, it became apparent to the PST members (as well as to the monitoring team) that his answers were not consistent with preferences he had clearly indicated during previous discussions with various team members. The APC smartly suggested having additional conversations and coming back to the decision in a few days. The individual's mother, who was on the speakerphone, supported this and said that she wants him to move where he'll be happy. The PST will need to be certain to properly support this individual's decision making (as noted above in T1a). The APC also wisely suggested ending the meeting and not using this time to begin a conversation about needed supports. This was a	

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		wise decision because the meeting had already lasted for an hour, the individual appeared exhausted (and perhaps confused), and the PST would be more effective in identifying needed supports at a later time, after a decision about a provider and home was made. • A special PST meeting was held for Individual #245 to discuss his interest in re-activating his referral. The team reviewed his 10-day visit with his sister that was arranged in preparation for the individual living with his sister in an adult home care arrangement. It had not gone well and both the individual and the team determined that this was not the place for him to move. His referral was rescinded, but he had spoken with various team members about wanting to consider moving to a group home. During the meeting, it did not appear to the monitoring team that the individual fully understood the topic. For example, when asked if wanted to look at group homes, he said "yes," and then later responded to other questions by saying "blue house" and "needles." His team members, however, appeared to know him very well and were in full agreement that a referral was appropriate. To the monitoring team, this appeared to be a good example of supported decision making. • The PST for the individual who had moved to the community (Individual #192) held a meeting to review two issues that had arisen since his transition. One was him having, unexpectedly, a housemate who was 11 years old. The other was regarding the residential provider getting the individual to his community job. The PST discussion was appropriate, to the point, and plans were made. The monitoring team spoke with the APC after the meeting about the importance of resolving the housemate issue. • The facility's newsletter, The Bridge, September 2010 edition, noted that two individuals (Individual #22, Individual #92) visited a community home for possible placement. It stated that although the experience was exciting and positive, the home didn't quite meet all their needs and, as a result, their teams were going to explore more community options.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP clearly indicated the staff responsible for certain actions and activities. Target dates, however, were not included for implementation of all supports. Instead, the number of days allowed for completion was provided. The newer draft CLDPs, however, indicated specific target dates and the expectation is that specific target dates, rather than general timelines, will be included in all future CLDPs. Therefore, this provision item was rated as being in substantial compliance.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to	The CLDP contained evidence of individual review. Moreover, the process for placement involved the individual in a very profound manner (e.g., discussion, home visits, and decision making described in great detail in the CLDP).	Substantial Compliance

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	facilitate their decision-making regarding the supports and services to be provided at the new setting.	In addition, the monitoring team's observation of activities related to the two CLDPs that were in process (Individual #1, Individual #92) clearly demonstrated a high level of individual involvement as well as involvement of the individual's family members. As noted in a number of places in this section of the report, the monitoring team recommends that the facility, in its efforts to support each individual's preference, proceed carefully and individually in assessing and determining each individual's preference so that mistakes will not be made. Therefore, the monitoring team has rated this provision item as being in substantial compliance.	
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The APC reported that she reviewed all assessments and all assessment updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. As indicated in the previous monitoring report, a completed tool or checklist was recommended to indicate that all required assessments were completed, submitted, and updated within 45 days. The facility's self-assessment indicated that this was being developed. Moreover, it appeared to be part of the new CLDP; thus, implementation of the new CLDP process should address this need perhaps without the addition of a new checklist tool.	Noncompliance
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-	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 list of essential and nonessential supports in the CLDP was inadequate to meet the requirements of this provision item. First, the CLDP did not identify needed supports from a wide range of possible supports that would be appropriate for this individual, especially given the list of prioritized outcomes on page 26 of the CLDP. Second, the	Noncompliance

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	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.	supports, both essential and nonessential, were not described in adequate detail. Almost every support was written in this way. The wording did not provide the facility, the receiving provider, or the post move monitor with adequate guidance regarding the development, implementation, and monitoring of supports for this individual. This was noted in the previous review and continued to be a problem. This flawed manner of identifying and defining supports needs to be corrected. Below are some examples of supports illustrating this: • Furniture • Additional home staff • Supportive employment (restaurant name) • Spending money The monitoring team understands that the new CLDP process will require the CLDP to describe, in defined observable terms, each support so that it can be observed, measured, and recorded. The developers of the CLDP should also be sure to include criteria for the presence of each support. Further, the new CLDP process includes standardized list of supports, so that the PST can focus upon those supports unique to each individual. This will be important in order for SASSLC to achieve substantial compliance with this provision item.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	As noted in section E (Quality Assurance) of this report, quality assurance processes were at the early stages of development at SASSLC and the inclusion of data regarding section T of the Settlement Agreement was not occurring. The APC and PMM were not yet involved in doing any QE-related activities, such as monitoring of the facility's status on any section T provision items. Two activities at SASSLC, however, were related to data collection on most integrated setting practices and could be incorporated into the facility's QE program. One was the weekly and monthly reports completed by the APC. The data from these reports could be tracked by the APC and also submitted to the QE department. Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QE department and to its senior management team. Examples include: • Individuals placed • Individuals referred • Obstacles to placement • Action plans related to obstacles • Educational activities The second activity was self-monitoring checklists developed, but not yet implemented	Noncompliance

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		or piloted, by the post move monitor. She had three different new checklists with guidelines on scoring. These tools, once piloted, may be very useful to the facility and may even serve as a helpful model to other SSLCs.	
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 developed an initial report designed to ultimately meet the requirements of this provision item. The statewide report provided an overview of how obstacles were to be identified, a definition of each of 12 different categories of obstacles, and a description of 11 steps the state and facility might take to address some of these obstacles. As discussed with DADS management, the goal was for the state to gather all of the data on the 12 categories of obstacles and create a statewide plan. In addition, the statewide report would include • an appendix for each of the SSLC that provided data specific to that facility, • additional information specific to that facility, such as related to location, population, staffing , and • steps to overcome that facility's specific obstacles. Some obstacles might be able to be resolved at the facility-level, while others will need state intervention. The data that will be used were being entered into the system as each individual planning session transpired. This was to occur beginning 9/1/10, however, no data were submitted to the monitoring team. If implemented, this appeared to be a reasonable approach to reaching substantial compliance with the requirements of this provision item. The monitoring team recommends that further information be collected regarding one type of obstacle, that is, LAR preference for the individual to remain at the SSLC. Rather than solely listing this as an obstacle, the report should indicate the reasons for the LAR's	Noncompliance

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		preference (i.e., reluctance to support referral). This information will be helpful to DADS and to each facility.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a document titled "Community Placement Report." It was dated 1/6/11, included information for all of calendar year 2010, and had six sections • current referrals (eight individuals) • community placements (one individual) • rescinded referrals (three individuals) • three sections regarding individuals who were not referred for various reasons(nine individuals) This provision item was found to be in substantial compliance given the current contents as well as the facility and state's intention to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T1a, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The state indicated that at this time, its data system did not include this information, but it was working toward being able to produce these data in the near future.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		

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T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SASSLC was implementing the post-move monitoring process. The facility was fortunate to have a competent post-move monitor. Over the past year, she had worked to improve the post move monitoring process at the facility. In addition, she appeared motivated to conduct post move monitoring in the most effective way possible. Since the last onsite review, post-move monitoring was conducted for Individual #192 (7-day and 45-day), Individual #329 (45-day and 90-day), Individual #76 (90-day), and Individual #102 (90-day). Individual #192's 45-day post-move monitoring was completed during the week immediately preceding the onsite review. The monitoring team appreciated the efforts of the PMM to complete the post-move monitoring document so that it could be included in this review. These six post-move monitoring visits were 100% of the post-move monitoring that was required, that is, due to the few placements that occurred, very little post-move monitoring was required. Two of these six were for individuals placed from other SSLCs within SASSLC's geographic catchment area. The post-move monitoring was completed within the required timelines. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. Post-move monitoring continued to include a visit and observation at the residence when the individual was at home <u>and</u> a visit to the individual's day program site. As a result, it sometimes required a number of days for the PMM to complete the post-move monitoring. This demonstrated a thoroughness in post-move monitoring and the monitoring team was impressed by it. A new post-move monitoring form was developed by DADS and was implemented by the PMM for the first time for Individual #192's 7-day and 45-day monitorings. The monitoring team reviewed this new form. It included some improvements, such as a place to indicate where the visit occurred (e.g., home, day program), and a column for evidence for each support. Once implemented properly, this column should indicate the evidence as determined by the PST during the construction of the CLDP. The PMM will, therefore, need to enter the evidence she found in the comments section. After reviewing the implementation of the new form and the resulting completed document, the monitoring team found, unfortunately, that the design of the form had the unplanned effect of stopping the conduct of some of the very things that the monitoring team very much liked about the way post move monitoring was conducted and documented.	Noncompliance

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		Three issues with the new PMM form are presented below: • The new format had only a narrow column on the right side for comments. The monitoring team recommends that the form be revised to include a larger space for comments. One way to do so would be to create a row under each support instead of using a narrow column. Making it standard practice to add notes in a cumulative manner is also recommended. The monitoring team discussed this with the PMM and she made this change when she completed the 45-day form for Individual #192. Her intention was to continue to do so going forward. As a result, the 45-day monitoring form for this individual was more comprehensive and informative than any of the other five post move monitoring forms completed since the previous onsite review. For example, it included very specific details about her visits and interactions with the individual as well as plans for follow-up for three important issues that were discussed during the week of the onsite review at a post move PST meeting at SASSLC and during the monitoring team's visit to the individual's home (see T2b below): the provider's frequent failure to get the individual to his community employment, incorrect early discontinuation of two medications, and a reference to a highly unlikely psychiatric and behavioral problem found in a psychiatrist's note. • The previous form had a column for the PMM to indicate yes/no/na for each support. The new form did not contain this column, but should. This will make it easier for the reader to quickly determine the PMM's evaluation of the presence or absence of each support. PMM comments, without the forced indication of yes/no/na, will not be sufficient to indicate the thorough post-move monitoring of each support. This was also discussed with the PMM and, as a result, when she completed Individual #192's 45-day post move monitoring form, she added to the end of the narrative of each support whether the support was "met" or "not met." This was helpful to the monitoring team's review of the completed form. • The inclusion of a column to indicate the evidence that the PST determined would be required to be present to indicate presence of the support was an excellent and needed addition to the post move monitoring process. The determination of evidence is something that should be discussed and determined by the PST (with input from the APC and PMM) during the planning for transition, including, most importantly, in the finalization of the CLDP. The description of evidence, however, needs to include criterion, too. For example, Individual #192's essential and nonessential supports were not written in a detailed manner (as noted above). Similarly, the information in the evidence column of the post move monitoring report was not specific and merely indicated where the PMM should look for information (e.g., inservices document	

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		sign in sheet, email reports, transportation), but not what those documents should indicate. This gave the PMM little to work with. Making this type of determination should not be the PMM's responsibility; instead it should be done by the PST, most preferably, during the CLDP meeting. Thus, the PST, at the CLDP meeting, needs to identify, for every essential and nonessential support: o what evidence should be present o the criterion for this evidence The PMM participates in the development of every CLDP. Her responsibility, therefore, should be to ensure that the PST has provided her with enough detail so that she can thoroughly conduct post move monitoring. This includes both a well-defined description of each support as well as a well-defined description of the way she should determine the presence of each support, including the criterion. This item is being rated as being in noncompliance, however, the monitoring team expects that with implementation of the revised CLDP and post move monitoring processes, as well as with responsiveness to the recommendations made in this section of the report, that SASSLC will obtain substantial compliance at the next onsite review. The rating of noncompliance is not a reflection of the work of the PMM; she was dedicated to doing a thorough job as evidenced by her many questions, responsiveness to comments from the monitoring team, and her follow-up to any support problems identified during her post move monitoring visits. The monitoring team and the PMM and APC had the opportunity for numerous productive and interesting discussions regarding the CLDP process, the determination of essential and nonessential supports, determining criterion for these supports, and the post-move monitoring process during the week of the onsite review. The APC and PMM reported that they 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	As noted above in section T2a, post-move monitoring visits were occurring at SASSLC. The monitoring team had the opportunity to accompany the post-move monitor on a visit to the group home of Individual #192. His 45-day review was conducted the week prior to the onsite monitoring review in order to meet the required timeline. The purpose of this visit was to learn about the post-move monitoring process, see the community home and day program, meet the individual, learn about transition and services, and see the status of some of the essential and nonessential supports. The monitoring team wishes to thank the PMM and the community agency for making	Not rated

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	Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	arrangements for this visit to occur. Three individuals lived in the home. It was acquired by the provider recently (October 2010). The home had an open floor plan, was clean, and had new furniture. There were few decorations or items that made the home feel like a home. Perhaps over time, this will be accomplished by the provider. Overall, the individual appeared happy and comfortable in his home. Even so, the plan was for him to move to a new home with another individual from SASSLC who was in the process of transitioning (Individual #1) once the new home was ready and the other individual's transition was completed. Individual #192 agreed with this plan and was looking forward to it, according to staff reports. The new home was to be operated by the same provider. A number of problems in service provision made the monitoring team concerned about the stability and competence of the provider, D&S. First, documentation of staff training for new staff could not be found, but later turned up. This indicated a disorganization in management of this type of information. Second, the individual missed work due to a variety of provider mistakes, such as the scheduling of doctor's appointments and other activities during his work time (which was only three hours per day, only two days per week). Third, two medications were not administered for six days at the beginning of January 2011. The individual was not injured or harmed in any way, but this was another indication of the provider's lack of thoroughness and attention to detail. Finally, the front yard of the home was covered in leaves. It was the only home in the neighborhood without a clean and neat front yard. The concern was not so much the content of any one of these four problems, but that there were so many in such a short period of time. The monitoring team recommends that SASSLC be very diligent in its post move monitoring of this provider. The PMM actively engaged in interactions with the individual, group home staff, and the provider agency case manager in a respectful and professional manner. For example, she did not hesitate to ask questions, require documentation, and schedule additional follow-up activities. This item, however, was not rated because the monitoring team did not have the opportunity to observe the conduct of an actual post move monitoring visit.	
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	This item does not receive a rating.	

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	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.		
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	SASSLC had not had any alternate discharges during the past six months.	Not rated

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	pursuant to a court order vacating the commitment order.		

Recommendations:

1. Resolve issue of questioned validity of history of pedophilia that was in a psychiatry note and transferred to the CLDP of Individual #192.

2. The PSPs for Individual #140 and Individual #150 were almost identical. Look into this and determine whether this was correct or was an error.

3. Implement new DADS policy on most integrated setting practices, when it is disseminated.

4. Complete the development of facility specific policies and procedures. Once completed, they should be reviewed and approved by DADS central office.

5. Provide competency-based training for QMRPs regarding how to facilitate and lead the new style PSP meetings.

6. Ensure that a thorough and meaningful discussion of optimistic optimal living characteristics occurs during the PSP meeting. Ensure that the optimistic living vision section of the PSP addresses the individual's needs for success in the community, not only his or her preferences.

7. Ensure that the opinions of professionals regarding referral are obtained and explicitly documented, separate from the preferences of the LAR and the team as a whole.

8. Properly and validly assess the preferences and decision making of individuals regarding most integrated settings.

9. Identify and address the obstacles to each individual's movement to the most integrated setting within the PSP for each individual.

10. The PSP document should also:
    a. reflect the level of intensity of discussion that occurred at the meeting,
    b. refer the reader of the PSP to appropriate assessments where appropriate to do so,
    c. include a brief paragraph about the individual's history, and
    d. include an explicit statement regarding how the individual was assessed for placement.

11. Update the facility's tool for monitoring the PSP meeting so that it is in line with the new style PSP meeting and so that it contains monitoring of the discussion of the most integrated setting/optimistic living vision.

12. 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 T1f.

13. Create a correct and thorough lists of individuals who
    a. have requested to move, but have not been referred, and
    b. would be referred except for the preference of the individual's LAR. This list should be for individuals who can, as well as those who cannot, express a preference.

14. Ensure that training objectives are related to community living and to any identified obstacles. For those individuals who are referred, a larger set of training objectives should be considered.

15. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g.

16. Determine desired outcomes and assess the effectiveness of educational activities, including the provider presentations, MRA trainings, the CLOIP process, and community tours.

17. Consider the comments given in section T1c regarding the new CLDP form, including (a) add psychiatry to the list of assessments, (b) reword or remove the comment on page 12 regarding action plans, and (c) include the standard items from page 6 in the pre-move list on page 23.

18. Use an approved checklist to indicate that all required assessments were completed and submitted within the required timelines of this provision.

19. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Ensure that a wide range of all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
    b. Define each support in observable and measureable terms.
    c. Define the manner in which the presence of each support will be verified.
    d. Include a criterion along with the evidence required for each support.

20. Consider revising the post move monitoring form as per the comments in T2a, regarding (a) making more room for comments, (b) providing comments in a cumulative manner across the three visits, (c) including a yes/no/na column, and (d) specifying evidence <u>and</u> criterion for each support.

The following are offered as additional suggestions to the facility:

21. DADS should continue to provide feedback and suggestions on the facility's CLDPs to the APC. In addition, consider creating a metric to measure the quality of the CLDPs and consider creating a criterion to indicate that the facility has mastered CLDPs. This might then result in less frequent reviews of CLDPs eventually being necessary.

22. Complete the task of modifying the monitoring teams' checklist tools to be more useful to the APC and PMM.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o Human Rights Committee (HRC) meeting minutes 8/1/10 – 10/30/10 o List of individuals for whom an LAR had been obtained since 8/1/10 o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans for: • Individual #276, Individual #234, Individual #86, Individual #298, Individual #150, Individual #304, Individual #298, Individual #250, Individual #254, Individual #188, Individual #327, Individual #7, Individual #342, Individual #284, Individual #64, Individual #333, Individual #253, and Individual #349. Interviews and Meetings Held: o Lawrence Algueseva, QE Program Auditor Observations Conducted: o Observations at all residences and day programs o Human Rights Committee Meeting 2/10/11 o Self-Advocacy Meeting o Annual PSP meeting for: • Individual #201, and Individual #302
	Facility Self-Assessment: The facility's POI indicated that the facility would begin meeting with LAR providers in the area and begin recruiting efforts for the Guardianship Committee in December 2010. They had assigned a rating of noncompliance to all items in this provision and were waiting on the new state policy to address consent and guardianship issues. The monitoring team agreed with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: Since SASSLC did not indicate it was in compliance with any of the provisions of this section, and particularly since it indicated it was waiting on the final statewide policy and training before taking most actions, the monitoring team reviewed a small sample of documents in order to be able to assess progress, if any, from the previous review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. Comments are as follows: • Provision item U1 was determined to be in noncompliance. The facility did not maintain a

	prioritized list of individuals needing an LAR. Not all PSTs were adequately addressing the need for an LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility was not actively pursuing guardianship for individuals at SASSLC. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had an active Human Rights Committee in place to review restrictions requested by the PST.

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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.	SASSLC did not have a policy in place for developing and maintaining 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. The state developed a draft policy to address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it plans to take action in these areas once the policy was finalized. The facility had appointed a new rights officer since the last monitoring visit, but he had recently resigned leaving a vacancy in that position again. Another new rights officer was appointed the week of the monitoring visit. This staff member will have the responsibility to develop a process to meet compliance with provisions described in Section U. At the time of the monitoring visit, the facility had not begun to establish a list of individuals with need for an LAR or advocate. In 18 PSPs reviewed, there were 10 individuals (56%) who did not have guardians. There was at least minimal discussion of the individualized need for an LAR in five (50%) of the 10 PSPs for individuals who did not have guardians. Examples included: • Individual #276 did not have an LAR or advocate. There was no indication that the team had discussed the need for guardianship or her ability to give informed consent. She had informed the team that she wanted to live and work in the community. The team decided that she was "not ready" for community placement even though she had not been adjudicated incompetent to make that decision and there was no discussion regarding her ability to make an informed decision regarding appropriate placement. Her rights assessment completed on 12/17/09 indicated that the team agreed that she was unable to give informed consent for medical decisions, programmatic decisions, financial decisions, restrictive/intrusive practices, and release of her records based on her PALS assessment. On 7/8/10, the Human Right Committee approved a restriction for her to not be able to have "private meetings and visitation" with her friend who did not live at SASSLC. According to the justification presented to the HRC, her friend gave her food and money to buy snacks that were not on her weight loss	Noncompliance

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		diet. The individual was provided with an opportunity to give input on this decision. She stated that this friend was her only visitor and she would like to continue to have visitations with her. There was no indication that the team considered a least restrictive alternative that would allow the individual to continue her relationship with her friend. • Individual #234 did not have an LAR. The PSP noted that her niece served as an advocate. The team discussed her ability to provide informed consent and determined that she did not have the ability to make informed decisions in a number of areas including freedom of movement, freedom of choice, money management, and giving and/or withdrawing informed consent. There was no indication that a referral had been made for guardianship. • Individual #150 did not have an LAR. In the living options discussion section of his PSP, it was noted that he had the ability to articulate his preferences. The relationship section noted that "his sister is involved, but not his guardian, and gives informed consent in all areas." His PSP further stated that his rights were restricted in freedom of movement, money/funds, and consent. His rights assessment indicated that he did not need an advocate because he advocated for himself along with the team and his sister. The rights assessment did indicate that he was unable to give informed consent. There was no record of discussion in the PSP regarding the need for guardianship due to his inability to give informed consent. • Individual #250's PSP indicated that he did not have an LAR, but that his sister was his advocate. The PSP did not reflect discussion regarding his ability to offer informed consent or the need for guardianship. • Individual #254's PSP did not address guardianship. The PSP stated that the plan "was developed by the individual, his guardian, and his team." There was no other mention of his guardian or guardianship in the plan. The PST signature sheet did not include a guardian's signature. • Individual #188 did not have an LAR. His PSP indicated that his mother was his advocate. It further indicated that the team had mailed guardianship information to his mother. His living option discussions section indicated that the individual was aware of community living options and he would prefer to live in a small group home. It further stated, "However, his mother prefers that he continues to live in his current placement." The CLOIP MRA "agreed with his mother's request" to keep his residence at SASSLC. There was no indication that the team had discussed his need for guardianship. • Individual #7 did not have an LAR. The PSP indicated that her mother was her advocate. There was no discussion in her PSP regarding her ability to make informed decisions or her need for an LAR. Her rights assessment did not indicate that information about the guardianship process had been shared with	

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		her mother. It further indicated that she was unable to give informed consent based on assessments and the PST annual review process. • Individual #284 did not have an LAR. Her PSP indicated that her sister was her advocate. Her PSP reflected that her rights assessment indicated that she was not able to give informed consent in the areas of making choices regarding food/drink, holding and managing money, and restraint usage. The PSP stated that her family had opted not to pursue guardianship, but her sister served as her advocate. The team determined that a referral to the SSLC Guardianship Coordinator was not applicable. • Individual #64 did not have an LAR. Her PSP indicated that her mother was her advocate. Her PSP summarized her rights assessment by noting that restrictions were recommended in the areas of money management, freedom of choice regarding food, dental sedation and restraint, and informed consent. Her PSP noted that information was shared with her mother regarding the guardianship process. • Individual #333 did not have an LAR. The PSP indicated that the team had determined not to make a referral to the SSLC Guardianship Coordinator because his grandmother advocated on his behalf. • Individual #349 did not have an LAR. The PSP indicated that the team had discussed guardianship and his ability to make informed decisions. His PSP noted that his mother and sister were his primary correspondents and they were not interested in pursuing guardianship. The PSP went on to list areas in which he had rights restrictions including: money management, giving and withdrawing informed consent, dental sedation and restraints, and making choices in regards to food/drink items. There is concern that the facility is routinely restricting basic rights of individuals living at SASSLC with no discussion regarding the individual's ability to give informed consent or determination of the need for an LAR. The facility was not in compliance with this provision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain	SASSLC did not have policy or procedure established to implement this provision item. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. According to documentation provided to the monitoring team, there was one individual at the facility who had obtained a guardian since 8/1/10.	Noncompliance

#	Provision	Assessment of Status	Compliance
	LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility did have some rights protections in place including an assistant ombudsman housed at the facility and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at SASSLC. The HRC, chaired by the rights officer, included a parent representative, an individual living at the facility, the facility chaplain, and facility staff from various disciplines. There was also a self-advocacy group on campus. The monitoring team attended the self-advocacy meeting held the week of the monitoring visit. The group was led by the rights officer and encouraged individuals to begin advocating for themselves. See sections E and T of this report for more discussion around self-advocacy. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals. The facility was not in compliance with this provision.	

Recommendations:

1. Develop a prioritized list of individuals in need of an LAR.
2. Develop a list of LAR providers in the area.
3. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR.
4. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming an LAR.
5. 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.
6. Continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.
7. Ensure that any restriction of rights for an individual is approved through the Human Rights Committee approval process.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o Organizational chart, July 2010 o SASSLC policy list, two pages, not dated o List of typical meetings that occurred at SASSLC o SASSLC POI, December 2010 o SASSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/7/11 o Table of contents for the active record and the individual notebook o Table of contents for the master record, dated 7/5/10 o List of all staff responsible for management of unified records o Materials used and signature attendance sheets for refresher training done by URC for home managers, 11/16/10, 11/19/10 o Description of how documents flow from completion to filing in the record o Description of how reviews of unified records are conducted by the URC o Ten completed unified record reviews, November 2010 and December 2010 o Documentation of follow-up activities to unified record reviews for five reviews, December 2010 o Description of how the facility implements and assesses implementation of provision item V4 regarding the use of records to make decisions regarding service provision: by doing an interview with PST members after the PST meeting o Completed staff questionnaires regarding the unified records, one page form, 34 completed, December 2010 o Completed brief verbal questionnaire of PST members following annual PSP meeting, seven completed, December 2010 and January 2011 o Email regarding individual notebooks from Becky McPherson to Janet Prince Page, 12/9/10 o Active records of many individuals who lived at SASSLC during observations in residences o Review of active records and/or individual notebooks of: • Individual #315, Individual #47, Individual #1, Individual #3, Individual #180 o Review of master records of: • Individual #255, Individual #43 o 20 individual active records listed in section M <u>Interviews and Meetings Held</u>: o Janet Prince Page, RHIT, Coordinator of Medical Records o Noemi Cardenas, Unified Records Coordinator o Tamara Neal, Records Clerk

	o Moneke Tyner, Settlement Agreement Coordinator o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Numerous staff and clinicians during observations in residences Observations Conducted: o Records storage areas in residences o Overflow and master records storage area
	Facility Self-Assessment: The facility's self-assessment, called the POI, was submitted to the monitoring team. The POI was revised since the last onsite review. The new version was shorter and more likely to be useful to the facility. It listed the four provision items, what the facility did or planned to do for each provision item, and actions it had taken towards addressing five of the recommendations made in the previous monitoring report. SASSLC self-rated one provision (V1) as being in substantial compliance and the other three as being in noncompliance. The facility had made a lot of progress in its recordkeeping practices and in its work towards achieving substantial compliance with this provision. The monitoring team wishes to acknowledge these efforts. As indicated below, however, the monitoring team did not agree with this rating for V1 because more work needs to be done to achieve substantial compliance. Even so, it is very likely that SASSLC will do so in the near future. The monitoring team agreed with the facility's self-ratings for the other three provision items. Note, however, that progress was also occurring in those three provisions.
	Summary of Monitor's Assessment: Overall, SASSLC had made a lot of progress towards achieving substantial compliance with the items of this provision. Moreover, unified records coordinator and the coordinator of consumer records were responsive to many of the recommendations and suggestions made in the previous monitoring report. The unified records consisted of a multi-volume active record, an individual notebook, the beginnings of a master record of historical and legal documents, and an overflow record of thinned and purged materials. The new records followed the state's policy. A facility-specific policy was written and was submitted to DADS central office for review and approval. Training and refresher sessions were provided to staff and managers. Since the last review, all of the active records had been converted to the new format. This was a large project that was overseen by the unified records coordinator and implemented primarily by the home records clerks. The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. The nursing section, however, was very large and consideration should be

	given to either reducing the size or subdividing so that it is more manageable for all staff. Also, it would be helpful for there to be information as to what consents are appropriate and required for each individual. Individual notebooks were also in place for each individual and those that were reviewed by the monitoring team appeared to contain most everything required by the facility's table of contents. Many managers and staff at the facility, however, reported that the notebooks were cumbersome, difficult to use, included duplicated materials, and required a lot of extra effort to carry and ensure that they did not get lost or misplaced. A master record existed for each individual, however, they were not consistent across individuals in terms of contents and set up. This should be corrected. The unified records coordinator conducted a survey of staff at all levels to learn more about their use and satisfaction with the new recordkeeping systems. Thirty-four responses were received across a range of positions at SASSLC (e.g., direct care staff, QMRPs, physician, nurses, OTs, psychologists). There were a variety of responses, including many that might be helpful to the facility as it works towards improving recordkeeping activities. A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of the active record and individual notebook were conducted by the unified records coordinator. She assessed whether each record in her sample contained all of the required documents as well as whether the documents were completed and filed according to the recordkeeping guidelines. She then followed-up on any deficiencies. This was a good process. The facility would benefit if the results of these reviews were summarized, included in the facility's QE program, and presented to senior management from time to time. SASSLC had taken an initial step towards determining whether and how the unified records were used in making treatment decisions as specified in provision V4. Specifically, recordkeeping staff conducted brief interviews with a sample of PST members following annual PST meetings. It is likely that, ultimately, a set of activities will be required in order to meet the requirements of V4.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for	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 Agreement. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was	Noncompliance

#	Provision	Assessment of Status	Compliance
	each individual consistent with the guidelines in Appendix D.	numbered 020.1, was dated 3/5/10, and was adopted in full by SASSLC. The facility-specific policy, numbered 300.10, "Consumer Record, Policies and Procedures Manual" had recently been sent to DADS central office for approval. SASSLC made considerable progress in meeting the items of this provision since the previous onsite review. At the time of this onsite monitoring review, all of the records at the facility had been converted, and every individual was reported to have an active record that was in the new format, as well as an individual notebook. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record (though see below) • Overflow files The creation of the new active records and individual notebooks was described by the URC as a joint effort between the URC and CCR and the home record clerks. All of the facility was converted over a short period of time. The URC conducted additional refresher training sessions for 16 home managers regarding recordkeeping policies and practices. The topics included a review of the DADS policy, information about the individual notebooks, and the record check out procedures. These 30- minute sessions were a good idea, especially given the many daily job requirements of the house management staff. The facility's records activities continued to be overseen by Janet Prince Page, Coordinator of Consumer Records (CCR), and Noemi Cardenas, Unified Records Coordinator (URC). They were professional, organized, and committed to doing whatever was necessary to meet the requirements of this provision. They were eager to receive feedback and suggestions and to make changes to recordkeeping practices if needed. In fact, they had engaged in a number of activities in direct response to recommendations and suggestions from the monitoring team during the previous onsite review and in the previous monitoring report. The URC had done a particularly nice job of advancing the facility's record review procedures (see section V3 below). In addition, there continued to be eight records clerks, one for each home (though one of these positions was vacant at the time of the onsite review). The records clerks had primary responsibility for managing and maintaining the records under the direction of the URC. For example, Tamara Neal, records clerk for 766 was interviewed by the monitoring team. She was in her position for about a year. Her responsibilities included filing, thinning of files, and inputting injury reports. She also did the upkeep on the individual notebooks, including moving documents from the individual notebook to the	

#	Provision	Assessment of Status	Compliance
		active record. Numerous positive comments about the home records clerks were found in the staff questionnaires and surveys that are discussed below. <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 constructed following the order of sections from the state's table of contents. The active records were divided across the binders in the same way for all individuals across the facility. The active records contained the state-provided table of contents. A review of observation notes and IPNs in the active records indicated that they appeared to be in good format, easy to read, and ordered correctly (note, this comment refers to the format and appearance of the observation notes and IPNs, not to their content; content is reviewed when applicable in the review of each provision of the Settlement Agreement in the other sections of this report). The unit directors reported that, in their opinion, implementation of the new active records had not had any negative impact on service provision. The active records of Individual #315, Individual #47, and Individual #1 were reviewed in some detail. Overall, they were well organized, neat, and consistent. Clear tabs separated consultation sections. • The contents of the consent section in Volume 1 differed across each individual. It would be helpful if there was some indication of what consents were required to be in each individual's active record. • The nursing sections of the active records were very large. The facility should undertake a review of what is in the nursing section and determine if it can be reduced or perhaps subdivided. <u>Individual notebooks</u> There were a variety of opinions about the individual notebooks at the facility. Even so, the notebooks were in place as per the state's policy. The individual notebooks reviewed by the monitoring team appeared to contain most everything required by the facility's table of contents. The unit directors reported that the individual notebooks, for their staff, were difficult to maintain and transport, especially given that the individuals moved around campus throughout the day. Another reported issue was that the books were cumbersome and sometimes competed with staff's ability to address behavioral incidents with individuals.	

#	Provision	Assessment of Status	Compliance
		Further, there were times when information was reportedly needed by clinical staff or by management, but was not available because it was in the individual notebook. An extra task each day was now for someone to do a walk-though of the day program building to ensure that no individual notebooks were left behind before the building closed down at around 5 p.m. Other comments about the individual notebooks were written in the staff survey conducted by the URC (see below) and should be reviewed by the facility. Further, the CCR reported that all of the facilities received an email from DADS central office that allowed facilities to determine whether or not to use individual notebooks at all, as long as the information that was in the notebooks was available to staff, that systems for documentation were in place, and that staff were knowledgeable. SASSLC was still determining how to proceed regarding individual notebooks at the time of the onsite review, but had taken some actions to move information from the individual notebooks into more centralized binders. For example, individual's bowel movement data sheets were moved from each individual notebook into a single binder per home. A performance improvement team might be warranted to address ways of improving the implementation of individual notebooks. The facility, however, should review with central office before discontinuing the use of individual notebooks because the Settlement Agreement specifically calls for their use in Appendix D. The individual notebooks of Individual #296, Individual #1, and Individual #3 were reviewed in some detail. Overall, they appeared to follow the standard format. Master records Master records were maintained by the CCR in her office. Two master records were reviewed in detail. One was for an individual who had lived at SASSLC for many years (Individual #43) and the other record was for an individual who had been placed at SASSLC more recently (Individual #255). The first individual's master record had only a few documents in it and an old cover sheet called a "purged list." An updated cover sheet was needed, items needed to be gathered, and items needed to be ordered correctly. For the second individual, the master file checklist needed to be updated, and a variety of required items had to be obtained (e.g., ICAP, trust fund information). SASSLC needs to go through all of the master records. They need to be updated, missing information needs to be obtained, and a new table of contents needs to be created and used. Overflow files	

#	Provision	Assessment of Status	Compliance
		Documents taken from each individual's records were stored and managed by the recordkeeping staff according to the record thinning schedule provided by the state. Staff Perspectives SASSLC, in response to a recommendation in the previous monitoring report, conducted a survey of staff regarding the active records and individual notebooks. It was conducted in December 2010 and 34 responses were received across a broad range of staff positions: 21 direct care staff, five QMRPs, one physician, three nurses, two OTs, and two psychologists. The questionnaire was very brief, which is always appreciated by those who are asked to respond. Although 34 staff represented a relatively small percentage of those who could have responded, the information may be useful to the facility as it moves forward with its development of recordkeeping practices. Overall, the results indicated a range of satisfaction, but more importantly pointed to some areas that the facility might explore further, including: • The use of reverse chronological ordering • Increasing the standard required for IPN entries • Changing the way individual notebooks are used Possible next steps for SASSLC include summarizing the results in graphic/tabular format along with a brief narrative of the most important findings, collaborating with other SSLCs and DADS central office in making any changes to recordkeeping practices, and forming a performance improvement team to focus on the use of the individual notebooks. The monitoring team also had the opportunity to talk with many staff across the campus regarding the active records and individual notebooks. • An LVN with eight years experience at SASSLC said that she liked the new active records and found it easier to find documents in them. • A direct care staff member who had worked at SASSLC for one year said the individual notebook allowed him to have information available to him if he needed it. He said that after an incident occurred with an individual, he found the individual notebook and recorded the required information. • A direct care staff member with three years experience at SASSLC said that the individual notebooks were hard to use and difficult to carry. She said that she was afraid of losing them, especially on outings and was concerned about confidential information that was in them. • An RN in one of the residences said that the active records were confusing for some staff and as a result some things got written in the wrong places. She said that these types of things were getting better and had improved since the active records were first begun.	

#	Provision	Assessment of Status	Compliance
		The URC and CCR reported that DADS central office was interested in hearing feedback and comments from the facilities regarding all aspects of recordkeeping practices, including the tables of content and guidelines. This was great to hear. SASSLC should take this opportunity to share what it has learned with the central office staff.	
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). Facility-specific policies are likely to be developed as DADS completes its set of statewide policies. Then, as noted throughout this report, the facility will need to ensure that any facility-specific policies are in line with the state policy and that approval is obtained from the DADS central office. The facility might benefit from having its own spreadsheet indicating which facility policies are related to which DADS policies.	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.	The SASSLC URC continued her excellent work in developing, modifying, and implementing a quality assurance review of five unified records each month. Ten reviews from November 2010 and December 2010 were reviewed by the monitoring team. The URC used two documents to review the active record and individual notebook. One was a modification of the monitoring team's checklist that referred to the many components of Appendix D of the Settlement Agreement. The second document was the table of content for the active record and individual notebook that were revised to include two columns: one in which she indicated whether the document was present, and the second in which she indicated whether the guidelines for that document were followed. For any item marked "no," she noted any required actions. Following this was a page listing additional specific findings from her review. The reviews appeared to be thorough; the URC reported that it took her approximately two hours to complete a review for a single individual. The information, however, seemed like it would be very useful to home record clerks, house managers, QMRPs, and others. One of the noteworthy aspects of the review was the URC's detail in reviewing the inclusion of SPO information. She looked to ensure that there was an SPO for every objective included in the PSP, and that each SPO matched the PSP and the PSP progress	Noncompliance

#	Provision	Assessment of Status	Compliance
		notes. In addition, she tracked completion of any deficiencies noted. She did so by making a second copy of her review and then handwriting on it to indicate when each item was completed (with a check mark) or if it was still in progress (noted with an X mark), as well a with a short comment, such as "Corrected 1-5-11" or "did not get a response from nursing." As a result of this work, SASSLC is close to achieving substantial compliance with this provision item. To do so will require inclusion of the master record in the record reviews. It will also require that there is some sort of summarizing of the data from the reviews in both a graphic/tabular format and in a short narrative that describes the highlights of the data. Moreover, the information should be tracked and trended over time and included in the facility's QE program. The information should include, for example, number of reviews conducted, number of deficiencies and number of outstanding corrections.	
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.	SASSLC had taken a first step towards addressing this provision item. The step was a direct response to the monitoring team's suggestion during the previous onsite review that the CCR and URC try to find out how PST members use the unified record to make treatment decisions. The CCR conducted short verbal interviews of one or two PST members following one or two PSP meetings each month to find out how they use the record. The interview included 10 questions and was done either in person or on the phone; the idea being to make it easy for the interviewee. Seven completed forms were reviewed by the monitoring team and, although not much useful information was obtained, it represented a good starting point. Moreover, the DADS central office was adapting this for use at all the facilities. Another variation of this would be to perhaps ask QAQI Council members to describe how each of their departments uses the records as per the requirements of this provision item. The answers might provide some direction to the CCR and URC. These activities, however, are just one or two of a number of actions that each facility will need to take towards meeting this provision. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the	Noncompliance

#	Provision	Assessment of Status	Compliance
		facility to address in meeting the requirements of this provision item. • At the PSP meeting for Individual #180, the RN looked at her active record in regards to constipation and medication, but did not then contribute any new information to the meeting. • At the CLDP meeting for Individual #1, the psychiatrist looked through the active record when referring to his own summaries of the individual's condition and status. • In over 50% of homes observed, individual notebooks were located in locked rooms. Therefore, their usefulness for data collection and reference of plans by direct care staff was greatly reduced (see K4 for details). • Individual notebooks were frequently found in record rooms or were located in the residence after the individual had left for other activities. The individual notebooks were locked up in the Medical Record rooms in some homes so were not readily available for use. In one case, it took a staff member more than five minutes to locate the book when asked. • Information on health risks, particularly aspiration risk, monitor for signs and symptoms of illness such as diabetes mellitus, and detailed instructions on positioning options were not available in notebooks for several individuals, including Individual #218, Individual #37and Individual #300. • In all three observed psychiatric clinic encounters, the individuals record was available and the physician was actively reviewing documents. Additionally, the psychiatrist had the record during the PST observation and was systematically reviewing the record and documenting during that encounter.	

Recommendations:

1. Indicate what consents should be in the consent section of each individual's active record.
2. Consider reducing the size of nursing section of the active record.
3. Address the many problems regarding implementation and use of individual notebooks.
4. Create a complete master record for each individual.
5. Provide feedback and suggestions to DADS central office as indicated in V1.
6. Complete the development of policies as described in provision item V2.
7. Create a spreadsheet showing how facility-specific policies relate to DADS policies.

8. Include the master record in quality assurance reviews.

9. Incorporate recordkeeping activities into the facility's quality enhancement program, including ensuring the data collected by the recordkeeping staff during their record audits are included in the QE program.

10. Summarize and report on quality assurance review findings; include the information in the facility's QE program.

11. Ensure that any needs or problems identified in the record audits are corrected.

12. Ensure records are used in making care, medical treatment, and training decisions. Determine a way to assess whether or not this is occurring.

The following are offered as additional suggestions to the facility:

13. DADS central office should consider whether or not to standardize the table of contents for the master records across SSLCs.

14. Use the information gathered from the staff survey on the use of records at the facility.

1. Determine if the Settlement Agreement allows for discontinuation of individual notebooks.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ASAP	As Soon As Possible
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 Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BS	Bachelor of Science
BSC	Behavior Support Committee
BSP	Behavior Support Plan
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Criminal Background Check
CBC	Complete Blood Count

CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCR	Coordinator of Consumer Records
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
CXR	Chest X-Ray
DADS	Texas Department of Aging and Disability Services
DARS	Texas Department of Assistive and Rehabilitative Services
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
e.g.	exempli gratia (For Example)
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMS	Emergency Medical Service
ENT	Ear, Nose, Throat
EPS	Extra Pyramidal Syndrome
ER	Emergency Room
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FSPI	Facility Support Performance Indicators

FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Grams
H	Hour
HCG	Health Care Guidelines
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HST	Health Status Team
HTN	Hypertension
IC	Infection Control
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
IMRT	Incident Management Review Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
KUB	Kidney, Ureter, Bladder
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LFT	Liver Function Test
LOD	Living Options Discussion
LOS	Level of Supervision
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBS	Modified Barium Swallow
MD	Medical Doctor
MERC	Medication Error Review Committee

MG	Milligrams
MH	Mental Health
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
NA	Not Applicable
NAR	Nurse Aide Registry
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NPO	Nil Per Os (nothing by mouth)
OCD	Obsessive Compulsive Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
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
PO	By Mouth (per os)
POI	Plan of Improvement
PPD	Purified Protein Derivative (Mantoux Text)

PPI	Proton Pump Inhibitor
PR	Peer Review
PRN	Pro Re Nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTA	Physical Therapy Assistant
QA	Quality Assurance
QE	Quality Enhancement
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDRR	Quarterly Drug Regimen Review
QMRP	Qualified Mental Retardation Professional
R	Respirations
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SASSLC	San Antonio State Supported Living Center
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
T	Temperature
TB	Tuberculosis
TCID	Texas Center for Infectious Diseases
TMax	Time Maximum
TSH	Thyroid Stimulating Hormone
UIR	Unusual Incident Report
URC	Unified Records Coordinator
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study

VNS	Vagus nerve stimulation
XR	Extended Release